Research Design Plan for the Evaluation of the Healthy Indiana Plan

Final Evaluation Design Plan

December 22, 2009

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Policy Research, Inc.

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I. INTRODUCTION

A. Background

The Healthy Indiana Plan (HIP) was created to reduce the number of uninsured Hoosiers, offering coverage that requires enrollee contributions, promotes preventive health care, and encourages enrollees to be responsible health care consumers. Launching HIP was a high priority for Governor Mitch Daniels, state legislators, and the Family and Social Services Administration (FSSA), who worked together in 2007 to pass a bill authorizing the program and to obtain needed federal waivers. From the time the legislation passed, it took only eight months until enrollment in the program began. As of July 31, 2009, 46,206 adults were enrolled in HIP.

HIP provides health insurance coverage to uninsured working-age adults with incomes under 200 percent of the federal poverty level (FPL). The program aims to promote personal responsibility by providing a high-deductible health plan for enrollees and incorporating the concept of health savings accounts in the form of Personal Wellness and Responsibility (POWER) accounts [1]. Enrollees must make monthly contributions to their POWER accounts, and POWER account funds are used to pay for services subject to the deductible.[1] When funds are not exhausted, POWER account contributions can be rolled over to the following year to reduce required contributions, provided enrollees obtain preventive services that are predetermined for each individual based on age, gender, and personal disease history.[2] Enrollees receive services through contracts with one of two private insurers or through an Enhanced Services Plan (ESP). Key design features of HIP are listed in Figure I.1.

HIP operates under the authority of an 1115 Medicaid demonstration waiver granted by the Centers for Medicare & Medicaid Services (CMS) to the Office of Medicaid Policy and Planning (OMPP) within FSSA. The 1115 demonstration waiver was approved by CMS on December 14, 2007 and program operations began on January 1, 2008. The demonstration waiver is set to expire on December 31, 2012. States are required to evaluate their 1115 Medicaid demonstration waivers and, to fulfill this requirement, Indiana contracted with Mathematica Policy Research and Cindy Collier Consulting, LLC, a subcontractor to Mathematica®, in March 2009 to conduct an independent and comprehensive evaluation of HIP. This report sets forth a detailed description of the evaluation Mathematica will conduct. The basis of Mathematica's design plan is the Evaluation Plan Indiana submitted to CMS on September 12, 2008. Mathematica's plan builds on and enhances the State's early plan.

[1] The HIP benefit package includes "first dollar" coverage (no deductible and no co-payments) for at least $500 in preventive services. During the first year of program operations, both participating plans chose to offer unlimited coverage of preventive services [2].

[2] To be eligible for a POWER account rollover in 2008, all enrollees were required to have an annual physical exam. In addition, beginning in 2009, blood glucose screening and up-to-date Tetanus-Diphtheria booster shots are required for all enrollees; flu shots and colonoscopy are required for all enrollees ages 50 through 64; pap smears are required for all women; mammograms are required for women ages 35 through 64; Chlamydia screening is required for women ages 19 through 25; and cholesterol testing is required annually or as required by a person's specific disease history for men ages 35 through 64 and women ages 45 through 64 [2].

Figure I.1. HIP Eligibility and Program Features [3]

HIP eligibility requirements:

- Adults ages 19-64, including caretakers of children and non-caretakers (childless adults)
- Uninsured for six months prior to enrollment
- No access to employer-sponsored coverage
- Incomes less than 200 percent of FPL and not eligible for Medicaid or Medicare coverage

HIP benefits and financing features:

- Coverage for all Medicaid-covered services except pregnancy-related care, dental care, and vision services
- Deductible of $1,100 funded through the POWER account
- POWER account requirements and features include:
  - Enrollee monthly contributions are set on a sliding scale not to exceed 5 percent of income, with a maximum of $1,100 per year; the State contributes the remainder
  - Preventive service use is fully covered up to $500, without reductions in POWER account balances or co-payments
  - Unused POWER account funds reduce the next year's required monthly contributions, if enrollees obtain required preventive services
  - Employers may contribute up to 50 percent of the member's required contribution
- Coverage through choice of two contracted capitated health plans, MDwise or Anthem
- Enrollees with certain high-risk conditions such as internal cancers, HIV/AIDS, hemophilia, aplastic anemia, and organ transplants are covered under the Enhanced Services Plan (ESP), administered by the Indiana Comprehensive Health Insurance Association (ICHIA)
- Health care services are reimbursed based on Medicare rates, or 130 percent of Medicaid rates for non-Medicare-covered services
- Enrollment is capped at 34,000 for non-caretaker adults. A waiting list is maintained when the cao is reached
- Plans to implement a buy-in program for adults with incomes exceeding 200 percent FPL—adults pay the full cost of the program without state subsidy for the POWER account or premium

B. RESEARCH ISSUES THE EVALUATION WILL ADDRESS

Indiana established seven goals for HIP and Mathematica's evaluation will assess outcomes and achievement of each goal. The goals are:

1. Reduce the number of uninsured low-income Hoosiers
2. Improve access to health care services for low-income Hoosiers
3. Promote personal health responsibility and value-based decision making
4. Promote primary preventive health care
5. Prevent chronic disease progression with secondary preventive care
6. Provide appropriate and quality-based health care services
7. Assure state fiscal responsibility and efficient management of the program

We use these goals to structure the discussion of our analysis plans.

C. CHALLENGES

As of the writing of this evaluation design report, there are two major challenges to the evaluation. The first is that HIP itself is in flux, with program features changing as the program matures, including how the plans are paid by the State, how providers are paid by plans, and which members are enrolled in the ESP program. Although it is important for our implementation analysis to document and follow these changes, several analyses should only be conducted when key program components are finalized. Such program design changes (for example, changes in risk arrangements) make it difficult to attribute program effects, particularly when multiple changes occur at the same time. As evaluators, we will have to take all program design changes into account as we structure our analyses of data and, more importantly, interpret the results. When possible, we will control for key program design changes to isolate the effects of the change from the overall program effects.

The second known challenge to the evaluation is the availability and quality of encounter data. Encounter data that the plans are submitting to OMPP will underpin many of our planned analyses, particularly those that assess HIP's effects on personal responsibility, primary preventive care, and prevention of secondary disease progression. While the health plans have recently resolved early challenges with data submission formats, interviewees reported that first year data submitted by one plan, MDwise, appeared incomplete [2]. At the State's request, MDwise made changes to its subcontracting arrangements in the summer of 2009 to address this issues and the changes are expected to improve the State's ability to monitor the program [2].

It remains unclear whether complete encounter data from the first year of program operations will ever be available for the evaluation. If these data eventually become available, then the challenge posed by the missing records will be resolved. If these data are permanently lost to the evaluation, then some analyses will either be limited to Anthem members (and perhaps

ESP members) or not include the period during which the claims and encounter data are incomplete. Should we have to limit our analyses to only one plan, then we will also analyze enrollment biases to understand if Anthem and MDwise members are systematically different from one another and we will need to determine differences in the plans' approach to managing care. If Anthem enrollees have higher health care costs than those in MDwise, either because they have more chronic conditions, the plan's approach to managing care is more costly, or Anthem members are less likely to seek care outside the health plan, then analyses based on only data from Anthem will overstate the prevalence of chronic conditions and the level of health care costs for HIP overall. These analyses will be required to assess the generalizability of the Anthem-only results to HIP overall.

MDwise and Anthem also expressed concern that encounter data may not accurately reflect preventive service use, especially for services such as blood glucose screening or flu shots that members may receive freely during community promotional events or at their place of employment. This issue is commonly encountered by studies based on Medicaid administrative data. Many of our analyses will focus on services less likely to be obtained outside Anthem or MDwise, including clinical services such as mammograms, pap smears, and colonoscopies.

D. CONTENT OF THIS REPORT

The rest of this report describes our approach to evaluating HIP and determining the extent to which the program has achieved its goals. Chapter II is an overview of the principal data sources we will use to conduct our work. While we will rely on secondary data sources such as program eligibility records and claims and encounter data, we will collect primary data through key informant interviews, a survey of HIP enrollees, and telephone interviews with providers. Chapter III describes the evaluation plan, and is divided into seven sections, each focused on one of the seven HIP program goals. Chapter IV provides a timeline of evaluation activities, and describes our plans for reporting evaluation findings.

II. OVERVIEW OF THE MAJOR DATA SOURCES

This chapter describes the types of data we plan to use to evaluate HIP. The evaluation will rely on six major data sources:

1. Key informant interviews
2. A survey of new and established HIP enrollees
3. Telephone interviews with safety net hospitals and other providers serving HIP enrollees
4. Claims and encounter data submitted by Anthem, MDwise, and the ESP and claims and encounter data for working-age adults in the Hoosier Healthwise (HHW) and Care Select programs
5. Administrative records, including application, eligibility, and POWER account records and health plan documents and reports such as provider lists, plan financial information, and other plan data
6. State-level data collected by the Census Bureau and by other national information sources

1. Key Informant Interviews

Key informant interviews will be a primary data source for our understanding of how HIP is being implemented and how the program changes as circumstances change. We will conduct key informant interviews through an in-person site visit during the first year of our contract, and through telephone interviews in subsequent years.

The first set of key informant interviews was completed in July 2009. Mathematica and Cindy Collier Consulting interviewed 49 "key informants" or stakeholders in the HIP program from May through July 2009. Two interview teams, consisting of two interviewers on each team, conducted a two-day site visit to Indianapolis on May 27 and 28, 2009. We also conducted several interviews by telephone prior to and after the site visit. Interviewees included individuals involved in the program's development and daily implementation. These individuals included staff from OMPP and the health plans; representatives from consumer advocacy groups and professional groups, such as the state medical and hospital associations; and political supporters, such as the governor and selected state legislators. Interviews also included individuals involved in the creation of HIP who are no longer involved with the program [2].

In subsequent years, we will conduct key informant interviews by phone. We will identify key issues to discuss during these interviews through continuous monitoring of HIP, including information gathered from our regularly scheduled calls with our OMPP project officer. We will also monitor the publicity the program receives and key websites including those maintained by OMPP and the health plans. Our ongoing monitoring will include reviewing HIP dashboard data as they become available and information Milliman produces in its role as the program's actuary.

While the first set of key informant interviews focused primarily on initial implementation issues, we expect that in later years our interviews will focus on program refinements, financing issues, and long-term stability, as well as political and economic changes that arise.

Information gathered will be used to help us understand and describe the implementation of HIP and its evolution. We will also use what we learn as we interpret findings from other components of the evaluation, including the analyses of enrollee outcomes, based on survey and administrative data, and provider outcomes, based on telephone interviews and program and health plan documents.

2. Survey of HIP Enrollees

During 2010 we will conduct a survey with 1,600 HIP enrollees. Using the eligibility records we abstract from Indiana's Medicaid information management system, we will draw a stratified random sample of 2,133 cases, in which half will be new participants (those in their first month of HIP coverage when the survey sample is drawn) and half will be established participants (those continuously enrolled at least 13 months in HIP when the survey sample is drawn). The survey will cover such topics as:

- **Recent history of health insurance coverage**, to distinguish chronically uninsured enrollees from other enrollees (new enrollees only and how long they were uninsured)
- **Health status overall**, including both physical and mental health status, chronic conditions, receipt of disability benefits, and work-related health limitations
- **Access to care** such as having a personal doctor during the previous six months (for new enrollees this question will refer to the six months before enrollment)
- **Utilization of care**, including preventive and specialty care, prescription medications and emergency room visits during the previous 6 or 12 months (for new enrollees, this question will refer to the period before enrollment)
- **Unmet health care needs** and **barriers to utilization** of health care (for new enrollees, this question will refer to the six months before enrollment)
- **Satisfaction** with HIP
- **POWER accounts**, including knowledge of how the account works and program incentives
- **Demographic characteristics** such as gender, age, race/ethnicity, education, household size, household income, and employment status

The draft survey instrument is included in Appendix A. Many of these items have been drawn from existing survey instruments, including the Behavioral Risk Factor Surveillance Survey (BRFSS). The instrument has been designed for telephone administration and Mathematica's computer-assisted telephone interview (CATI) system. It is designed to take about 30 minutes to complete and will be offered in English only. We anticipate completing

surveys with 1,600 participants (800 new and 800 established) and achieving a 75 percent response rate. We will offer an incentive of $20 to encourage participation.

As part of the instrument design process, we will conduct a pretest in November 2009. The purpose of the pretest is to: (1) identify any items that respondents find confusing or particularly difficult and make appropriate modifications to the script, the question wording, or interviewer training materials; (2) test the timing of the draft instrument to ensure it falls within the anticipated length; (3) identify any implementation issues that would be useful to cover during the interviewer training (such as responses to frequently asked questions, refusal-aversion responses, or issues that arise in the mock interviews). The pretest will include completing interviews with 12 HIP enrollees using a hard-copy version of the questionnaire. Using a hardcopy for the pretest will enable us to make revisions to the instrument in the most cost-efficient manner possible, before we begin programming our CATI system.

a. Sampling

Starting in February 2010, Mathematica will abstract the eligibility records for every person enrolled in HIP in the previous month (January 2010 or the earliest month for which records are available). Once we have these records, we will select those for all new and established enrollees. Candidates for the survey will be:

- **New enrollees** who will be in their first month of program participation when the survey sample is drawn (for those required to contribute to their POWER account, it will be the first month they make their contribution)
- **Established enrollees** who will be starting a second year of HIP coverage (continuously enrolled) when the survey sample is drawn

In both instances, although the samples are being drawn when the enrollees are entering either their first (new enrollees) or thirteenth (established enrollees) month, because of the nature of telephone surveying, enrollees may be interviewed up to 4 months after the sample is drawn. Thus, new enrollees may have up to 4 months of HIP enrollment experience, while established enrollees may have up to 17 months of HIP enrollment experience.

We will also include a second level of stratification. Because HIP has had to impose a cap on the number of non-caretakers enrolling in the program, we will need to take extra steps to make sure we obtain adequate numbers of non-caretaker enrollees in our sample. The enrollment of non-caretakers is capped at 34,000 and the program closed enrollment to this group in March 2009. As of the date of this report, enrollment of non-caretakers is open for a very short period of time, for up to 5,000 enrollees, following which it will be closed indefinitely. When enrollment is open to this group will be determined by the State and we will work with OMPP to identify a strategy that will ensure the survey is able to interview adequate numbers of both new and established non-caretakers.

We will draw a random sample of enrollees from each of these four groups (new caretakers, established caretakers, new non-caretakers, and established non-caretakers). We will repeat the process of selecting eligibility records, stratifying them into the four groups of enrollees (as feasible), and draw random samples of each group for five consecutive months. Sampling over a

period of several months is advantageous because it reduces the likelihood that the differences across new and established enrollees are due to seasonal variations, outreach and enrollment activities, or other external events. We plan to abstract and draw samples from February through June 2010. Each monthly survey sample will consist of a stratified random sample of roughly 428 enrollee cases in equal proportions across the strata: 107 new caretakers, 107 established caretakers, 107 new non-caretakers, and 107 established non-caretakers. The number of cases selected each month will most likely change as we gain experience with the population and learn about response rates.

For this survey to be successful, we will need the most current contact information possible. For this reason, the files to be used for sample selection will be extracted one month before the release of each sample wave (during February through June of 2010). This schedule allows us enough time to select the sample and verify contact information while using the most recent information possible. When sampling records, we will use information on the enrollee's full enrollment history, including application dates; re-determination dates (if applicable); and demographic characteristics such as gender, age, race, ethnicity, and caretaker status. For contact and locating purposes, we will also use the enrollee's first and last name, current address and telephone number, date of birth, social security number (if available), and any alternate telephone numbers or contact information.

b. Computer-Assisted Telephone Interviewing

Interviews will begin in March 2010 and end six months later in September. Although we only sample enrollees for five months, our interviews will span a longer time period to allow us sufficient time to locate and obtain our targeted response rate. We will use CATI to administer the telephone survey. Web-based surveys are still not typically possible with low-income populations and CATI surveys provide several advantages over hard-copy questionnaires. These advantages include:

- The skip pattern logic of CATI questionnaires is fully computerized, so that interviewer choice and error in question branching is eliminated.
- The CATI program produces question word choices, including inserts and the randomization of response category order, for the interviewer.
- The program checks response code validity on closed-ended questions during the interview so that invalid codes cannot be entered into the data files.
- Acceptable ranges for continuous variables, such as age and dates, are checked during the interview.
- Consistency checking between related items is performed online, and questions with inconsistent entries are asked again to minimize interviewer entry and respondent error.
- The CATI program performs substantial editing during data collection, which nearly eliminates the need for data-retrieval calls.

Once the instrument is finalized and programmed, it will be rigorously tested to ensure the CATI program matches the programming specifications and follows all skip patterns, range checks, and pre-filled response items as intended.

c. Interviewer Training

Mathematica has a large, reliable staff of professionally trained interviewers and locators who are experts in obtaining quality survey data and high response rates from people with low incomes and/or education levels. We will staff this project with experienced interviewers who have interviewed low-income populations about health care issues.

Mathematica requires telephone interviewers to have project-specific training, in addition to the general training they receive upon hiring. During project-specific training, they will learn about the purpose of the HIP evaluation and how the data will be used. Training time will also be devoted to a discussion of the HIP population; procedures for ensuring that the designated sample member is reached; and practices for maintaining confidentiality of the data. Supervised, carefully scripted role-plays are incorporated into training so that interviewers will be familiar with the types of situations they might encounter. Interviewers also practice contact procedures, methods of gaining cooperation and avoiding refusals, and full administration of the CATI instrument. Survey Director Holly Matulewicz conducted the project-specific interviewer training in November 2009 for the interviewers assigned to complete the pretest interviews. She will conduct a second training in March 2010, just prior to the launch of full-scale data collection.

d. Contacting Sample Members

Data collection for the survey will take place from March through September of 2010. Although sampling will end in July, the actual field period when we are collecting data will run through September because some respondents may be difficult to locate and may not respond immediately to our request for an interview.

Mailings. To maximize our ability to make contact, we propose to send several mailings to sample members. Before any telephone contact, we will mail an advance letter, printed on HIP stationary so that recipients will be more likely to open and read it. The letter will describe the study and sponsor, introduce Mathematica, encourage participation, offer an incentive for completing the survey, emphasize confidentiality, and provide a toll-free number for sample members to call to schedule an appointment. Subsequent mailings will be sent to sample members depending upon the need and the issue. For example:

- If we are having difficulty contacting a person, we will send a postcard that other family members can read. The postcard will explicitly encourage family members to forward the card to the sample member so that he or she may contact Mathematica. The postcard will also mention the incentive and the general nature of the study, but will not give specifics.
- If we have what we believe is a valid address but are unable to obtain a telephone number because it is unlisted, we can mail a letter or postcard emphasizing that we have tried to reach the person but were unable to obtain the telephone number—and

request that he or she call us at our toll-free number. The incentive will be highlighted to encourage participation.

Telephone Contact. Interviewers will maintain a record of contacts for each case. They will use contact sheets to guide their interactions with respondents, so the data collection team will be able to track and monitor the number, frequency, and results of all contacts. The outcome of each attempted contact will be entered onto the contact sheet and filed according to the date and time when it should be retried.

We have found the following elements useful in reaching respondents and completing interviews:

- ***Scheduling Procedures.*** We will attempt all interviews according to optimal contact schedules, based on our extensive experience in similar studies, including dialing during daytime, evening, and weekend hours.
- ***Multiple Attempts.*** We will place a high limit on the number of telephone attempts to interview sample members. Although cases that appear to be "dead ends" will be withdrawn from active interviewing attempts, we will run them periodically against search databases for fresh leads and mail follow-up letters and postcards to all known addresses.
- ***Toll-Free Number.*** We will use a toll-free number for sample members to contact us with questions about the study, to schedule an appointment for an interview, or to complete an interview on-the-spot. This number will be included in our answering-machine script, in the advance letter, and in the postcards.
- ***Rapport.*** We will carefully train interviewers to establish rapport and positive interpersonal relationships, and to skillfully address anticipated questions or concerns of respondents.
- ***Overcoming Reluctance.*** Interviewers will be trained to emphasize the importance of the study with sample members and impress upon them that participating in the study is confidential and will not affect them or their enrollment in HIP adversely. Follow-up letters will be tailored to address any concerns and circumstances that come up during the initial calls. We will establish a toll-free telephone number and send letters to sample members with unpublished phone numbers urging them to call the toll-free number.

We anticipate calling respondents between 9 A.M. and 9 P.M. Eastern Standard Time, unless a sample member has requested an appointment outside those hours.

e. Maintaining the Sample and Avoiding Attrition

To minimize sample attrition and maximize data available for analysis, Mathematica will focus on increasing response, avoiding initial refusals, converting refusals into cooperation, and locating hard-to-find sample members (typically the greatest threat to sample maintenance).

Increasing Response. Obtaining a high response rate will ensure a sample that represents the experiences of HIP enrollees accurately, and provides the most robust estimates possible of program effects. To achieve our proposed response rate, we will offer a $20 incentive following the completion of an interview. Incentives are a cost-effective method for increasing survey response. They are particularly useful for sample members who (1) would otherwise require field follow-up, (2) may be reluctant to talk on the telephone, or (3) require significant locating beyond what can be accomplished by telephone. In the advance letter, we will highlight the survey's $20 incentive and will mail all survey respondents their check within four weeks of completing the interview.

Avoiding Refusals. Despite interviewers' best efforts, some sample members will refuse to participate. When this happens, interviewers will try to ascertain a reason for the refusal (for example, the respondent is too busy, not interested, does not believe in surveys, or does not want to talk about his or her health care issues), because having this knowledge makes us more effective at converting a refusal. In addition, each interviewer will have a list of anticipated frequently asked questions and refusal-aversion responses at his or her station. These suggested scripts help interviewers respond to sample members' questions and concerns and can serve as a tool to avert potential refusals.

Should a refusal occur, the interviewers will distinguish whether it was a "soft" or "hard refusal, because it may not be desirable or cost-efficient to try to convert hard refusals. These observations will be documented in detail on the contact sheet for the case. Examples of soft refusals include statements such as, "I'm too busy," or "I'm not interested." Hard refusals include statements such as, "Don't call me again," or "Take me off your list." Decisions about whether to follow up with an initial refusal will be made by supervisors on a case-by-case basis.

Converting Refusals. To convert refusals, Mathematica will send a letter to the sample member that attempts to persuade him or her to participate. The letter will be mailed about seven days after the initial refusal and will address the importance of the survey and the sample member's concerns, as well as mention the incentive payment. The goal is to encourage the sample member to call Mathematica to discuss participation in the study. About a week after the letter is mailed, a specially trained interviewer who is expert at gaining cooperation will call the sample member. The interviewer will address the sample member's reason for refusing, stress the importance of the survey, and encourage him or her to participate. If the sample member refuses a second time, we will cease all calls. We may send one more letter near the end of the field period with the toll-free number, but no follow-up call will be made after that letter is sent.

Locating Hard-to-Find Sample Members. Inadequate response rates are often the result of locating difficulties, rather than poor cooperation. We will begin locating as soon as we release the sample for interviewing, as all cases with incomplete telephone or address information will go through our searching procedures. Locating procedures will also be initiated when mail is returned with an invalid address. It is our experience that low-income populations can be quite mobile and some locating will be necessary even with fairly recent information. To make locating operations as cost-effective as possible, Mathematica will begin by checking with directory assistance (DA). If DA provides a new telephone number, we will call it directly and, if we reach the sample member, explain the survey to him or her before proceeding.

If we are unable to obtain a new telephone number from DA, we will continue our locating efforts by searching major national databases such as LexisNexis. Using LexisNexis, locators can search for sample cases matching by name or date of birth. Mathematica uses a range of other databases to supplement LexisNexis, including MetroNet system, DTec Search, and residential telephone listings available on the Internet. Each provides specialized capabilities for locating sample members, their spouses, relatives, and other contacts based on various names, addresses, telephone numbers, or dates of birth. The databases draw on telephone directories, credit bureaus, real estate transactions, magazine subscriptions, and other sources. The post office is another important source of locating information. If a letter is returned with a forwarding address, we will re-mail the letter with a note asking the sample member to call us to discuss the survey. We will also re-contact DA to see if there is a telephone number associated with the address. If these efforts do not lead us to the sample member, we may then ask OMPP, the HIP enrollment broker, or the HIP plans to help us by checking their records for any updated name, address, or telephone information. If the HIP enrollment broker or the HIP plans have concerns about privacy issues associated with sharing contact information for specific enrollees, then we will ask OMPP to collect this information on our behalf.

f. Ensuring the Collection of High Quality Data

Supervisors will monitor roughly 10 percent of all completed interviews by listening in and viewing the interviewers' screens while interviews are in progress. Interviewers are informed that they will be monitored but do not know when observations will take place. Monitoring interviews ensures that study procedures are being adhered to by interviewers, such as introducing the study clearly and encouraging participation, responding to sample member questions appropriately, reading questions exactly as written, recording responses accurately, and probing in a neutral non-biased manner. Any deviation from procedure is addressed directly after the monitoring session with the interviewer. It is also recorded in the monitoring system so that the interviewer will be monitored again to see if improvement in performance has been achieved.

g. Focus on Quality Control

Mathematica will build quality control (QC) measures into all phases of data collection, including CATI development, data collection, data coding and editing, and final file production. Examples of our QC procedures include:

- ***CATI Program.*** Check the logical paths of all questions and responses, that data write correctly to the database, that preloaded information is utilized correctly, that all internal range and logic edits are performed, and that screen wording is correct.
- ***Locating.*** Review the information we obtain from eligibility records; carefully train locators on procedures, especially confidentiality requirements; conduct periodic reviews of ongoing "difficult-to-locate" cases to ensure that locators are using all relevant locating sources; hold locator meetings and debriefings to discuss locating difficulties and share new ideas; and check nonresponse by respondent characteristics and increase efforts as indicated.
- ***Interviewer Quality Assurance.*** Provide comprehensive training to interviewers, test interviewers on their knowledge of the training materials, observe interactive role-

plays extensively, monitor 10 percent of all interviews, use memoranda to update training materials and procedures, meet with interviewers to discuss problems and issues and share ideas, and hold interviewer debriefings.

- ***Post-Survey Completion Editing.*** Check the data file against CATI edits, review all range and any edit overrides, check item tallies, check interviewer comments, and edit update procedures.
- ***Data File.*** Check file frequencies to ensure use of proper variable names, locations, length, type, and order; recheck after final merges; check documentation to ensure consistency; and check all derived variables and recodes.
- ***Documentation.*** Clearly label all files, contents, and locations, and verify that all study procedures have been documented.

As part of her role as Survey Director, Holly Matulewicz will coordinate with all members of the survey implementation team to ensure adherence to these protocols and standards and she will answer questions or resolve implementation issues on an on-going basis.

h. Sampling Weights

After the data files have been checked and cleaned, a sampling statistician will construct weights to adjust for the stratified sampling design and response rates. These weights will be used in our analyses so that, when possible, findings can be generalized to the overall population of HIP enrollees.

i. Assessment of Response Bias

Though we will do everything possible to ensure a high response rate, we will still assess the data to determine whether nonresponse biases our data in any particular way. This assessment will use basic demographic information available from the eligibility records we use to draw the samples. We anticipate this information will at least include gender, date of birth (for the calculation of age), and health plan (including enrollment in the ESP).

3. Survey of Safety Net and Other Providers

To assess the achievement of HIP's second goal, to improve access to health care services, we will study the financial effects of HIP on safety net hospitals and program effects on non-hospital providers. For this analysis, we will conduct telephone interviews with providers and review documents. Our methods will vary between safety net hospitals and non-hospital providers because of the differential effects HIP is likely to have on these two types of providers.

For telephone interviews with safety net hospitals, we will work with OMPP staff and the state hospital association to identify all safety net hospitals in the State. We understand that in 2007, Indiana had 14 safety net hospitals. Before we begin, we will get updated information from the state hospital association to verify the number receiving Disproportionate Share Hospital (DSH) funds each year. Once identified, we will request documentation that indicates the levels of DSH funding these hospitals received before HIP was implemented (we will also seek information about pre-HIP levels of uncompensated care and charity care by hospital), as well as

after HIP began operations.[3] We will also seek other information such as HIP revenues by hospital.

Because of limited project resources, we do not expect to interview administrators at all safety net hospitals. We will select a sample that represents the range of Indiana's safety net hospitals in terms of size; levels of DSH funding, uncompensated care, total HIP inpatient days, and charity care; and geographic location.

Our interviews will focus on developing an understanding of:

- The financial impact of HIP and whether HIP revenues have adequately compensated for the diverted DSH funds
- Hospitals' experiences with plans paying Medicare rates (early interview data indicated that some hospitals, critical access hospitals in particular, had some issues regarding plan payments)
- Relationships between hospitals and the HIP health plans over time
- Role in HIP outreach or enrollment, if any

During the interviews, we will ask hospitals to provide any relevant documents that we were unable to obtain before the interviews. Ideally, we will obtain several years of financial reports to help us understand DSH payments, uncompensated care levels, and charity care rates before and after HIP implementation.

We will also conduct telephone interviews with providers and/or administrators of practices serving disproportionate numbers of HIP enrollees, including federally qualified health centers (FQHCs) and rural health centers (RHCs). To conduct this survey, we will use claims and encounter data and the provider tables available through the MedInsight portal.

It is our expectation that we will be able to sort claims by provider identification number, and then examine the frequency of provider identification number to identify those providers with the greatest number of claims. We expect that we will be able to further sort by procedure code, to ensure that we select primary medical provider visits (for example, using a general office visit code). Such a sorting should identify the primary medical providers serving the greatest number of HIP patients, whom we could then contact (obtaining contact information from the records or participating plans or through our state contacts). Given that we want to include some FQHC and RHC respondents, we will include at least the largest of these providers, selecting from those FQHCs and RHCs that have the greatest number of claims in the given time period (even if they are not the highest frequency overall in the claims).

[3] Hospitals report uncompensated and charity care information in their Medicare cost reports, which are public documents. However, because hospitals vary in their reporting of this information, we will want to obtain state and hospital association data, and data from the hospitals themselves to verify the cost reports.

As of the date of this report, we are uncertain of the quality of the provider ID numbers, and thus, unsure whether this approach to identifying providers will work as expected. If this strategy is not feasible, we would instead use a multi-pronged approach for identifying high-volume providers. First, we will try to work with the HIP health plans to have them identify primary medical providers with the greatest number of HIP patients. If that approach is not feasible, we would then approach the Indiana Primary Health Care Association, the Medical Society, as well as knowledgeable advocates, such as David Roos of Indiana Covering Kids and Families, to see if they could offer us assistance in identifying high-volume HIP providers. For example, the Indiana Primary Health Care Association might be able to identify high-volume FQHC and RHC HIP providers. Or, we might submit a list of topics to the Indiana Primary Health Care Association or Medical Society, and ask them to email the list to all their provider members; any providers who were interested in giving us input could contact us. Such approaches have proven fruitful in other Mathematica evaluations, and we would expect that one of these proposed avenues would enable us to reach high-volume HIP providers.

Provider/administrator interviews will provide key background and historical information on providers' roles in serving Medicaid, uninsured, and low-income working-age patients prior to HIP. Other topics we will explore with non-hospital providers will include:

- Challenge to participating in HIP
- HIP payment rates (similar to hospitals, early interview data indicated that some FQHCs experienced problems being paid Medicare rates by the plans)
- Adequacy of provider networks, particularly for specialty care
- Comparisons of HIP patients to adults covered by other forms of insurance (Medicaid, Medicare, private insurance) and those without insurance
- Administrative issues associated HIP

More detailed questions are presented in Chapter III, Section B in the analysis plans for program Goal 2, Improve Statewide Access to Health Care Services for Low-Income Hoosiers.

4. Claims and Encounter Data

The claims and encounter records that the health plans submit to the State will be a critical source of information about the health care utilization patterns of all HIP enrollees. Our analysis plans also include several comparisons to working-age adults who are enrolled in Medicaid either on the basis of their poverty status or on the basis of disability and we will need claims and encounter records for these people as well.

Information about how HIP enrollees and similar Medicaid beneficiaries use care, the type of care they receive, and their diagnoses will be used to assess the achievement of Goals 3 (promotion of value-based purchasing), 4 (promotion of primary prevention), 5 (prevention of chronic disease progression), and 6 (provision of quality-based health care services). In addition, information from these records will be used to identify HIP providers for telephone interviews to understand the provider effects of the program (see the previous section and the discussion of the

survey of safety net and other providers). The diagnosis codes that appear on these records will also be used to identify people with chronic conditions.

The current plans include accessing both HIP and Medicaid claims and encounter records through the MedInsight portal. Either once or twice a year, we will extract eligibility records for all HIP enrollees and Medicaid beneficiaries who are working-age adults, not dually eligible for Medicare, and eligible on the basis of poverty or disability. Once identified, we will abstract all the claims and encounter records for these individuals that are available at the time of the extraction. Although the records we extract will have been subject to some preliminary inspection and linkage by Milliman, we anticipate that we will conduct a series of standard validation runs designed to check for the completeness of the records and level of missing information.

Once the validation runs have been checked and we have identified initial data anomalies and discussed them with appropriate staff at OMPP or the health plans, we will begin the construction of research files. To construct our research files, we will first sort records by service dates and aggregate records for line items into single visits or inpatient stays. We will then create an array of service utilization measures that reflect our plans to assess service utilization by type of service (such as office visits for primary care, preventive care screenings and tests, office visits for acute care, emergency room visits, and inpatient stays). Service utilization measures will include binary indicators of the receipt of care (such as the receipt of a mammogram) as well as number of visits or length of stay for facility-level care. The construction of these measures will require the use of procedure and facility type codes (and possibly provider type codes) that are generally available in claims and encounter records.

If feasible, we will also use the provider identification numbers found in the claims and encounter records for HIP enrollees to identify the providers who serve disproportionate numbers of HIP patients. We want to identify primary medical providers in particular and will use procedure codes to distinguish those who provide a disproportionate amount of primary and/or preventive care. To do this, we will use the procedure codes that appear on these records and indicate evaluation and management visits or some type of specific preventive service.

Lastly, we will use the diagnosis codes that appear in inpatient and ambulatory claims records to identify HIP enrollees and similar Medicaid beneficiaries with chronic conditions. To identify these people, we will use the Chronic Illness and Disability Payment System (CDPS) that Kronick et al. [4] developed for the construction of capitated payments for Medicaid beneficiaries. The CDPS distinguishes 20 major categories of diagnoses, which correspond to body systems or type of diagnosis. Of the 20 categories identified by this system, 18 can be considered chronic conditions.[4] The system can identify people with multiple chronic conditions; Table II.1 presents the 18 categories, which are not mutually exclusive.

[4] The two nonchronic condition groups are categories for infants and pregnancy.

TABLE II.1 CHRONIC ILLNESS AND DISABILITY PAYMENT SYSTEM: CHRONIC CONDITION CATEGORIES

Cardiovascular	Substance Abuse
Psychiatric	Cancer
Skeletal and Connective Tissue	Developmental Disabilities
Nervous System	Genital
Pulmonary	Metabolic Conditions
Gastrointestinal	Eye
Diabetes	Cerebrovascular
Skin Conditions	Infectious Disease
Renal Conditions	Hematological Conditions

We favor using an approach such as the CDPS to identify chronic conditions because the algorithms used to identify the presence of these conditions have been fully tested and reviewed by a panel of clinicians. Also, several states use the CDPS when setting capitation payments and the software can be obtained free of charge. Lastly, the CDPS also distinguishes between low cost and high cost chronic conditions within each condition category, which allows for a more detailed analysis of high cost conditions. We anticipate that several condition categories will be rare among HIP enrollees (such as substance abuse and chronic genital and eye conditions) and our work will focus on the most common chronic conditions (likely to be diabetes, cardiovascular, and pulmonary conditions).

5. Administrative Records

a. Application Records

Our analysis of Goal 1, reducing the number of uninsured, and several components of our other analyses would benefit from access to program application records. These records provide important information about who does and does not enroll in HIP. More importantly, these records would be our only source of information about the income levels of all HIP enrollees, a piece of information we can get from no other source for all enrollees.

The applications records are collected by the Indiana Department of Family Resources (DFR), and housed in the Indiana Client Eligibility System (ICES). Those applications determined conditionally or fully eligible for HIP are sent to the State's vendor, EDS, which operates the state's Medicaid Management Information System (MMIS), known as the Advanced Information System (AIM). We will work with OMPP, DFR, and EDS to specify the required fields needed, so that we can obtain an extract of information from all HIP application records either annually or bi-annually.

b. Eligibility and Enrollment Files

Through EDS, OMPP maintains eligibility and enrollment records for each HIP enrollee and Medicaid beneficiary. Eligibility records generally provide detailed information about dates of program eligibility, the basis of eligibility, choice of health plan, and eligibility for Medicare coverage. These eligibility records will be a key data source for our study of enrollment patterns (Goal 1).

We will abstract the eligibility records for all HIP enrollees. Then we will conduct standard validation runs that check the completeness of the records and identify initial data anomalies that we will need to understand to use the information correctly (such as understanding when identification numbers may change or when caretaker status is missing). We will then construct research files that include monthly arrays of eligibility status (month-by-month indicators of program enrollment) and measures of the basic demographic information (gender, age, race/ethnicity, and caretaker status).

We will also abstract the same records for working-age adult Medicaid beneficiaries for analyses that will compare HIP enrollees to matched samples of Medicaid beneficiaries eligible on the basis of poverty or disability. We will abstract and validate all records for beneficiaries in the appropriate age range and in the appropriate eligibility groups. We will then conduct a propensity score matching analysis to select a sample of Medicaid beneficiaries. The propensity score matching will rely on basic demographic information available in the eligibility record and we will select two samples, one from among working-age adults in the poverty-related eligibility groups and one from among adults in the disability-related eligibility groups. These two comparison groups will be used in our analyses of value-based purchasing (Goal 3), primary care (Goal 4), prevention of disease progression (Goal 5), and quality of care (Goal 6).

c. POWER Account Information

OMPP is interested in understanding whether POWER accounts incentives worked as expected—that is, whether participants with "skin in the game" change their behavior and make more cost-conscious decisions about their health care.

Anthem and MDwise maintain participant-level records on monthly POWER account contributions, usage of POWER account funds, and annually calculate and record whether enrollees qualified for rollover of their POWER accounts. Mathematica will obtain these files, assess their quality, and link them with other data (for example, application files and encounter data files) to analyze whether POWER accounts can be linked to health care use, suggesting that HIP enrollees engage in value-based purchasing and increased use of preventive care services.

d. Other Secondary Administrative Data Sources

To complete our planned analyses, the evaluation requires several types of secondary data, much of which we will need to obtain from the participating health plans and various state offices. They include:

- Provider lists, as well as geographic analyses of travel times to providers within the network, to help assess whether HIP increased the number of providers serving low-income populations (Goal 2)
- Audited plan financial records, to help assess plans' financial performance (Goal 6)
- Plans' procedural data, to understand plan rules and operations under HIP, and plan monitoring reports submitted quarterly to OMPP, to help assess how plans performed operationally (Goal 6)

- OMPP quarterly reports to CMS (needed as part of ongoing monitoring to support analysis of all goals)
- Other financial data regarding HIP, including but not limited to:
  - OMPP expenditure information for HIP and Hoosier Healthwise
  - the approved budget neutrality agreement with CMS, and any future changes to that agreement
  - assessments by Milliman (the State's actuarial consultant, contracted to assess and track waiver budget neutrality) of budget neutrality monitoring
  - data from the Indiana Department of Revenue to monitor trends in monthly cigarette tax revenues and the dedicated funds that support HIP (Goal 7)

6. Other Sources

Several of the planned analyses require the use of data collected nationally. We expect to draw on several national sources:

- Census Bureau data, including data from the Current Population Survey (CPS) and the American Community Survey (ACS), both of which collect data on insurance status (Goal 1)
- Bureau of Labor Statistics (BLS) data, which tracks unemployment rates monthly by state and for the nation as a whole (Goal 1).
- National data on quality measures (Health Effectiveness Data and Information Set [HEDIS]) and satisfaction (Consumer Assessment of Healthcare Providers and Systems [CAHPS]), which will be used as benchmarks to compare HIP quality and satisfaction (Goals 5 and 6)

III ANALYSIS PLAN BY PROGRAM GOALS

Mathematica's role as the evaluator for HIP is to gather available data from the State and other sources, to develop new sources of data and new analyses, and then to integrate these two to provide an independent assessment of HIP's achievements. State administrative staff and the program's actuary, Milliman, are already producing considerable amounts of information about the program and its initial accomplishments and issues. Mathematica will use this information, but expand upon it. Our contribution as the program's evaluator will be to validate and synthesize the information we gather and to assess it in the context of health care reform and similar coverage expansions. Our key contribution will analyses based on the primary data we collect from enrollees and providers. Most notably, we will conduct a telephone survey of HIP enrollees, which will allow us to compare new enrollees and their experiences before enrolling in HIP to established HIP enrollees who have experience with the program. This survey will allow us to obtain more detailed information about the people enrolling in the program than what is available through administrative records, including information about health status, use of services and access to care before enrolling in HIP, knowledge of POWER accounts and the program's incentives, and adequacy of the provider network once in HIP.

In this chapter, we describe our analysis plans for the evaluation of HIP. The chapter is organized by the program's seven goals to demonstrate how the analyses will measure program achievements of each goal. The description of the analysis plan for each goal starts with a summary table that provides an at-a-glance description of the research questions, outcome measures, data sources, methodological approach, and analytical issues or limitations to the work. We then provide details about the methods we will employ to assess program performance. Finally, we discuss any key analytic concerns or limitations of the design.

A. Goal 1: Reduce the Number of Uninsured Low-Income Hoosiers

To determine the extent to which HIP is associated with either reducing uninsured rates among working-age adults or mitigating rising uninsured rates, we will assess program enrollment patterns and uninsured rates. To help us understand the factors that might influence these rates, we will assess enrollment rates in relationship to larger economic trends that can be expected to influence the number of people enrolling in the program and the number without insurance coverage.

TABLE III.1 GOAL 1 ANALYSIS PLAN

Research Questions	Measures	Data Sources	Methodology	Issues and Limitations
Enrollment Patterns and Enrollee's Characteristics				
-How many people enrolled in HIP? -What are the characteristics of those who are covered by HIP? How do their characteristics compare to those of uninsured working-age adults? -Can spikes in applications/enrollment be linked to outreach activities? -Once enrolled, do participants stay enrolled? Are certain characteristics associated with enrollment or disenrollment?	-Number enrolled by month -Distribution of demographic characteristics of enrollees, and working-age uninsured adults -Number of applications by month -Average length of program participation overall and by demographic characteristics and health status -Disenrollment rates and characteristics of those who disenroll	-HIP eligibility records -Program application files -Health plans' quarterly and annual reports -State quarterly and annual reports to CMS -Program claims and encounter data (diagnostic codes to identify enrollees with chronic conditions) -CPS data (for characteristics of the uninsured)	-Month-by-month trends in enrollment -Month-by-month trends in number of new applications -Descriptive statistics that compare HIP enrollees to similar working-age uninsured adults -Retention rates	-Limited information on demographic characteristics of the uninsured, which gives us few options for identifying with certainty that HIP attracted a disproportionate number of people with poor health -Availability of application files is uncertain as of the date of this report
Uninsured Rates				
-What is the HIP participation rate? -How did uninsurance rates for working-age adults change during the demonstration period? -Which demographic groups appear to have benefited most from HIP's introduction?	-Participation rate (number enrolled per low-income uninsured working-age adult) -Percentage of low-income working-age adults uninsured, by age, by gender	-CPS data -HIP eligibility records for counts of enrollees and their demographic characteristics -Bureau of Labor Statistics (statewide economic indicators)	-Year-by-year trends in HIP participation rates -Year-by-year trends in the percentage uninsured and by demographic subgroups	-Participation rates will be crude measures because of difficulties identifying the number of uninsured who do not meet HIP eligibility criteria -Economic conditions make it extremely difficult to identify the effect of HIP on uninsured rates -Time lags in national data sources may delay some analyses to later years of the evaluation

CPS = Current Population Survey.

1. Program Enrollment Patterns

Low-income adults under the age of 65 have high rates of poor health, are the least likely to have health insurance coverage, and in turn, have poor access to health care in the United States [5]. Although Medicaid covers most low-income children, it has limited coverage for their parents and generally does not cover childless adults, leaving uninsured a large share of low-income adults with significant health needs [5].

HIP was designed for this population of adults who frequently struggle to obtain coverage. To assess the extent to which the program has reached low-income, working-age Hoosiers who would be uninsured if HIP coverage were not available, the analysis will address the following two primary questions.

1. How many adults enrolled in HIP and is this number large enough to affect uninsured rates? HIP was designed for adults who have been without insurance coverage for at least six months and have no offers of employer-based insurance. Because these eligibility criteria should effectively prevent crowd out and the substitution of private insurance for public insurance, those enrolling in the program most likely would have been uninsured if not for HIP.
2. How do HIP enrollees compare demographically to the overall population of low-income, working-age adults who are uninsured? It will be important to determine whether or not HIP has attracted a general cross-section of the working-age uninsured. If only particular subgroups have found the program attractive, this may have implications for the long-term sustainability of the program.

We will examine monthly enrollment patterns, overall and by subgroups (such as by poverty level) to understand the size of the program and how it changes over time, the extent to which people cycle in and out of the program (known as churning) and how long on average enrollees remain in the program.

Using HIP eligibility records, we will assess the following measures of enrollment by month:

- Monthly counts of enrollees
- Monthly counts of new entries and exits
- Point-in-time measures of length of enrollment and retention

We will graphically report these data. We will include monthly counts of new entries and exits to assess the underlying dynamics of program enrollment and to identify large increases in people entering or exiting the program. The overall monthly counts will also be presented by health plan (Anthem, MDwise, and the ESP) to illustrate any relationships between enrollment and the plans. Similarly, monthly enrollment counts will be presented by caretaker status or any other dimension that may help Indiana understand links between program enrollment and program policies.

A key factor in HIP's ability to reduce the number of uninsured Hoosiers will be its ability to enroll eligible individuals and keep them enrolled. Outreach and marketing are key activities for any new program, particularly during the program's start-up phase. However, ongoing outreach and marketing are also needed because people's eligibility changes frequently [6]. Indiana proposed to develop an aggressive outreach and marketing campaign for HIP to build awareness for the program. As the program matures, we will track how the State and health plans tailor outreach and marketing to attract different segments of the eligible population.

We also want to understand the link between outreach and enrollment in HIP to identify effective outreach and marketing activities. To do this, we will first examine the monthly trend in new HIP applications to identify spikes in new applications.[5] We will then review health plan quarterly reports and discuss with key informants outreach activities that occurred or economic factors (such as a plant closing) that would explain the increases or trends we see. Because many outreach and marketing activities are localized, this analysis will be done at the county level.

Important to any study of enrollment patterns is an examination of retention—do HIP enrollees remain in the program? The effects of a program in which enrollees frequently cycle on and off the program (known as churning) will be diminished because the program has fewer opportunities to have a positive effect on enrollees' health status. We will use program eligibility records to examine the average length of program participation, overall and by key groups such as by plan and demographic characteristics (including income). We will also assess retention by chronic conditions reported on claims and encounter records. Table III.2 provides an example of the type of data we will present for this analysis.

TABLE III.2 LENGTH OF ENROLLMENT BY INCOME, BY HEALTH PLAN, AND BY CHRONIC CONDITION

Characteristic	Median Length of Enrollment (Months)	Percentage Enrolled After 12 Months	Percentage Enrolled After 24 Months	Percentage Enrolled after 36 months
		By Income Level		
Total				
≤ 100% FPL				
100-200% FPL				
		By Plan		
Total				
Anthem				
MDwise				
ESP				

[5] We prefer to use application numbers for this analysis, particularly given the application queues that have occurred. As of the writing of this report, it was not clear whether the evaluation would have access to application records. If these records are not available, we will use the program eligibility records.

Table III.2 *(continued)*

Characteristic	Median Length of Enrollment (Months)	Percentage Enrolled After 12 Months	Percentage Enrolled After 24 Months	Percentage Enrolled after 36 months
		By Chronic Condition[a]		
Diabetes (Type 2)				
Cardiovascular				
Pulmonary				
Circulatory				

Note: This table is for example purposes only. We will use encounter data to identify what the most common chronic diseases are within the HIP population and report results for those conditions, using the Chronic Illness and Disability Payment System (CDPS), a risk adjustment system designed specifically for Medicaid programs [4].

FPL = federal poverty level.

2. HIP Enrollee Characteristics

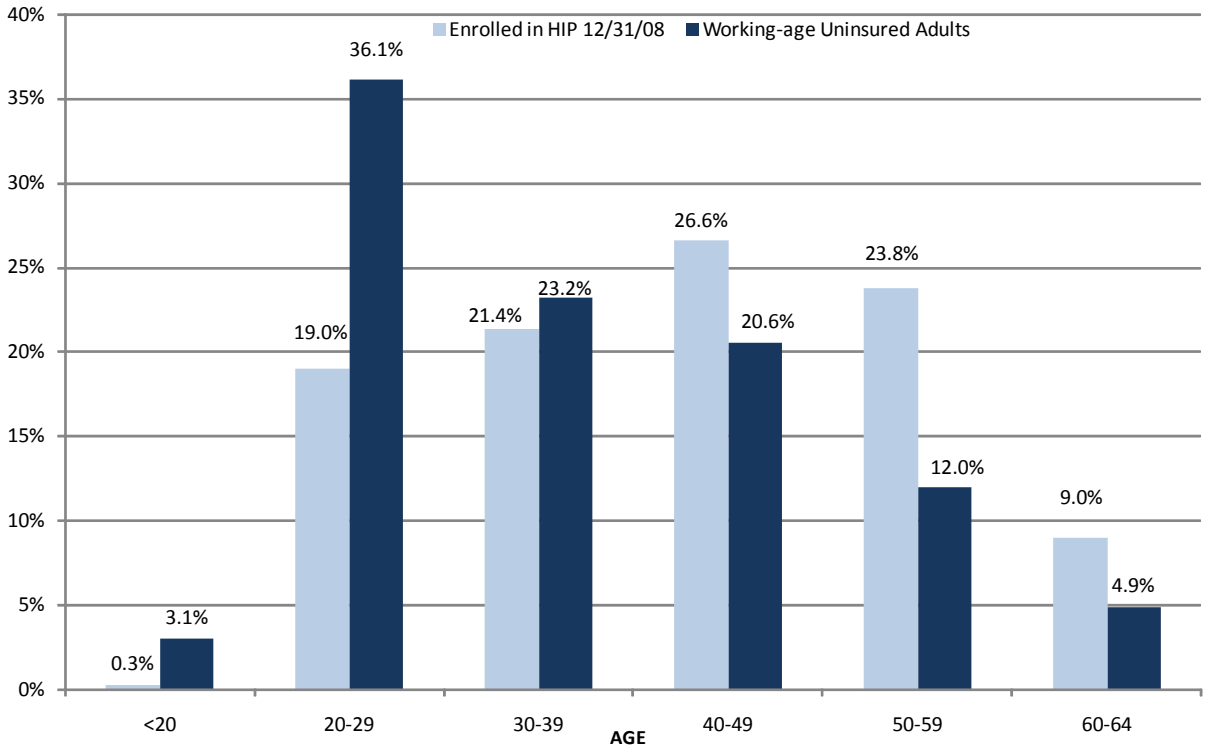
To understand who HIP enrolled, we need to describe the basic demographic characteristics of HIP enrollees. We will use HIP eligibility records to report characteristics such as:

- Age, race, gender, caretaker status, and income as a percentage of the poverty level
- Urban/rural residence (metropolitan statistical area [MSA] versus non-MSA)
- Distribution of chronic conditions based on diagnosis codes reported in the claims and encounter records

We will construct cross-sectional analyses (enrollees at a point in time) that present distributions of characteristics overall and by key subgroups, including by health plan and caretaker status. Breakouts by subgroup will be important for understanding enrollees in depth. We will include indicators of chronic conditions to provide information about the health care needs of enrollees.

To determine whether HIP attracted a general cross-section of the uninsured, we will compare these characteristics to what is known about the demographic characteristics of low-income, working-age uninsured Hoosiers. Figure III.1 illustrates one approach to a graphic display of this type of comparison. As the figure shows, HIP is disproportionately enrolling individuals who are age 40 and older, and those in their 20s are underrepresented in HIP [2].

Figure III.1. Age Distribution of HIP Enrollees and Working-Age Uninsured Adults in Indiana with Income Under 200 Percent FPL



Source: OMPP Dashboard Data [7]; U.S. Census Bureau, Current Population Survey [8].

3. Uninsured Rates

At the time HIP was being designed, the State expected to cover enough adults to reduce the uninsured rate among low-income adults. Administrators expect 120,000 individuals to enroll over the five-year demonstration period [9]. To assess the achievement of this goal, we will examine program penetration rates (also known as participation rates) and trends in the uninsured rate before and after HIP was introduced.

Although enrollment patterns are one key element to understanding the achievements of HIP, whether the program affects state uninsured rates will depend on its ability to achieve reasonably high participation rates (that is, the percentage of eligibles who enrolled). Using HIP eligibility records and Current Population Survey (CPS) data, we will calculate the annual participation rate in HIP as follows:

HIP Participation Rate =

(Total Number Enrolled in HIP)/(Total Number of Low-income Working-age Uninsured Adults)

This rate is a crude measure of the effect HIP has on the problem of uninsured working-age Hoosiers. Measurement error is built into the denominator because we do not know how many of the uninsured working-age adults in Indiana are eligible for HIP (uninsured for at least six months and no access to coverage through an employer). If project resources allow, we will try to use other data sources, such as the Medical Expenditure Panel Survey (MEPS), to develop estimates of the number likely to be eligible.

We will also track other economic indicators over time to interpret this participation rate, including: state Medicaid enrollment levels; state unemployment rates; and the HIP application queue. Behaviorally, one would expect that as unemployment increases in the State, so would Medicaid enrollment, HIP enrollment, and the queue for HIP applicants. We need to view trends in these other figures in concert with the participation rate to understand what is driving changes in the participation rate (that is, to explain factors affecting the denominator).

We will also track how uninsured rates trended before and after HIP implementation. As shown in Table III.3, we will construct three-year averages with existing data from the CPS. Using two different three-year averages, we find that the uninsured rate for adults ages 19-64 in Indiana was about 16 percent in the years prior to HIP's implementation. As more years of CPS data become available, we will be able to compare uninsurance rates after HIP implementation to these from the period before HIP. We will break out the analysis by poverty subgroups to identify whether HIP has different effects at different levels of income. Our analyses will include uninsured rates for higher incomes to track larger trends and to provide contextual information.

TABLE III.3 TRENDS IN THE RATE OF UNINSURANCE OF INDIANA ADULTS, AGES 19-64, BY POVERTY LEVEL

	Number of Uninsured Adults, ages 19-64, CPS 3 year average		Rate of Uninsured Adults, ages 19-64, CPS 3 year average		Number of HIP Enrollees
Poverty Level	2002-2004	2005-2007	2002-2004	2005-2007	12-31-2008
Less than 100% FPL	140,902	166,040	42.0%	43.9%	27,038
100-200% FPL	184,001	168,923	33.7%	30.3%	10,530
201-400% FPL	206,325	163,793	16.0%	12.6%	NA
More than 400% FPL	112,518	127,024	7.3%	7.7%	NA
TOTAL	643,746	625,780	17.3%	16.2%	37,568

Sources: OMPP Dashboard reports, December 29, 2008 and December 31, 2008 [7]; U.S. Bureau of the Census, Current Population Survey [8].

Our analysis of HIP's effects on uninsured rates, combined with economic indicators, will help reveal which groups have been helped most by the program. Current economic indicators show that the recession is affecting groups differently; for example, Bureau of Labor Statics data show that, of the 4.464 million jobs lost since December 2007, 78 percent were jobs held by males, and 22 percent were jobs held by females [10]. In addition to gender differences, there may be age differences, with younger adults—already the group most likely to be uninsured, according to the CPS—having more difficulty entering the job market than older, more

experienced workers. We expect that we will be able to present uninsured rates by age, gender, and poverty levels to help us develop a better sense of whether and how HIP may be affecting these rates.

While CPS data are commonly used for analyses of this type, during the life of this contract, new data from the American Community Survey, described below, will become available that will enable us to do county-level analyses. If we have the resources to do so, we will conduct regional or small area analyses of uninsured rates to account for economic conditions if the economic downturn varies across regions of the State; anecdotal evidence indicates that this has occurred as various regions in the State have experienced higher rates of layoffs and employer closures. A county-level analysis might identify whether some HIP enrollees have moved in from other states where it was more difficult to obtain coverage.

4. Key Analytical Issues and Limitations

Our analyses of the relationship between HIP and uninsured rates face several limitations. Perhaps the most significant issue is the recent economic downturn. Given the economic conditions in at least the first two years of program implementation, the participation rate in HIP is expected to be low; not because the program is unattractive, but because of increasing uninsured rates and poor economic conditions that are overtaking the program and increasing the number of eligible individuals. In addition, although it is currently open to non-caretaker adults, the program has been closed for periods of time to new non-caretaker adult enrollment. To offset this misimpression, we will not report participation rates as a stand-alone measure, but rather with state economic indicators such as trends in unemployment rates available from the Bureau of Labor Statistics, Medicaid enrollment trends, and HIP application trends.

Other challenges include limitations of the data. National data sources, such as the CPS, have large lag times between collection and availability. Sample sizes in the CPS force us to aggregate data across years and we cannot conduct small area analyses. A new data source, the American Community Survey (ACS), will begin to produce data during the contract period; starting in 2008, the ACS included health insurance questions that would allow us to use this new data source to measure uninsured rates. Because the ACS is conducted annually in every U.S. county, American Indian and Alaska Native Area, and Hawaiian Home Land, these data will support estimates of uninsured rates at the county level, rather than at the state-level (the level of the CPS data). If the data prove to be of good quality, we will consider using the ACS data for small area analyses of intra-state variation to supplement what we can do with the CPS data.

CPS data provide only a few elements of demographic information for the uninsured working-age adult population (such as age, gender, race, and income as a percentage of FPL) that we can use to assess overall state uninsured rates. While we can use some of this information to make inferences, we have few options for identifying with certainty that HIP attracted a disproportionate number of people with poor health (that is, that HIP attracted the sickest people).

B. Goal 2: Improve Statewide Access to Health Care Services for Low-Income Hoosiers

Providing coverage will not necessarily increase access to health care services for enrollees of HIP if their access to providers is limited. To determine whether HIP provides adequate access to care, we will assess three aspects of this issue:

1. HIP provider networks and their adequacy
2. Effects of the program on providers, particularly safety net hospitals
3. Pent-up demand for services and reports of unmet needs

The following table summarizes our analysis plan for this goal.

TABLE III.4 GOAL 2 ANALYSIS PLAN

Research Questions	Measures	Data Sources	Methodology	Issues and Limitations
Provider Networks				
-How do providers react to the increase in payment rates? -Are the provider networks adequate? -How do providers perceive the program; do providers view HIP as a Medicaid expansion or as a standalone program?	-Percentage change in number of Medicaid and HIP providers by provider type (primary and specialty care) -Number of providers per enrollee compared between Medicaid and HIP -Percentage of plan members within 30 miles of PMP/60 miles for specialists -Number and percentage of HIP providers taking new patients -Provider views on HIP	-Medicaid and HIP provider lists maintained by OMPP and health plans -State compliance data regarding adequacy of plan networks -Provider interviews	-Year-to-year changes in the number of Medicaid and HIP providers -Compare the number of enrollees per HIP provider to the same measure for Medicaid - Assess plan compliance with program targets for adequacy of networks by type of provider (primary and specialty) -Provider reported perceptions of HIP and its enrollees relative to other patients served	-The overall counts of providers may mask access issues if providers limit their participation in HIP to small numbers of enrollees -Access to specialists will be important and measuring the adequacy of the specialists networks is more difficult because needs are not as general throughout the population and it will be harder to identify specialists limiting their practices to a small number of HIP enrollees -Small sample of providers interviewed means data on HIP perceptions will not be broadly generalizable

Table III.4 *(continued)*

Research Questions	Measures	Data Sources	Methodology	Issues and Limitations
Effects on Providers				
Safety Net Hospitals -How did the transfer of DSH funds into the HIP program affect safety net hospitals?	-DSH payment rates/levels pre- and post-HIP -HIP payment levels to hospitals (presented by safety net and non-safety net hospitals) -Charity care (uncompensated care) rates -Uninsured patient visit rates -Medicaid and total inpatient days pre-and post-HIP -HIP patient visit rates (safety net and non-safety net hospitals)	-State administrative data on DSH funding -Hospital association data on hospital finances and utilization rates -Hospital-supplied data on finances, utilization, HIP revenues among a sample of safety net hospitals -Telephone interviews with key informants and a sample of safety net hospitals	-Comparison of DSH levels pre-HIP to HIP payments going to safety net hospitals -Comparison of changes in the level of charity care provided by safety net hospitals pre- and post-HIP -Overall market effects of HIP, assessed through review of all hospitals HIP revenues and utilization trends	-Ability to tease out working-age adults from all data sources (financial, utilization) -Gaining safety net hospital administrators' participation -Our plan will need to take into account lag times for hospital data sources, which suggests we delay these analyses until later in the evaluation
Other Providers Serving HIP Enrollees -What have been the experiences of high volume HIP providers participating in HIP?	- No quantitative measures, but experiential perspectives on implementation experiences, including experience serving HIP patients and referring for specialty care	-Program claims and encounter data to identify high volume HIP providers -Indiana Primary Health Care Association data, if needed to identify high volume FQHC and RHC HIP providers -Key informant interviews	A descriptive assessment of the perspectives of high volume HIP providers on the effects of HIP on their practices	-Our ability to identify high volume HIP providers will depend on the quality of the provider identification numbers in the claims and encounter data and whether these numbers identify group practices or individual clinicians -Gaining provider participation for telephone interviews

Table III.4 *(continued)*

Research Questions	Measures	Data Sources	Methodology	Issues and Limitations
Pent-up Demand, Unmet Need, and Access to Care				
-Do new enrollees appear to enter HIP with pent-up demand for services? -Is enrollment in HIP associated with improved access to care? -Is enrollment in HIP associated with a decline in reported unmet need? -Once enrolled, are waiting times for preventive, acute, and specialty care within recommended guidelines?	-Utilization of services by month -Percentage accessing care (overall and by type of care) -Percentage who have a personal doctor -Percentage reporting unmet need overall and by type of service -Distribution of waiting times for appointments by type of service	-Claims and encounter data for HIP, HHW, and Care Select -HIP Enrollee Survey	-Comparative analyses between new HIP enrollees and established HIP enrollees -Regression analysis methodologies to control for demographic characteristics and health status	-New enrollees are not the ideal comparison group and our interpretation of results will acknowledge the limitations of our approach

DSH = Disproportionate Share Hospital; FQHC = federally qualified health center; OMPP = Office of Medicaid Policy and Planning; RHC = rural health clinic.

1. Provider Network Analysis

Following the state legislation for HIP, the program adopted a Medicare rate structure for reimbursing HIP providers with the expectation that this higher level of reimbursement (compared to Medicaid rates) would create a willingness among providers to serve HIP enrollees. Whether or not this level of reimbursement will be sufficient to provide adequate access for HIP enrollees is an empirical question and the focus of our provider network analysis. This analysis will have two components to assess whether HIP has in place adequate provider networks to serve its members throughout the State. First, we will analyze whether reimbursement rates for the program have resulted in a sufficient number of providers participating in HIP and then we will analyze whether the provider panels meet standards of network adequacy with regard to geographic standards and program compliance targets.

Number of Providers. We will assess the effect of HIP's provider payment policy by measuring the change in the number of providers serving HIP enrollees and/or Medicaid beneficiaries after the implementation of HIP. Providers may restrict their practice to HIP enrollees only or to Medicaid beneficiaries only, but we will assess the overall number of

providers serving both programs to capture any spillover effects to Medicaid. While the increase in the number of providers does not directly measure whether the increased reimbursement is the reason for participation, it serves as an important indicator of whether the program was able to reach beyond the State's base of Medicaid providers and gives a sense of the program's capacity to serve its enrollees.

We will count the number of providers by type of provider (primary medical provider [PMP], specialist physicians, community health centers, and hospitals) in each Medicaid and HIP plan. The example shown below uses 2007 as a baseline from which to measure the magnitude of the change in the number of Medicaid and HIP providers combined.

The calculation to determine whether there has been an increase in provider take-up of HIP for PMPs will be:

Percentage Change in Physicians Serving Medicaid and/or HIP =

[(PMPs serving Medicaid and/or HIP in 2008) – (PMPs serving Medicaid in 2007)]/

(PMPs serving Medicaid in 2007)

A similar calculation will be completed for specialists if project resources permit.

We can further analyze the adequacy of HIP provider panels on a per-member basis, to compare provider availability within HIP to provider availability in Medicaid and in Indiana overall. The most recent statistics show that, as of December 2008, there were 2.6 practicing physicians per thousand residents in Indiana (PMPs and specialists).[6] For HIP, we would calculate:

HIP Participating Physicians Per 1,000 HIP Members =

(Total HIP Participating Physicians)/ (Total HIP Enrollees/1,000)

This rate will be calculated for HHW and separately for PMPs and specialists for both programs if possible.

Determining year-to-year trends in both calculations will help us assess whether more providers participate over time, which would indicate an increased capacity to serve HIP (and potentially other Medicaid) enrollees as well as signal that the financial incentives of HIP—with a higher payment rate than traditional Medicaid—may have helped increase provider access.

Through previous research, we know that provider lists alone will overstate the numbers of providers actively participating because many providers may not be accepting new patients or may limit their practice to a small number of patients. As a result, the calculations above are crude measures of provider participation in the program. If the health plans can provide an

[6] This includes all physicians in the state except federally-employed physicians. This statistic represents 98 percent of physicians in the state [11].

appropriate level of detail, we will conduct a sensitivity analysis by running the above calculations for providers accepting new HIP or Medicaid patients.

Geographic Standards. The distance members must travel to see a physician can create barriers to accessing care and increase the opportunity costs of doing so. Recognizing this, OMPP established travel standards for participating health plans: PMPs must be available within 30 miles for enrollees, and specialists must be available within 60 miles. Using documentation the plans submit to OMPP, we will review and summarize whether HIP plans are meeting these standards. Furthermore, we will use plan documents to assess whether plan networks meet more stringent standards such as 5 miles for urban settings and 10 miles for rural settings.

HIP Compliance Targets. In addition to determining plans' ability to meet a basic set of geographic accessibility targets for their provider network, the plans have other performance targets [12]. We will assess and summarize compliance by comparing data submitted by the plans to HIP compliance targets, which include:

- Percentage of members with access to pharmacy within 30 miles of their residence - target: 98 percent of a plan's members meet this requirement
- Percentage of members with access to at least two providers of each required specialty type within 60 miles of their residence – target: 90 percent of a plan's members meet this requirement

2. Analysis of the Effects on Providers

Our analysis of the effects on providers will involve two different approaches. One will assess the program financial implications for safety net hospitals, the other will assess program effects on non-hospital providers.

a. Safety Net Hospitals

DSH funds were created by Congress in 1981 to offset lower Medicaid payment rates implemented at that time [13]. States are permitted to make supplemental Medicaid payments to facilities that provide a "disproportionate share" of care to Medicaid beneficiaries and the uninsured [13]. DSH funds are the largest source of federal funding for uncompensated hospital care, and are intended to preserve access to these hospitals for Medicaid beneficiaries and the uninsured [14]. The Indiana Hospital Association has told us that in 2007, 14 hospitals in Indiana qualified for DSH funding.

Because HIP is a Medicaid program, Indiana must finance part of the program costs. Indiana's approach includes the redirection of a portion of their DSH funds because hospitals that received DSH funds (in compensation for providing care to uninsured patients) are expected to see these lost revenues return to them through providing care to HIP-insured patients [2].[7]

[7] The other main revenue sources are an added state cigarette tax of 33 cents per pack, plus contributions made by enrollees to their POWER account.

Moreover, HIP payment rates are higher than Medicaid payment rates (and, Medicaid payment rates have not increased since 1993), which makes the program appealing to the hospitals [15].

While the redirection of DSH funds makes sense from the State's perspective, it is not clear how it will affect the financial status of safety net hospitals. Safety net hospitals in other states that re-directed DSH funds to support uninsured expansions reported mixed results. For example, Hawaii re-directed DSH funds to finance a Section 1115 demonstration waiver in the 1990s and its safety net hospitals were able to negotiate contracts with the health plans with reimbursement rates that included extra funds to cover their lost DSH payments. At about the same time, Tennessee was doing something similar and its safety net hospitals experienced low payment rates, delays in health plan payments, and an increase in the number of uninsured individuals after the state capped new enrollment into the 1115 demonstration waiver [16]. In both states, an analysis of all hospitals' experiences under Section 1115 Medicaid demonstration waivers revealed that non-safety net hospitals began playing a bigger role in providing health care to Medicaid patients and those newly enrolled in the demonstrations [16]. The implication for safety net hospitals was that their ability to provide charity care was undermined while Medicaid beneficiaries experienced an increase in provider choice.

Given the change in financing for Indiana's safety net hospitals, we are interested in understanding (1) how HIP affected the finances of safety net hospitals, and (2) whether the number and type of uninsured patients they served changed after HIP was implemented. Key questions we will address include: Do HIP patients use safety net hospitals or do they go elsewhere for acute care and inpatient services? Do the volume of services and payment rates for those services compensate the safety net hospitals for the loss of DSH funds? How did the level of hospital charity care change after HIP?

We propose a two-pronged approach to the analysis of effects on safety net hospitals:

1. Review of safety net (and non-safety net) hospitals' financial and payor-mix data, rates of charity care, DSH trends prior to HIP implementation, and HIP use and revenues, using American Hospital Association (AHA) data, hospital cost reports, state administrative data, and claims and encounter records
2. In-depth interviews with safety net hospital administrators, as well as others such as state officials, the state hospital association, the health plan administrators, and advocates

We will review all publicly available financial reports and key financial indicators related to the working-age adult population for safety net and non-safety net hospitals. We will review and compare how these indicators have changed over time, as well as compare DSH amounts to HIP payment levels for safety net hospitals.

Key financial indicators will include:

- Pre-HIP DSH funding levels, for 2005, 2006, and 2007
- Pre- and post-HIP uncompensated care amounts, 2005-2010
- Pre- and post-HIP Medicaid inpatient days 2005-2010

- Pre- and post-HIP uninsured days, 2005-2010
- Pre- and post-HIP total inpatient days (to give broader market context)
- HIP revenues by hospital, and HIP costs by hospital

Our strategy for selecting safety net hospitals is described in Chapter II. Our interviews will be designed to supplement the data analysis, providing background and history on hospitals' role in the development and implementation of HIP (this information was already gathered through interviews completed in May 2009). Other questions we want to ask key informants in future interviews include:

- Hospitals' experiences with plans paying Medicare rates (early interview data indicated that some hospitals, critical access hospitals in particular, had some issues regarding plan payments)
- Relationships between hospitals and the health plans over time
- Enrollment or outreach activities
- Hospitals' long-term view of HIP and its financial impacts

In addition, in our spring 2009 site visit, Brian Tabor of the Indiana Hospital Association noted that an important aspect was finding ways to help pay for POWER account contributions for patients enrolled in HIP. He noted that various groups in the State, including safety net hospitals, were trying to supplement POWER accounts to aid enrollment. Through our key informant interviews, we will identify any such efforts and document the role hospitals play in working with various groups to support HIP enrollment and retention.

Using all the data available, we will compare HIP payments relative to previous DSH payments and changes in the levels of charity care to determine how HIP affected the finances of safety net hospitals. We will also examine the data, and compare it to information for non-safety net hospitals, to understand whether HIP had unintended consequences—good or bad—in the hospital market, such as increased provider choice or increased administrative burden, among other possible consequences. Our interpretation of the information must be done carefully because some of the trends we see will be influenced by general economic conditions.

b. Non-Hospital Providers

Non-hospital safety net providers—federally qualified health centers (FQHCs) and rural health centers (RHCs)—traditionally have provided care to socioeconomically disadvantaged individuals, including Medicaid beneficiaries, the uninsured and other vulnerable populations [17]. They are legally obligated to provide care for people who cannot afford it [18]. For the uninsured, safety net providers often are a lifeline to services because these patients typically have few resources to pay for care.

It was expected that the implementation of HIP would lead to an increase in insured persons seeking care at FQHCs and RHCs, along with a decrease in uninsured and/or uncompensated

visits. Based on our key informant interviews in May and June 2009, however, we are not certain that HIP has had or will have an effect on the majority of FQHCs and RHCs. Although both plans have contracted with these providers, Anthem indicated that few of their HIP patients have sought care at these centers. The plans' impression is that HIP enrollees probably have postponed care in the past (that is, they either have not sought care anywhere or went to an emergency room (ER) for ambulatory care needs) rather than seeking out FQHCs or RHCs for care. Bolstering this view, representatives from the Indiana Primary Health Care Association indicated that uninsured working-age adults are a very small percentage of the patient panel at any one FQHC.

Given this input, we propose to re-focus the evaluation of HIP's effects on non-hospital safety net providers. Rather than concentrating exclusively on FQHCs and RHCs, we propose to talk with providers and/or administrators in primary care practices—clinic-based and private practices—who serve a substantial number of HIP patients. We want to understand providers' perspectives on HIP and their experiences serving HIP patients; their experience referring HIP patients for specialty care,[8] and whether that differs from their experiences for patients with other types of insurance (Medicare, Medicaid, private coverage, uninsured); whether they feel payment rates are adequate; and whether using a Medicare-based payment calculation has been easy to implement. This analysis will be a qualitative review of effects based on providers' experiences.

As described in Chapter II, we will use claims and encounter records to identify non-hospital providers who serve disproportionate numbers of HIP enrollees. We will also identify the FQHCs and RHCs that serve the largest numbers of enrollees. Once we have identified and selected providers for our analysis, we will conduct telephone interviews with administrators.

Provider/administrator interviews will provide key background and historical information on providers' roles in serving Medicaid and uninsured patients. Other questions we want to ask HIP providers include:

- How did they view and/or respond to HIP when it was announced?
- Do they see HIP as a Medicaid expansion, or as a standalone program?
- What has been the biggest challenge to participating in HIP?
- How much did the increased payment rates incentivize them to participate in HIP?
- Are their HIP patients established patients they had treated before HIP, or are they new patients?
- Are payment rates adequate, in their opinion? Are the Medicare rates being passed down to the providers? Was implementing a Medicare-based payment methodology easy to do?

[8] Our key informant interviews also revealed that primary care access was not a problem for HIP enrollees, but that specialist access was difficult. These findings validate an ongoing concern in Indiana; a 2004 report by FSSA indicated that specialty access was a significant gap in the state's safety net [19].

- Have there been challenges to referring HIP patients for specialty care? If so, what have been the challenges (for example, limits on types of providers who participate, or geographic/travel time issues)?
- Do providers find that HIP patients have more health problems, generally, than privately insured working-age adults they treat?
- Do providers also serve a significant number of Medicaid patients? If so, are there any differences (administratively or otherwise) between serving these populations? What are the differences? What about comparing HIP to other insurers (Medicare, private insurance)—do experiences serving patients enrolled in HIP differ from serving patients with other types of insurance?
- Do the providers accept uninsured patients? If so, have they tried to help them enroll in HIP or see if they qualify for it?

3. Pent-Up Demand, Unmet Need, and Access to Care Analysis

Improving access to care must also be analyzed from the enrollees' perspectives: Do they enter the program with pent-up demand indicative of poor access before becoming insured? Do enrollee reports of unmet needs decline after enrolling in HIP, and do they perceive that their access to care has improved? In this section, we describe our plans to use claims and encounter data and the HIP enrollee survey data to evaluate access to care. The analysis is organized around three issues of interest: (1) pent-up demand, (2) unmet needs, and (3) access to care when needed.

Pent-Up Demand. Those who are uninsured may postpone health care use until they are insured, due primarily to the cost of care. This can create a "pent-up" demand for services: when first covered by insurance, they may immediately seek care to address conditions that have gone untreated. In addition, when providers realize the enrollee has not had routine medical care, they are likely to order a range of tests and procedures and then treat the patient for any conditions that are identified. Using claims and encounter data submitted by the plans, we will examine enrollees' use of services shortly after they enroll and again after they have gained experience with the program. Specifically, we will calculate the average number of physician visits, lab tests, and prescriptions each month someone is enrolled. By assessing utilization month by month, we will be able to determine whether service use is unusually high during the first months of coverage and then declines and remains at lower levels 6, 12, or 18 months after enrollment. This type of pattern would suggest many enrollees enter HIP with pent-up demand for care.

We also will look at pent-up demand from a cost perspective. If HIP participants have gone without health care for long stretches of time, they may seek more care in their first year of enrollment. In addition, this care may be especially costly than care received by comparable HHW and Care Select beneficiaries. We will compare utilization and costs of HIP enrollees to matched samples of Medicaid beneficiaries (poverty and disabled-related groups) to determine whether HIP enrollees differ substantially from traditional Medicaid beneficiaries in their use and costs of care.

Using the algorithm created to identify the Medicaid comparison groups (that is, Medicaid poverty-related adults and Medicaid disabled-related adults), we will compare first year total HIP services used (and their cost) per enrollee to the comparison groups' per-beneficiary service use (and costs) for the same period.[9]

Unmet Needs and Access to Care. The survey of HIP enrollees will provide critical information about how HIP influenced access to care, medical homes, and unmet need. Specifically, the experiences of the new HIP enrollees while they were uninsured will provide the point of comparison for the experiences of established HIP enrollees as they enter their second year of program participation. New HIP enrollees will be asked to report their access to care, whether they had a usual doctor and unmet needs during the six months before enrollment into HIP. This information will be compared to similar information reported by established HIP enrollees during the previous six months. The key questions will be:

- Whether the enrollee used care during the six months before enrollment (or previous six months) and the location of his or her last visit (physician's office, emergency room, community health center, hospital)
- Whether the enrollee had a usual physician during the six months before enrollment (or previous six months) and had to change doctors upon enrollment into HIP
- Whether the enrollee used an emergency room (ER) when he or she could not get an appointment with a physician and number of ER visits during the six months before enrollment (or previous six months)
- Whether during the six months before enrollment (or previous six months) the enrollee had unmet needs for:
    - Preventive care
    - Acute care
    - Specialists
    - Prescription drugs
- Whether wait times for appointments improve and become shorter when someone enrollees in HIP for:
    - Preventive visits
    - Specialty care

[9] Our analysis of costs may not be feasible if some plans pay capitated rates to some providers or the provider payments are not recorded in the encounter records plans submit. We understand the HIP health plans pay providers on a fee-for-service basis.

4. Key Analytical Issues and Limitations

Our analyses of whether HIP provides adequate access to care face several important analytical issues and limitations. As mentioned above, the analysis of provider network adequacy may provide an imprecise picture of access because providers may limit their practices to small numbers of HIP enrollees. The calculations we perform will, however, give a sense of the capacity the HIP health plans have created through their provider networks. Perhaps more importantly, access to specialists may be most important to measure, given the high need for specialty care among HIP participants in the first year of program operations. However, counts of specialists are more problematic and difficult to interpret because specialty care needs are not general throughout the population.

Analyzing program effects on providers may be complicated if we cannot disentangle uncompensated and charity care by age group. A lack of information about the amount of uncompensated and charity care provided to working-age adults will limit our ability to draw conclusions about the financial effects of HIP on safety net hospitals. More importantly, it is possible that the population HIP covers is extremely small for most hospitals and the program may not have a noticeable effect on the hospital specific measures we plan to analyze. The lack of detailed data and the small size of the population highlight the importance of telephone interviews to obtain general impressions of program effects.

Another issue our provider interviews will face is garnering provider participation in telephone interviews; hospital administrators and those who manage practices are typically hard-pressed to find time for telephone interviews. However, the Indiana Hospital Association strongly indicated that safety net hospitals would be interested in participating. Non-hospital providers may have less interest, but Mathematica staff have experience conducting such interviews for research studies in the past, and as such, we believe that working with the plans, the Indiana Primary Health Care Association, the medical society, and advocates, combined with a flexible approach (that is, willing to conduct interviews in the evening or off-hours or by email), we can garner provider and administrator participation.

Measuring access and the unmet needs of enrollees will provide our most direct understanding of whether enrollees in HIP have adequate access to care. While we believe our planned analyses are strong, they have limitations. For example, our strategy of using new enrollees and their experience during the six months before enrolling in HIP when they were uninsured to compare with HIP enrollees who have experience with the program is a good approach to measuring the effects of HIP on access to care when random assignment is not available. However, the new enrollees who respond to the survey may be slightly different from the established enrollees if outreach and marketing efforts changed dramatically between the two groups or eligibility policies changed so that new enrollees are systematically different in some important way. The most relevant example of this situation is the enrollment of non-caretaker adults. As of this report, enrollment of non-caretakers is open for a very short period of time, for up to 5,000 enrollees, following which it will be closed indefinitely. The enrollment of non-caretakers is capped at 34,000 and the program closed enrollment to this group in March 2009. When enrollment is open to this group will be determined by the State and we will work with OMPP to identify a strategy that will ensure the survey is able to interview adequate numbers of both new and established non-caretakers.

C. Goal 3: Promote Value-based Decision Making and Personal Health Responsibility by Participants in the HIP Program

HIP uses several financial incentives to encourage enrollees to become thoughtful health care purchasers and active participants in maintaining or improving their health. These incentives begin upon enrollment, when most HIP enrollees are required to contribute to the cost of their care through an individual Personal Wellness and Responsibility (POWER) account. This account, styled like a health savings account, is funded partly by enrollees' monthly contributions and partly by the state.[10] Enrollees draw on their POWER accounts to pay for the first $1,100 in non-preventive services each year.[11] If members complete specified preventive services during the year, any remaining POWER account funds rollover to the following year, reducing the required participant contributions.[12] To reduce the use of emergency rooms, HIP also includes co-payments for non-emergent visits.

The primary research question for evaluating Goal 3 is—do the POWER accounts and HIP's financial incentives promote value-based decision making and personal health responsibility among HIP enrollees? We will address this research question by conducting four related analyses, as summarized in the table below.

TABLE III.5 GOAL 3 ANALYSIS PLAN

Research Question	Measures	Data Sources	Methodology	Issues and Limitations
POWER Account Contributions				
Are HIP-eligible Hoosiers willing to contribute to POWER accounts at the level required?	-Conversion rate -Mid-year exit rate -Renewal application rate -Take-up rate after renewal	-Program eligibility records -Health plan POWER account records	-Compare rates by level of required POWER account contribution and employer contributions -Descriptive statistics and regression analyses	Unlikely to control adequately for effects of income and other factors such as job market opportunities

[10] Enrollee's contributions are on a sliding scale; no enrollee pays more than 5 percent of household income. Employers may pay up to half of an individual's contribution to the POWER account.

[11] After the $1,100 deductible, participants incur no additional costs. Plans are required to provide the first $500 of preventive health care at no cost; however, both MDwise and Anthem provided unlimited preventive services to HIP enrollees during the first year of program operations.

[12] To be eligible for a POWER account rollover in 2009, enrollees were required to have an annual physical. In addition, beginning in 2009, blood glucose screening and up-to-date Tetanus-Diphtheria booster shots are required for all enrollees; flu shots and colonoscopy are required for all enrollees ages 50 through 64; pap smears are required for all women; mammograms are required for women ages 35 through 64; Chlamydia screening is required for women ages 19 through 25; and cholesterol testing is required annually or as required by a person's specific disease history for men ages 35 through 64 and women ages 45 through 64.

Table III.5 *(continued)*

Enrollee Knowledge of Program Incentives				
Do HIP enrollees understand the POWER account incentives and do those incentives promote cost-conscious decision making?	-Percentage of participants responding correctly to POWER account knowledge questions -Percentage of participants reporting cost-conscious medical decision-making due to POWER accounts	HIP Enrollee Survey	-Compare responses by level of required POWER account contribution, length of participation, presence of chronic conditions, and plan enrollment -Descriptive statistics	Small sample sizes may limit ability to conduct some subgroup analyses
POWER Account Rollovers				
To what extent do participants achieve POWER account rollovers?	-Percentage of participants who spend less than $1,100 and complete all preventive services -Average value and distribution of rollover amounts	Health plan POWER account records	-Compare outcomes by level of required POWER account contribution and employer contributions -Descriptive statistics	May have limited sample that achieves POWER account rollover, making effectiveness of incentive difficult to identify
Value-Based Purchasing				
Do participants tend to select lower-cost services, compared to other Medicaid beneficiaries?	-Number of acute care office visits -Number of emergency room visits -Ratio of emergency room visits to total acute care visits	Claims and encounter data for HIP, HHW, and Care Select	-Compare outcome measures for HIP (contributors, and zero contributors) to matched sample of Medicaid adults -Year-by-year trends -Regression analysis to control for demographic characteristics	Unlikely to control adequately for knowledge of costs of services and effects of income and other factors such as job market opportunities

HHW = Hoosier Healthwise.

1. POWER Account Contributions

With a traditional Medicaid program expansion, all those who apply and are found eligible become enrolled. However with HIP, participants are not fully enrolled until they make the first POWER account contribution, and continuing monthly payments are required to remain enrolled. Making these payments is the first signal enrollees give regarding how they value this

program and its benefits. Whether individual enrollees choose to make POWER account payments will depend on the expected value of HIP relative to those payments and to other options that enrollees have to meet their health needs (particularly through charity care or sliding-scale programs), as well as other competing household expenses.

Although the architects of HIP intended that all participants would have some "skin in the game," a significant proportion of enrollees (35 percent) were not required to make POWER account contributions during the first year of program operations, due to extremely low income levels or offsetting premiums for children covered through Indiana's State Children's Health Insurance Program (CHIP) [2]. Enrollees not making monthly contributions provide an important comparison group. Measuring continuing participation rates among enrollees who make POWER account payments and comparing them to rates for zero-contribution enrollees, will enable us to assess how required contributions affect willingness to participate in HIP.

We will assess the effect of POWER account contributions on people's willingness to enroll and remain enrolled in HIP by examining several key outcome measures: (1) the conversion rate from conditional to full eligibility status, (2) mid-year program exit rates, (3) eligibility redetermination rates, and (4) take-up rates after eligibility has been redetermined. We will construct these measures as follows:

- **Conversion Rate.** The conversion rate is defined as the percentage of conditional enrollees who make their first POWER account payment and become full enrollees. For those who are not required to make contributions, the conversion rate is 100 percent, by definition. Through January 2009, roughly 6,000 people were determined eligible for HIP, but never fully enrolled because they never made the first monthly POWER account contribution (14 percent of conditional enrollees).
- **Mid-Year Exit Rates.** HIP enrollees who do not make timely payments are locked out of HIP for a 12-month period. The mid-year exit rate is defined as the percentage of fully enrolled adults who are disenrolled from the program before redetermination, due to failure to make their monthly POWER account contributions. By definition, this rate will be 0 percent for those who do not make contributions. Through January 2009, only about one percent of fully enrolled members were terminated for failure to make subsequent payments.
- **Renewal Application Rate.** HIP enrollees must verify their continued eligibility for the program on an annual basis. Failure to complete the redetermination process results in a 12-month lockout from the program. The eligibility renewal rate is defined as the percentage of enrollees submitting eligibility renewal paperwork among those who remained enrolled throughout their first year. Through July 2009, 79 percent of those who had been enrolled for 12 months had submitted redetermination paperwork.
- **Take-Up Rates After Renewal.** As part of the renewal process, changes in enrollee incomes or household status may change the required POWER account contribution. Among those who are found still eligible at renewal, we define the take-up rate as the percentage who make their first POWER account contribution in the subsequent year. We will examine this measure separately for those whose required monthly

contribution increased, decreased, and stayed the same to identify whether take-up rates after renewal are sensitive to an increase in the monthly contribution.

To construct each of these measures we will use OMPP and health plan administrative data. We will report the measures on an annual basis, stratifying the results by level of required POWER account contribution (as in Table III.6). If we see conversion rates decrease as the monthly contribution increases as a percent of income, that result would be interpreted as the targeted population being sensitive to program costs.

TABLE III.6 CONVERSION RATE FROM CONDITIONAL TO FULLY ELIGIBLE ENROLLEES

POWER Account Contribution Level (Percentage of Income)	(A) Number Found Eligible in Calendar Year	(B) Number Who Made First POWER Account Payment	(C) Conversion Rate (B/A)
0%			
2%			
3%			
4%			
4.5%			
5.0%			
TOTAL			

While descriptive statistics are useful for identifying general patterns in the data, regression analysis is necessary to control for other factors that may influence the decision to make the monthly contributions (such as caretaker status and health status). We will develop logistic regression models that predict the likelihood of mid-year exit and submission of redetermination paperwork, based on enrollee characteristics.

In each case, we will develop two regression models—a basic model that assumes the effect of POWER account contributions is the same for all enrollees, and a model that allows the effect of POWER account contributions to differ by caretaker status. We propose the second model because early data provided by the HIP actuary suggests HIP caretakers have fewer health care needs and may value the program differently [20]. For final presentation purposes, we will calculate the regression-adjusted percentage of each group that meets each outcome measure, by POWER account contribution level (as in Table III.7).

TABLE III.7 REGRESSION-ADJUSTED LIKELIHOOD OF PROGRAM ENROLLMENT/DISENROLLMENT

POWER Account Contribution Level (Percentage of Income)	Percentage who Become Fully Enrolled		Percentage who Fail to Make Subsequent POWER Payments		Percentage who Submit Redetermination Paperwork		Percentage who Take Up Coverage After Renewal	
	Caretaker	Non-Caretaker	Caretaker	Non-Caretaker	Caretaker	Non-Caretaker	Caretaker	Non-Caretaker
0%								
2%								
3%								
4%								
4.5%								
5.0%								
TOTAL								

2. Enrollee Knowledge of Program Incentives

The next critical step in achieving value-based purchasing is for enrollees to understand the program's financial incentives and to engage in value-based purchasing as a result. These are two separate steps that should be assessed and measured distinctly. It is possible that enrollees understand the financial incentives, but do not engage in value-based decision making. For example, they may lack the information to make informed choices or may not value the potential POWER account rollover, or may have chronic conditions with anticipated treatment costs that would exhaust POWER account funds within the year, diminishing the potential rewards to pursuing value-based purchasing. It is also possible that enrollees engage in value-based decision making, but do not understand the financial incentives. For example, they may limit service use because they incorrectly believe that HIP covers only $1,100 of services.

Using data from the HIP enrollee survey, we will assess enrollees' understanding of the POWER account incentive structure and whether those incentives prompt value-based decision making. To avoid "priming" enrollees, the survey will first ask questions about medical decision making, before moving to specific questions about the POWER accounts. Based on anecdotal reports from stakeholders and the low exposure of HIP enrollees to high-deductible health plans and health savings accounts, we anticipate that understanding may be relatively low (for example, some may not understand the preventive care incentives tied to the POWER account or the possibility of rollover) [2]. Accordingly, we will begin the survey module with very basic questions, ramping up to more complex items. Questions include:

<u>POWER Account Understanding</u>

- Do you have a POWER account? If yes, what is your monthly contribution?
- What is the balance right now? How often do you check the balance?
- What happens when the money in your POWER account runs out before the end of the year when you must renew your eligibility for the program?

- Are there any health-related services that you are supposed to get next year? What services are those? What happens if you do not get those services?
- Once HIP tells you how much you are required to pay into your POWER Account, is there any way to have this amount reduced? If yes, what are the things that can happen to make someone's monthly contribution go down?

Value-Based Medical Decision Making

- Do you think the POWER account makes you more likely, just as likely, or less likely to seek medical treatment when needed?
- When seeking treatment, do you ask about how much it will cost or how much will be deducted from your POWER account before you get the treatment? Why is that?
- How many times have you used the emergency room in the last six months (or in the six months before enrolling in HIP)?

We will analyze the responses to these survey questions descriptively. For open-ended questions such as "What happens when the money in your POWER account runs out before the end of the year when you must renew your eligibility for the program?" we have developed likely response categories that we will refine based on results from the pretest of the survey instrument. Ultimately, we will classify responses by whether they suggest that the person does or does not know what actually happens if they spend through their POWER account funds. For example, we anticipate that participants might respond that they cannot get any more care, have to start paying for all their care, or the State pays all costs. Only the last answer would be categorized as a correct understanding of the POWER account system. Although categorizing responses to open-ended questions may be difficult, we are concerned that other approaches may inappropriately prompt respondents to give the "correct" answer.

For each item, we will analyze the results by POWER account contribution level as well as between new and established enrollees to identify changes in knowledge as enrollees gain experience with the program. Because the enrollee survey will occur relatively early in the demonstration, we will also examine the results by health plan enrollment (Anthem versus MDwise), as this may provide valuable operational feedback to help improve member communications for the remainder of the program.

We will conduct several sensitivity analyses. For example, we will compare enrollees who report being diagnosed with a chronic condition to those who do not have such a diagnosis because those without a chronic condition may be more likely to take advantage of the program incentives or more thoroughly research program features before enrolling.[13]

[13] Respondents to the survey of HIP enrollees will be asked about the following conditions: diabetes, heart attacks and strokes, emphysema, chronic bronchitis, asthma, cancer, and mental health conditions.

3. POWER Account Rollovers

If HIP enrollees have a financial stake in their health care spending and understand the POWER account incentives, then we would expect them to be cost-conscious consumers. The rate of POWER account rollovers provides some indication of cost-consciousness because a rollover accrues only when the enrollee has leftover POWER account funds and completes required preventive services. Other things being equal, we would expect enrollees who make larger contributions to achieve rollovers more frequently, and to have larger dollar-value rollovers.[14] These rollovers may increase over time as enrollees become more knowledgeable about the POWER account incentives. Our baseline for comparisons will be enrollees who make no contributions because we do not expect them to be responsive to POWER account incentives.

Our primary outcome measure will be the rate of POWER account rollovers, defined as the percentage of enrollees who qualify for total or partial POWER account rollovers, among those who begin a second year of coverage.[15] We will use administrative data to construct this measure. For those with zero contributions, we will compute a "pseudo rollover" rate, defined as the percentage of enrollees accruing fewer than $1,100 in non-preventive medical expenses, who have also completed all required preventive care.

If a substantial number of enrollees qualify for a rollover, we will conduct several additional descriptive analyses, examining the rollover rate by required contribution amount in the prior year, and the average and distribution of rollover amounts. We may also stratify the rollover rates by those who have chronic conditions and those who do not. This analysis addresses the issue that some HIP members may have chronic conditions that cannot be managed within POWER account limits.[16] For these enrollees, who can anticipate spending more than $1,100, the POWER account incentives are weakened. To identify chronically ill individuals, we will analyze diagnosis codes in the plans' claims and encounter data, using the CDPS, a risk adjustment system designed specifically for Medicaid programs [4].

Whether enrollees learn about the program incentives and gradually change behaviors over time is also of interest to the State. If sufficient numbers of enrollees qualify for a rollover, we may also conduct program-level and enrollee-level time trend analyses. Program-level analyses will examine changes in POWER account rollover rates overall by year (that is, the rollover rate in 2009, compared to 2010), while enrollee-level analyses will focus on those enrolled for at least three years, examining whether the likelihood of a POWER account rollover increases with

[14] Analyses that investigate the relationship between an outcome and the level of the monthly contribution will need to account of employer contributions. As a result, our analyses will focus on the monthly contribution that an enrollee makes, after the employer contribution is controlled for, either subtracted from the total contribution required or as a separate explanatory variable in a regression model.

[15] Enrollees will not know whether they qualify for a rollover until they have been in HIP 18 months (or more), because POWER accounts are not reconciled until 6 months after the first full year of coverage ends, to allow time for providers to submit all claims.

[16] Some individuals will have unavoidable acute illnesses that will place the possibility of a rollover out of reach; however, it is not feasible to identify this group in a systematic manner within the study's time frame and resources.

each year of program experience.[17] Program-level analyses point to whether the State or health plans may be improving communications to enrollees about the way that POWER accounts function, while enrollee-level analyses suggest how long it may take low-income enrollees to become familiar with and responsive to the high-deductible and health savings account concepts.

4. Value-Based Purchasing

The ultimate goal of POWER accounts and other financial incentives (such as co-payments for non-emergent visits to the emergency room) is to promote value-based medical decision making, motivating enrollees to choose a lower-cost alternative when possible. The comparison group for this analysis will be regular Medicaid beneficiaries, who have access to a similar array of services and are often receiving care managed by the same health plan and clinicians, but do not face HIP's financial incentives.

The intended mechanism for these differences is the cost-consciousness of HIP enrollees because they are more "activated" consumers than regular Medicaid beneficiaries. However, in comparing HIP to the regular Medicaid program, there is also a second possibility—that any observed effects are driven primarily by differences in health plan management approaches. For example, health plans might be more aggressive in scheduling office visits for HIP patients (compared to regular Medicaid patients) because they are concerned about HIP's high service utilization to date, and want to ensure that members promptly begin treatment for chronic conditions to minimize long-term costs.

While the State would benefit in either case, there is clear interest in understanding which explanation—a consumer-driven or health care management approach—is primarily responsible for outcomes. To get at this secondary question, we will also analyze utilization outcome measures by whether or not enrollees make a contribution to their POWER account. Comparing HIP enrollees who do not make a contribution to regular Medicaid beneficiaries will indicate the health care management-level effects. Comparing HIP participants who do make a contribution to those who do not will get at the consumer-driven effect because we do not expect zero-contribution enrollees to be cost-conscious consumers.

To determine how HIP's financial incentives may have impacted service utilization, we will use plan encounter data to examine the frequency of emergency room visits, office-based acute care visits, and the ratio of emergency room visits to total acute ambulatory care visits.[18] Using regression analysis, we will model a separate equation for each outcome and calculate

[17] We focus on those with at least three years of enrollment because early Milliman analyses suggest significant pent-up demand for care in the first year of enrollment [20]. If these results hold, the second year of enrollment will be the first opportunity many enrollees may have to achieve a rollover and utilization in their second year of enrollment is the more appropriate "baseline" for expected POWER account usage over the long run.

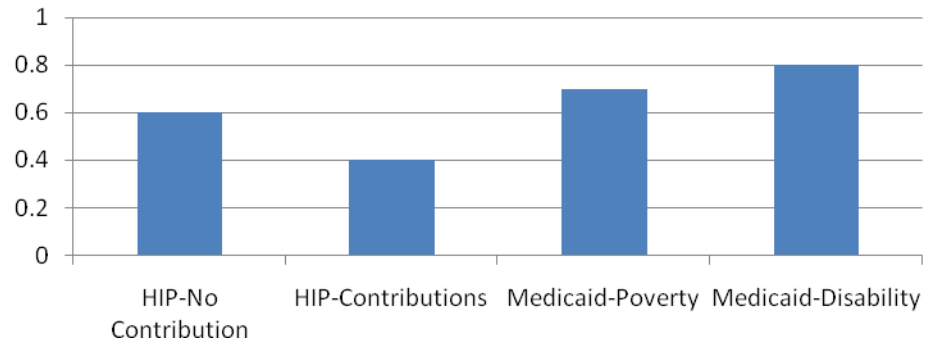
[18] If we are able to distinguish between emergent and non-emergent visits to the emergency room in encounter data (for example, if encounters indicate a beneficiary co-payment consistent with the HIP co-payment schedule for non-emergent visits), we will further refine this analysis to consider the ratio of non-emergent emergency room visits to total acute ambulatory care visits.

regression-adjusted means (such as average number of emergency room visits per year) for comparison across key subgroups (HIP-no contribution, HIP-contribution, Medicaid-poverty eligible, Medicaid-disability eligible).

The two Medicaid comparison groups will include working-age adults only and who are not eligible for Medicare coverage. We anticipate using a probabilistic selection method to match Medicaid adults who are similar to HIP enrollees on basic characteristics, such as age, gender, race, zip code of residence, and chronic illnesses (as measured by post-enrollment treatment for specific diagnoses). One matched sample will be drawn from Medicaid beneficiaries who are eligible on the basis of their poverty status (Hoosier Healthwise), and the other group will be drawn from those who are eligible on the basis of disability (Care Select). We choose these two comparison groups because we expect that beneficiaries in the poverty-related eligibility groups should be closely equivalent to zero-contribution caretakers. Also, the health plans have reported that HIP enrollees have high service utilization rates that appear similar to those observed in the disability-related Medicaid population. It is possible that some zero-contribution HIP non-caretakers may be very similar to the regular Medicaid disabled population.

An example of how we might present the results for emergency room utilization is shown in Figure III.2. We will estimate the equations separately for each calendar year, expecting that HIP participants may become more cost-conscious over time (and therefore the difference between comparison groups may grow larger over time), as they learn the program's incentives and have experiences with POWER account rollovers.

Figure III.2 Regression-Adjusted Ratio of Emergency Room Use to Total Acute Care Ambulatory Visits



Note: These data are fictitious and for illustration purposes only.

For these continuous measures, we will use a form of ordinary least squares for the regression analyses. We will control for as many demographic characteristics as possible, but information from eligibility and claims and encounter records is usually limited and does not include income and education levels. In addition, these analyses will require some specialized preparation of the data and the use of weights, because HIP enrollees and Medicaid beneficiaries may leave their respective programs mid-year. To account for mid-year attrition, outcomes will be annualized (that is, number of office visits for the year will be divided by the number of months enrolled in HIP [or Medicaid] and then multiplied by 12).

5. Key Analytical Issues and Limitations

Identifying with certainty that HIP enrollees respond to the program's financial incentives and engage in value-based purchasing is extremely difficult. In our analyses we face the difficulties of (1) disaggregating the effect of income and education levels from the effect of the monthly contribution; (2) measuring the incentive effects if large numbers of enrollees exhaust their POWER accounts before the end of the year; (3) studying enrollee behavior when they may not always have access to information that would allow them to make a value-based judgment; and (4) using claims and administrative data to detect utilization patterns that suggest value-based purchasing.

Several of our analyses described above relay on program eligibility and POWER account records. While these records provide rich information about someone's enrollment history and POWER account contributions, they do not contain information about family income (unless we obtain income from application records) and education levels. More importantly, they do not provide information on employment opportunities. As a result, our estimates of the relationship between POWER accounts and program enrollment will be measured with error, and we think they will be biased upwards. For example, those with incomes just below 200 percent FPL may be more likely to enter a new job with health insurance options, as compared to those with incomes at 100 percent FPL. Enrollees with a new employer-sponsored coverage option may simply stop making POWER account payments, without waiting for a formal redetermination of eligibility. If this scenario occurs more frequently among higher-income enrollees, then we will overestimate the difference in mid-year exit rates associated with POWER account contribution levels.

A more difficult challenge is presented by the possibility that large numbers of HIP enrollees may exhaust their POWER accounts and never have the opportunity of earning a rollover. During the first year of program operations, both plans reported that large numbers of HIP enrollees, between 70 and 94 percent depending on the plan, spent through their POWER account in 2008 [2]. If this high rate of spending primarily reflects pent-up demand, then spending may decline in subsequent years as enrollees have better access to care and learn how program incentives work. With this early information in mind, it may be most effective to delay some analyses related to POWER account rollovers until the pool of enrollees with at least two years of program experience is sufficiently large. However, if most enrollees turn out to have chronic conditions that cannot reasonably be treated within the $1,100 limit, the potential effectiveness of the rollover incentive may be diminished and difficult to identify.

Value-based purchasing is based on the premise that enrollees can make a judgment about health care services based on information on service costs prior to receiving or selecting a service. At least during the first year of program operations, enrollee access to cost information that would have permitted them to be value-conscious consumers varied by health plan (MDwise and Anthem) [2]. Both Anthem and MDwise issue monthly statements that detail each enrollee's service use and how service use affected the enrollee's POWER account; however, MDwise and its subcontractor responsible for the management of these statements had difficulties in consistently distributing the monthly statements during the initial 18 months of program operations. In addition, Anthem made cost information more readily available than MDwise. Anthem reported that since July 2008, its members may monitor their spending through online accounts, a tool that has not been available to MDwise members [2]. Through the online tool,

Anthem enrollees are also able to view comparative cost information and determine the impact on their POWER account of an appointment or procedure *before* they even schedule it [2]. Such tools improve the likelihood that enrollees will begin making value-conscious decisions.

Our plans also include using claims and encounter data to detect value-based purchasing by assessing patterns of care (emergency room and acute-care office visits in particular). For this work, the comparison groups of people who do not have the same incentives to engage in value-based purchasing include (1) HIP enrollees who do not make monthly contributions and (2) two groups of working-age adult Medicaid beneficiaries (those in the poverty-related eligibility groups and those in the disability-related eligibility groups). As with the analyses of POWER accounts and enrollment outcomes, these analyses will also be challenged by our inability to adequately separate the effects of income from the effects of program incentives. In addition, there may be other individual-level and program-level characteristics that affect patterns of care that our analyses cannot address in a regression framework. Finally, we note that Medicaid beneficiaries are not the ideal comparison group, but they are a good option when a random assignment study design is not available. Medicaid beneficiaries have lower incomes and qualify for a program in which, by definition, HIP enrollees cannot participate. Because of the very low income (and asset) requirements for eligibility, these Medicaid beneficiaries may have quite different care-seeking patterns than those who enroll in HIP, making it difficult to interpret observed differences.

Recognizing these challenges, we will supplement our analyses of administrative and encounter data with primary data that we collect through the HIP enrollee survey. These data will help us interpret our analyses of administrative information and they will support additional analyses for a sample of HIP enrollees. As described in Chapter II, the survey data will include a rich array of demographic characteristics and health status information for a sample of enrollees (also see the draft survey instrument in Appendix A). The survey will collect information on enrollee knowledge of their POWER accounts and program incentives and whether they engage in behaviors that suggest they are value-based purchasers. Because we will collect information on income, education levels, health status, and monthly contributions, we will improve our ability to separate income effects, from health status effects, from POWER account effects when we assess knowledge of program incentives and the utilization of emergency rooms.

Although the survey data will provide key information that is not obtainable from administrative records, some analyses may be limited because of sample size issues. We are aiming to complete 1,600 surveys—800 with new enrollees and 800 with established enrollees. Each group will be evenly divided between caretakers and non-caretakers. Samples of these sizes may appear adequate, but for some detailed subgroup analyses (that is, established enrollees by caretaker status by plan type) the subsamples may be too small to produce reliable estimates. At a minimum, we will produce "first-level" descriptive statistics for each of the subgroups of interest (such as, caretakers compared to non-caretakers and Anthem members compared to MDwise members).

D. Goal 4: Promote Primary Prevention for HIP Participants

HIP encourages the use of preventive services by providing them for free, and by tying participants' authorization to carry over unspent POWER account funds to the completion of

required preventive care. To identify whether HIP has promoted primary prevention, we will assess (1) general patterns of preventive care use compared to other similar Medicaid beneficiaries and national benchmarks; (2) how preventive care utilization changes after enrollment in HIP; and (3) enrollment rates in health promotion programs offered by the health plans.

TABLE III.8 GOAL 4 ANALYSIS PLAN

Research Question	Measures	Data Sources	Methodology	Issues and Limitations
Utilization of Preventive Care Services				
Are HIP enrollees more likely than regular Medicaid beneficiaries to receive preventive services?	HIP-recommended preventive services: -annual physical -blood glucose screening -tetanus-diptheria booster -cholesterol testing -flu shot -colonoscopy -mammogram -pap smear -Chlamydia screening	Claims and encounter data for HIP, HHW, and Care Select	-Compare rates for HIP (contributors, and zero contributors) to matched sample of Medicaid adults -Compare performance by plan enrollment -Regression analysis, and examine trends over time -Comparison to external benchmarks (HEDIS, HP2010)	-Service records available may not completely capture preventive service use, particularly for services many obtain free in the community; however, bias is likely to be the same for HIP and regular Medicaid -Unlikely to control adequately for effects of income and other factors such as job market opportunities
The Effects of HIP on Utilization of Preventive Services				
Do people increase their use of preventive care after enrolling in HIP?	-Self-reported preventive service use (physician visit, mammogram, etc) -Self-reported health status and change in health status	HIP Enrollee Survey	-Regression analysis to control for demographic characteristics	-Respondents' recall (particularly among new enrollees) -Direction of bias will likely result in overestimation of the effect of HIP

Table III.8 *(continued)*

Research Question	Measures	Data Sources	Methodology	Issues and Limitations
Participation in Health Promotion Programs				
Do HIP enrollees enroll in health promotion programs offered by the health plans?	-Enrollment counts (percentage of invited/eligible) for health plan health promotion programs -Participation by demographic characteristics (if available)	Health plan administrative data	Descriptive statistics	Analysis limited to data health plans can provide

HEDIS = Healthcare Effectiveness Data and Information Set; HHW = Hoosier Healthwise; HP2010 = Healthy People 2010.

1. Utilization of Preventive Care Services

Because HIP enrollees face unique financial incentives related to the POWER account, they are expected to utilize preventive services at higher rates than other Medicaid beneficiaries. Indeed, the expected boost in preventive care use (and assumed reduction in costs for preventable conditions) was considered part of the "return on investment" for using Indiana cigarette tax revenues to expand coverage. However, HIP enrollees may also have higher utilization rates due to differences in the way that health plans manage the different programs. For example, HIP members may seek out services because of the health plans' reminder campaigns, without an awareness of the POWER account implications.

To tease out the consumer-driven effect from the health plan management effects, we will compare preventive service utilization among HIP enrollees who make contributions to their POWER accounts, HIP enrollees who do not make contributions, and two comparison groups of adult Medicaid beneficiaries, those eligible on the basis of their poverty status and those eligible on the basis of disability. If HIP enrollees who do not make contributions are less likely to receive preventive services compared to those who make POWER account contributions, it suggests that the financial incentives are working as designed—having "skin in the game" has influenced behavior. If results also show that HIP enrollees who make zero contributions were more likely to receive preventive services compared to other Medicaid beneficiaries, this suggests that global program effects, through a combination of heightened awareness about preventive care and health plans' additional incentives, likely play a role in observed outcomes as well.

Using service records the health plans submit, we will construct measures of preventive service use as outlined in Table III.9. Beginning in 2009, HIP enrollees must complete these services to qualify for POWER account rollover (only an annual physical was required in 2008).

TABLE III.9 REQUIRED PREVENTIVE SERVICES FOR HIP PARTICIPANTS, BEGINNING 2009

Preventive Service	Male 19-34	Male 35-49	Male 50-64	Female 19-34	Female 35-49	Female 50-64
Annual Physical	X	X	X	X	X	X
Blood Glucose Screening	X	X	X	X	X	X
Tetanus-Diphtheria Booster	X	X	X	X	X	X
Cholesterol Testing		X	X		45+	X
Flu Shot			X			X
Colonoscopy			X			X
Mammogram					X	X
Pap Smear				X	X	X
Chlamydia Screening				< 25		

We plan to analyze these outcome measures using the same statistical approach outlined in Goal 3, Section 4. Specifically, we will create regression-adjusted estimates of the proportion of each population (HIP-contribution, HIP-no contribution, matched Medicaid adults [poverty and disability-related]) that completed the recommended service. We will run separate regressions for each service and for combinations of services (for example, the proportion receiving all recommended services). The models will control for potential explanatory factors such as age, gender (if applicable), race, eligibility category, zip code, and presence of chronic illnesses. Because HIP enrollees may learn more about (and be more responsive to) the program's built-in financial incentives as the demonstration continues, we will estimate these equations separately for each year. To the extent that resources allow and OMPP finds these analyses useful, we will also conduct subgroup analyses that examine the likelihood of receiving preventive care by plan enrollment (Anthem or MDwise), because we expect that health plan promotions and direct communications with enrollees may strongly influence observed rates.

While regression analyses provide an estimate of the impact of HIP on preventive service use, the state may also wish to learn how HIP program performance compares to other key benchmarks. Accordingly, we will identify comparable measures that are available at the national level, such as National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) Medicaid benchmarks (breast and cervical cancer screening), the National Health Interview Survey (colorectal cancer screening), or Healthy People 2010 (influenza vaccinations), as shown in Table III.10. We will compare scores for the HIP program (by plan) and for the comparison groups of Medicaid beneficiaries with each of these benchmarks.

TABLE III.10 HIP PROGRAM PERFORMANCE IN COMPARISON TO KEY BENCHMARKS

	HIP			Medicaid		
Preventive Measure	MDwise	Anthem	ESP	Poverty Related	Disability Related	Goal or Benchmark
Influenza vaccination						85%[a]
Breast cancer screening						65%[b]
Cervical cancer screening						79%[b]
Colorectal cancer screening						48%[c]

Sources:

[a] U.S. Department of Health and Human Services. "Healthy People 2010." [21]

[b] National Committee for Quality Assurance. "NCQA 90th percentile Medicaid benchmarks." [22]

[c] National Center for Health Statistics. "National Health Interview Survey." [23]

2. The Effects of HIP on Utilization of Preventive Services

Another way to quantify HIP's success in promoting primary prevention is to compare HIP enrollees to the uninsured. Because they have lower cost barriers and greater information about which services are recommended, HIP enrollees are expected to receive preventive care at greater rates than the uninsured. To the extent that the HIP program successfully "activates" enrollees, they may also be more likely to engage in healthful behaviors. In some cases, these changes in preventive care utilization and healthy behaviors could result in short-term improvements in health status. For example, enrollees who complete an annual physical and are counseled about weight management may begin a weight loss program, making them feel more energetic.

We will use the HIP enrollee survey to gather information on self-reported receipt of preventive care and health status. Since we will ask about experiences in the period before the interview (six months or longer depending on the question), responses from new enrollees (those enrolled in HIP for about a month) will reflect their experiences while uninsured, while responses from established enrollees (those beginning a second year of HIP coverage) will reflect the effects of HIP. Potential outcome measures that we will explore include:

- **Receipt of preventive care.** Survey questions will explore whether, in the past year, respondents had received a physician visit, had their cholesterol levels measured or had a blood glucose screening. For women, we will also ask whether they received a pap smear, mammogram, or were screened for Chlamydia.
- **Health status.** We will ask about enrollees' general self-reported health and any changes in health status over the past year.

For each measure, we will construct a regression model that predicts the likelihood that an enrollee received a service or reported a change in health status. These models will include controls for age, gender (if applicable), income, educational level, whether the enrollee has a

chronic condition, and whether he/she is a new or established enrollee. The difference between new and established enrollees is the estimated effect of the HIP program.

3. Participation in Health Promotion Programs

Early evidence from our 2009 interviews indicates that both MDwise and Anthem are taking additional steps to promote primary prevention activities by distributing member education materials and offering incentives to encourage participants to have an initial health assessment and practice ongoing healthy behaviors [2].[19] Both Anthem and MDwise offer various health promotion programs to try to improve the health of their members. We anticipate that these activities may be episodic, vary in scale over time, and have differing levels of financial incentives. The level of participation in these programs provides some indication of the level of enrollee "activation" and can assist in interpreting other measured outcomes. For example, if we find that a high percentage of enrollees participate in the programs, we would have more confidence in survey results that showed an increase in the receipt of preventive services.

If the data are available from the plans, we will document all programs and incentives offered throughout the demonstration period, as well as the number and percentage of HIP members who participate. We will also trend within-plan rates to determine whether changing financial incentives impact participation rates. If aggregate data are available (or if health promotion program participation records can be linked with administrative data), we will examine how demographic characteristics and health status (whether an enrollee has a chronic condition) are associated with participation, aiming to identify difficult-to-reach populations that may warrant more aggressive outreach from health plans. Because no benchmarks exist for participation rates in health promotion programs, our analysis will be limited to a descriptive review of the available data. We expect that these findings will be most useful from a program development and management perspective, illustrating the extent to which enrollees respond to more immediate financial incentives, like gift cards for getting preventive care.

4. Key Analytical Issues and Limitations

Similar to other analyses, the key analytical issues and limitations we face when assessing HIP and preventive care are associated with limitations of the data. Anecdotal reports from MDwise and Anthem suggest that encounter data may not capture all preventive service use, because enrollees may be able to obtain some services for free (such as blood glucose screenings) through community health events [2]. Although we have no reason to believe that HIP enrollees will be any more or less likely to obtain free preventive services than regular

[19] Initially, both MDwise and Anthem provided HIP enrollees with incentive payments in the range of $50 to $100 for completing health assessments at the time of enrollment and for making an initial physician visit, but these payments may be discontinued, given the additional costs associated with promoting the options and relatively low take-up rates (MDwise reported 9 percent). For 2009, MDwise is continuing its incentives, while Anthem is phasing them out in view of HIP's general cost pressures and is instead providing discounts for participants to attend healthy lifestyle programs, such as weight loss clinics.

Medicaid beneficiaries, we are concerned about a reporting bias in the data. Specifically, HIP enrollees have the incentive of a POWER account rollover to make sure their health plans know that they have obtained a particular service. After the 2009 POWER account reconciliation process has been completed, we will interview the health plans about their methods for verifying enrollee reports of out-of-system preventive care, as well as how those services may or may not be reflected in the encounter records. If the health plans do not alter their encounter records to reflect these services, and do not require enrollees to repeat the service for official documentation, then Medicaid and HIP encounter records are likely to be comparable, reflecting the same underreporting bias, which would allow us to make valid comparisons across the groups.

The survey of HIP enrollees will allow us to extend the analyses of preventive care utilization beyond those we can do with claims and encounter records. We will ask respondents to report the receipt of preventive care services either before enrolling in HIP (new enrollees) or before the interview (established enrollees). If we observe that the HIP program has increased preventive care use (that established enrollees report the receipt of preventive services more frequently than new enrollees), this will provide evidence that the program has had a positive impact on enrollees, even in the short-term. Our main challenge with this analysis will be recall error; enrollees may not accurately recall their preventive service use over the past year. The likely direction of these biases may cause us to overestimate the effect of the HIP program. For example, we might expect established participants to have better recall of service use (thanks to health plan electronic tools and the POWER account reconciliation process), and they may be less willing to report poor behaviors (having received a year of health promotion materials). Accordingly, we will interpret these survey results with caution and note the likelihood our estimates are upper bounds for the true effect.

E. Goal 5: Prevent Chronic Disease Progression with Secondary Prevention

By lowering cost and access barriers to care and activating members to be more engaged patients, HIP aims to slow disease progression among enrollees with chronic conditions. We initially planned to measure progress towards this goal by considering the experience of enrollees in the enhanced services plan (ESP), a separate plan designed for individuals with high-risk conditions. However, we suggest modifying these analyses to focus on all HIP enrollees with chronic conditions (whether or not they are enrolled in the ESP) because: (1) ESP enrollment has been much smaller than expected (less than one percent of enrollees), although the eligibility criteria and enrollment processes for ESP are under review and changes may open up this component of the program to more enrollees; (2) both health plans report that a large proportion of non-ESP enrollees have chronic disease, resulting in a higher-than-expected number of referrals to the plans' disease management programs; and (3) ESP eligible conditions do not include many of the most common chronic conditions, such as diabetes and heart disease.

To determine the extent to which HIP is able to slow disease progression, we will assess (1) the occurrence of preventable acute care use such as preventable or ambulatory-sensitive hospitalizations and emergency room visits; (2) process of care HEDIS measures; and (3) participation in the health plans' disease management programs.

TABLE III.11 GOAL 5 ANALYSIS PLAN

Research Question	Measures	Data Sources	Methodology	Issues and Limitations
Preventable Acute Care Use				
Are HIP enrollees with chronic conditions less likely than regular Medicaid beneficiaries to experience negative outcomes?	Preventable hospitalizations and emergency room use	Claims and encounter records for HIP, HHW, and Care Select members with chronic conditions	Compare rates for HIP (5 most common chronic conditions and one subgroup with multiple chronic conditions) to matched sample of Medicaid adults -Year-by-year trends -Regression analysis to control for demographic characteristics	Analysis of preventable hospitalizations may not be possible for all chronic conditions because of lack of valid condition-specific measures
Process of Care				
How does HIP perform on process of care measures for chronic conditions, compared to regular Medicaid? To external benchmarks?	HEDIS measures for common chronic conditions, as available	Claims and encounter records for HIP, HHW, and Care Select members with 5 most common chronic conditions	Descriptive statistics	-Process of care measurements may not be available for all chronic conditions we might consider -Completeness of encounter data will determine whether we can construct some measures
Utilization of Disease Management Programs				
Do HIP enrollees enroll in health plan disease management programs?	-Enrollment counts (percentage of invited/eligible) for health plan disease management programs -Participation by demographic characteristics (if available)	Health plan administrative data	Descriptive statistics	Analysis limited to the data the health plans provide

HEDIS = Healthcare Effectiveness Data and Information Set; HHW = Hoosier Healthwise.

1. Preventable Hospitalizations

If HIP enrollees are more activated patients and have better access to disease management programs, we would expect them to have fewer adverse events, such as preventable hospitalizations, than to similar Medicaid beneficiaries. In fact, HIP's unique financial incentives and active health plan involvement are specifically designed to encourage patients to see the doctor and receive cost-effective care. However, it is also possible that HIP enrollees misunderstand the financial incentives in HIP (for example, thinking that they have only $1,100 in coverage) and may restrict their use of services, ultimately resulting in higher rates of adverse events.

To assess the effect of HIP on preventable hospitalizations and the management of chronic conditions, we will compare HIP enrollees with chronic conditions to two matched groups of regular Medicaid beneficiaries (poverty-related and disability-related) with similar chronic conditions. Our overall approach to these analyses will closely mirror that of Goal 3, Section 4. First, we will apply the CDPS to claims and encounter data to identify HIP enrollees with chronic conditions in the five most common categories. The CDPS groups individuals into categories of chronic conditions—such as pulmonary conditions—rather than specifically identifying beneficiaries with a single condition (such as asthma). Within each category, the algorithm also identifies high-cost or low-cost chronic conditions.

After selecting the most common chronic condition groups, we will use propensity score methods to identify two matched groups of Medicaid beneficiaries with the same illnesses and comparable age, gender, race, and zip code of residence. We will then use software developed by AHRQ (Prevention Quality Indicators) to identify whether a patient experienced any preventable hospitalizations. The current version of AHRQ's software includes algorithms for identifying preventable hospitalizations related to diabetes, chronic respiratory diseases (asthma and chronic obstructive pulmonary disease [COPD]), and circulatory diseases (hypertension, congestive heart failure, and angina).

For each of these outcome measures, we will develop a regression model to predict a preventable hospitalization and to test for statistically significant differences between HIP enrollees and regular Medicaid beneficiaries. To the extent that sample sizes permit, we will develop separate regression models for each of the conditions, to determine whether the difference between HIP and regular Medicaid differs by condition. We might expect these differences if, for example, plans have robust and long-standing diabetes-management programs, but are slower or less effective at introducing programs for other conditions. Stratifying by condition will also allow us to examine the marginal effect of HIP for conditions where comparable disease management programs are also available for regular Medicaid. For example, Care Select, the state's program for Medicaid beneficiaries eligible on the basis of disability, operates disease management programs for diabetes, asthma, congestive heart failure, and hypertension (MDwise participates as a Care Select care management organization [CMO]).

2. Process of Care

Although the regression framework described above will provide the most robust tests of the effects of HIP on secondary disease progression, it may be difficult for HIP to affect a change in

these outcome measures over the period that we will examine. For example, a member with long-standing diabetes who has been inadequately treated may be difficult to bring under control, and complications of diabetes, such as vascular and vision problems, may be well underway and difficult to reverse. Given this limitation, process-of-care measurements may provide more immediate feedback on HIP's progress towards this goal. Logically, we would expect that changes in health plan management and consumer activation would first appear through changes in methods of care.

We will calculate HEDIS process-of-care measurements (as available) for the chronic conditions used in our regression analysis of adverse events. We will calculate these measures for HIP (by plan type) and for the comparison groups of regular Medicaid beneficiaries, and will compare these measures to national Medicaid benchmarks. Table III.12 shows potential measures for enrollees with cardiovascular conditions and diabetes.

TABLE III.12 HIP PROCESS-OF-CARE MEASURES AND COMPARISON TO NATIONAL BENCHMARKS

	HIP Program Statistics			Indiana Medicaid		NCQA HEDIS Benchmarks for Medicaid Population	
Process of Care Measures	MDwise	Anthem	ESP	Disability Related	Poverty Related	90th percentile	75th percentile
Diabetes Care							
Eye exam						68%	63%
HbA1c testing						89%	84%
Medical attention for nephropathy						86%	82%
Cardiovascular Care							
Cholesterol management						87%	82%
Controlling high blood pressure						66%	60%

ESP = Enhanced Services Plan; HEDIS = Healthcare Effectiveness Data and Information Set; NCQA = National Committee for Quality Assurance.

3. Utilization of Disease Management Programs

As noted above, both Anthem and MDwise offer disease management programs that use various techniques to try to improve health and control costs for certain target populations, such as those with diabetes or cardiovascular disease. Analysis of the types and intensity of the interventions that health plans provide will be used to help interpret the findings from our regression analyses. For example, we would expect to see the greatest difference between HIP and regular Medicaid for conditions for which HIP health plans offer the most intensive disease management programs.

If the data are available from the plans, we will document all programs offered throughout the demonstration period, using key informant interviews to learn about the specific interventions in each program and the types of outreach used to recruit participants. We will note

the number and percentage of HIP members with the condition who participate (using the number of members with the specified chronic condition that we identify from encounter data as the denominator). If aggregate data are available (or if participation records can be linked with administrative data), we will also examine how demographic characteristics and health status are associated with participation.

Because there are no benchmarks by which to measure "successful" participation rates in disease management programs, our analysis will be limited to a descriptive review of the available data. If major differences in recruitment emerge by plan type (Anthem versus MDwise), these analyses may prove useful from a program development perspective, helping state program managers identify the most effective techniques for engaging enrollees in care management.

4. Key Analytical Issues and Limitations

Detecting whether HIP effects the progression of chronic disease will be extremely difficult given the short time frame of the evaluation and the long-run nature of this particular goal. We anticipate that some people will enroll in HIP with advanced disease and the program will be challenged to bring the progression of these cases under control. Even among people in the initial stages of a chronic condition, it may take several years of enrollment in the program to identify whether the program was successful in arresting the progression of the condition. As a result, our analyses of this goal will focus on hospitalizations that may be preventable with appropriate ambulatory care, benchmarking of process-of-care measures for common conditions, and participation in disease management programs.

Our most difficult analysis will be the assessment of preventable hospitalizations. This component of our work may be limited because the AHRQ algorithms currently address a relatively narrow range of conditions. In addition, preventable hospitalizations by their nature should be relatively rare events and it is possible that the HIP population is too small to produce reliable estimates. If we find this issue to be evident, we will investigate the possibility of expanding the work to include emergency room visits to the conditions used in the AHRQ algorithms. Nevertheless, we must be prepared for the possibility that these analyses will only be considered exploratory at best.

We will interpret our results in the context of other analyses to determine whether we have a consistent body of evidence. For example, if we find that preventable hospitalization rates for cardiovascular patients in HIP are lower than those from regular Medicaid beneficiaries, it is not clear whether this difference is because disease management programs are more effective in HIP, or because HIP enrollees are healthy in some way that we cannot measure. In narrowing down possible explanations, we will look to whether process-of-care measures are better among this type of HIP enrollee and whether these enrollees are getting more preventive care. If we found, that HIP process-of-care measurements were better than those in regular Medicaid, we would be more confident that differences in preventable hospitalizations (and emergency room visits) are due to differences in health plan management of chronic conditions.

F. Goal 6: Provide Appropriate and Quality-Based Health Care Services

A critical goal for HIP is to provide appropriate and quality-based health care services. While OMPP is ultimately responsible for ensuring the quality of services delivered to HIP enrollees, much of the day-to-day responsibility rests with the two contracted health plans, Anthem and MDwise, through such activities as provider selection and credentialing, promotion of quality improvement activities, and monitoring of quality measures and complaint data. Thus, our approach for evaluating HIP's achievement of this goal includes (1) examining measures of clinical quality of care delivered within the two contracted health plans (Anthem and MDwise); (2) assessing satisfaction of HIP enrollees; (3) examining inquiry and complaint data from OMPP's IQ tracking log, as well as complaints/grievances data reported by the plans; and (4) analyzing the capacity of the HIP health plans to deliver appropriate quality care, based on telephone interviews and financial and operational reports.

TABLE III.13 GOAL 6 ANALYSIS PLAN

Research Questions	Measures	Data Sources	Methods	Issues and Limitations
Quality Performance of HIP Contracted Health Plans				
How do HIP contracted health plans perform on selected HEDIS quality measures?	HEDIS measures (examples subject to change): -Persistence of beta-blocker treatment after a heart attack -Disease-modifying anti-rheumatic drug therapy for rheumatoid arthritis -Use of imaging studies for low back pain -Antidepressant medication management -Follow-up after hospitalization for mental illness -Use of appropriate medications for people with asthma -Avoidance of antibiotic treatment for adults with acute bronchitis	-Plan-specific HEDIS reporting -HHW and Care Select reports -National HEDIS reports	-Compare results for Anthem and MDwise -Compare HIP results to HHW and Care Select results -Compare HIP results to national Medicaid benchmarks, as available	-Lack of statistical controls for differences in beneficiary characteristics which may partially explain differences in performance -HEDIS targets a limited number of clinical conditions, and focuses primarily on access to care

Table III.13 *(continued)*

Research Questions	Measures	Data Sources	Methods	Issues and Limitations
Enrollee Satisfaction				
How do enrollees perceive the quality of care they receive in the HIP program?	-Enrollee overall satisfaction with the program -Enrollee reports of having a medical home (usual doctor) -Enrollee reports that they have to change their usual doctor upon enrollment in HIP -Enrollee reports of services they need that are not covered by HIP -Enrollee reports of whether they think they received enough information to understand their POWER accounts	HIP Enrollee Survey	-Compare reports of new versus established enrollees -Provide descriptive statistics regarding factors related to satisfaction	May overestimate the level of satisfaction if recent disenrollees are more dissatisfied than current enrollees
Complaints and Inquiries				
To what extent do complaints or inquiries about HIP focus on quality of care issues? What types of quality issues are identified?	-Rate of total number of quality-related complaints per number of enrollees -Types of complaints related to access or quality of care	OMPP IQ tracking log	Month-by-month trends in complaints, by type	Complaints related to service delivery may be a signal of quality problems, but multiple complaints or emerging patterns will provide more robust evidence warranting further investigation

Table III.13 *(continued)*

Research Questions	Measures	Data Sources	Methods	Issues and Limitations
Health Plan Operations and Financial Performance				
What is the financial performance of health plans contracting with HIP? What operational issues may contribute to performance in delivering services of appropriate quality?	-State government and health plan staff assessments of operational and financial issues related to quality Health plan financial performance data: -Financial solvency/reserves -Revenues, costs, cash flow	-Telephone interviews with state and health plan staff -Document review -Financial records submitted to the State or other entities such as NAIC annual or quarterly filings	-Qualitative analysis to identify financial or operational topics or issues thought to be related to capacity to provide quality of care -Comparisons of health plan reports to national or state guideline benchmarks	-Financial performance may or may not be directly related to quality of care -Some data may not be HIP specific within health plans (e.g. financial assets)

HEDIS = Healthcare Effectiveness Data and Information Set; HHW = Hoosier Healthwise; IQ = Intranet Quorums; NAIC = National Association of Insurance Commissioners; OMPP = Office of Medicaid Policy and Planning.

1. Quality Performance of HIP Contracted Health Plans

To assess the quality of care delivered within the two HIP plans, we will examine audited, HIP-specific HEDIS measures reported by both Anthem and MDwise. HIP-specific HEDIS measure reporting will be required of the contracted plans starting in 2010. HEDIS measures represent well-accepted measures of quality using primarily data from administrative records, and relevant benchmarks for assessing performance are available. The 2010 HEDIS measure set contains 17 measures relevant to the adult Medicaid population. We are likely to use a subset of these 17 measures (examples are provided in Table III.13) depending on the measures that are actually reported by plans, and on the measures that are used in analyses related to Goals 3, 4, and 5. We will consult with OMPP about the HEDIS reporting requirements for ESP enrollees.

Our analysis will involve three main comparisons. First, we will examine how performance on HEDIS measures varies between the two plans to assess whether enrollees are having substantially different experiences, based on their choice of plan. Second, we will compare HIP HEDIS scores to the same measures for Hoosier Healthwise and Care Select to assess how the contracted health plans perform in serving HIP enrollees compared to how they and other plans perform in serving Medicaid beneficiaries. Third, we will compare HEDIS measure performance of the two plans to published national Medicaid performance benchmarks to assess how HIP quality performance compares to quality performance of plans treating Medicaid beneficiaries.

2. Enrollee Satisfaction with HIP

In addition to clinical quality measures, it will also be important to get enrollees' perspectives on quality of care by assessing their satisfaction with HIP. Although they rely on primarily subjective judgments, HIP enrollees have a unique vantage point from which to assess quality. Enrollee reports on quality also allow for a synthesis of various dimensions of quality into single measures, such as overall ratings, given enrollees' own values and unique circumstances. We will assess enrollees' satisfaction based on a survey of HIP enrollees conducted by Mathematica in 2010 (for more details on the survey see Appendix A).

A key part of the analysis will involve comparing new and established HIP participants, controlling for individual-level characteristics in a regression analysis, to see if greater experience with the program is associated with higher or lower satisfaction. To the extent that established HIP participants have high rates of satisfaction compared to newer participants, this may indicate that these participants are experiencing better quality of care than they had been accustomed to in the past. A potential bias in this analysis might occur if the most dissatisfied participants have disenrolled before being surveyed. While we believe that most disenrollees are likely to disenroll for largely non-voluntary reasons, we will investigate this potential for bias working with OMPP to identify ways we might assess reasons for disenrollment, and by looking at overall rates of disenrollment (see Goal 1).

We will also examine satisfaction for enrollees in each health plan to assess the relative performance of the plans, controlling for differences in individual-level characteristics. Other key subgroups, such as those with very low incomes and those in poor health will also be examined to assess HIP's ability to provide high quality care for the most vulnerable populations.

3. Analysis of HIP Complaint and Inquiry Data

We will also examine trends in complaint data to assess whether any quality issues arise over time and to identify specific areas of quality that emerge as issues for HIP. Complaints can be an important early signal of emerging or systematic quality issues that might not be picked up as quickly by annual surveys or data collection processes such as HEDIS.

To date, the large majority of inquiries/complaints on OMPP's IQ tracking log have focused on administrative issues, such as contributions to the POWER account, rather than service delivery [2]. The IQ tracking log is an ongoing management tool and its reports will provide a useful data source for assessing trends in complaints over the course of the first several years of the programs to gauge program performance. In addition, we will review the health plans' complaints and grievances data, which also are reported to the state.

We will examine whether complaints about service delivery or access to care—as a proportion of all questions or complaints about administrative issues and on a per enrollee basis—increase or decrease over time, potentially indicating emerging problems with quality or improving quality. We will also examine whether quality-of-care related complaints tend to focus on particular aspects of service delivery or types of providers to assess whether these might

be signals of more systematic issues in particular areas, warranting further analysis. If feasible, we will also look at complaint patterns within Anthem, MDwise and the ESP plan.

4. Analysis of HIP Health Plan Operations and Financial Performance

We will assess the financial and operational performance of HIP health plans to complement and provide further context to the quality analyses described above. The aim of this part of the analysis of Goal 6 will be to understand whether plans have, and are devoting, the resources necessary to provide appropriate quality of care, while assessing any plan-specific operational issues that might contribute to quality of care.

Our analysis of this aspect of Goal 6 will be divided into two parts. First, we will conduct annual telephone interviews with key OMPP and/or Indiana Department of Insurance staff to assess the critical financial or operational issues that might affect quality of care in HIP, followed by interviews with health plan staff on these topics. For example, we will want to discuss changes in methods for assigning enrollees to primary medical providers (PMPs), changes in plan and/or provider risk-sharing arrangements, or changes in quality improvement activities, data collection, or other oversight efforts by OMPP. In the course of these interviews, we will request any documents referenced that may be helpful in further understanding these issues, such as external quality review organization reports or other relevant findings.

Then, as appropriate, and based on what we learn during the telephone interviews, we will conduct an analysis of key health plan financial data reported to OMPP and/or the Department of Insurance or the National Association of Insurance Commissioners (NAIC) to assess whether plans meet key financial performance benchmarks with respect to such measures as adequacy of assets and liabilities, loss ratios, cash flows, and/or revenues compared to costs. We will use relevant state standards and/or standards established by the NAIC as key points of comparison for assessing these data.

In general, adequate reserves, revenues equal to or exceeding costs, and loss ratios indicating limited administrative costs compared to health care delivery costs would be indicators that the contract plans have the resources to deliver high quality services and are doing so efficiently. We are aware that corporate level reporting for large health plans can mask financial performance for a particular line of business. Thus, to the degree possible, we will investigate financial performance for each plan's HIP line of business as well as for Anthem and MDWise overall. As appropriate, we may also request and analyze other documentation on health plan operations with respect to staffing, service delivery, or development of provider networks.

5. Key Analytical Issues and Limitations

Our multiple analyses of the provision of appropriate and quality health care is designed to provide a body of evidence to assess how well the contracted health plans are providing care to HIP enrollees. Most of our analyses will be done at either the health plan or program level (assessment of clinical quality, complaints and inquiries, and plan financial performance) and we will not be able to disentangle this information and adjust for elements and factors that may help

us understand what is driving the results we find. For example, when assessing HEDIS measures, we will rely on plan-level data and will not be able to adjust for differences in enrollee characteristics. However, because most HEDIS measures involve assessing whether recommended services have been provided to enrollees with particular conditions, regardless of comorbidities or severity of illness for example, adjustments for these or other characteristics are less critical than for other outcome-based measures. Nonetheless, a key limitation to our analysis will be the inability to examine quality performance for subgroups within the two plans. We also may not be able to include comparable measures for the ESP enrollees, if reporting of HEDIS measures is not required for the ESP.

In the case of the analyses of complaints and inquiries, we may try to examine individual-level data, if feasible to get more detail on emerging trends of particular interest. A key limitation of this analysis will be the lack of relevant benchmarks for assessing whether complaints about quality are higher than expected; depending on our findings we may supplement our analysis with insights from experiences in other programs such as Hoosier Healthwise.

When analyzing the financial performance of the HIP health plans, the key limitation will be the ability of the HIP health plans to report HIP-specific financial information. Some information, such as assets or liabilities will likely not be HIP-specific and other data, such as revenue and costs, may or may not be specifically related to HIP depending on existing reporting requirements or how the health plans assign functions for serving different populations and programs within their organizational structures. Nonetheless, even general information will provide insight into the plans' ability to provide appropriate quality of care.

G. Goal 7: Assure State Fiscal Responsibility and Efficient Management of the Program

Indiana and the federal government want HIP to be a fiscally responsible program and managed efficiently. Section 1115 of the Social Security Act gives the Secretary of Health and Human Services broad authority to authorize experimental, pilot, or demonstration projects [24]. Several states have used Section 1115 authority to expand eligibility to individuals not otherwise eligible under the Medicaid program, provide services that are not typically covered, or develop innovative service delivery systems [24]. A key condition of all Section 1115 waiver demonstration programs is that they must be "budget neutral" over the life of the project, meaning they cannot be expected to cost the federal government more than it would cost without the waiver [24]. To assess Indiana's achievement of Goal 7, Assure State Fiscal Responsibility and Efficient Management of the Program, we will review and summarize both the federal and state financing issues related to the demonstration.

TABLE III.14 GOAL 7 ANALYSIS PLAN

Research Questions	Measures	Data Sources	Methodology	Issues and Limitations
Federal Financing Issues and Budget Neutrality				
-Does HIP meet the budget neutrality requirements set forth in the Special Terms and Conditions? -What types of program adjustments are needed to meet budget neutrality requirements?	-Amount of Federal spending -Program design changes (such as to benefits, capitation rates or eligibility requirements)	-Milliman budget neutrality assessment reports -Financial data from OMPP -Key informant interviews	Synthesis and description of Federal financing of the program and budget neutrality assessments for each program year	Identifying programmatic changes and their links to budget neutrality; timing of changes made
State Financing Issues				
-Are state expenditures on HIP less than or equal to planned financing? -Did the cigarette tax revenue generate the funds needed for HIP implementation? -How did enrollee contributions work as a financing model?	-State expenditures on HIP -HIP revenues by source -HIP revenues minus HIP expenditures	-Program financial data from Indiana Department of Revenue and OMPP -Key informant interviews	-Descriptive analysis comparing HIP expenditures to HIP revenues -Year-by-year trends in program expenditures relative to program revenues -Descriptive assessment of how well the four financing mechanisms worked (DSH funds, cigarette tax revenues, enrollee contributions, and employer contributions) -Year-by-year tracking of spending of the assigned cigarette tax revenues	Not providing new financial analyses, but synthesizing analyses of these issues in concert with all program goals

DSH = Disproportionate Share Hospital; OMPP = Office of Medicaid Policy and Planning.

1. Federal Financing Issues and Budget Neutrality

Coverage expansion programs such as HIP are difficult to implement. They require stakeholder buy-in to support coverage of a population not typically eligible for Medicaid. During the negotiations for Indiana's 1115 Medicaid demonstration waiver, CMS sought assurances that the federal government would not spend more than it would have had HIP not existed. Thus, any evaluation of HIP must examine whether and how the State met these requirements.

As part of our implementation analysis, we will interview key informants at Milliman and the State regarding the annual budget neutrality assessments Milliman performs, and review the annual reports on the issue. This assessment will tell us whether or not HIP was able to operate as expected from a financial perspective.

As part of the assessment of budget neutrality, we will examine whether program adjustments were required to meet budget neutrality requirements, and if so, identify what types of modifications were made. For example, a key factor in determining budget neutrality is the capitation rates paid to the participating plans and other risk sharing mechanisms the State may implement in HIP or in its Medicaid program (since it is total expenditures, including Medicaid poverty groups, but not the elderly and disabled or other special populations such as foster care children, that CMS assesses in the budget neutrality calculation). We will pursue this line of study primarily to help inform both the State and CMS retrospectively about whether the budget neutrality agreement was reasonable, given the information known at the time the agreement was made. We will also look at trends over time within the program, to understand program adjustments made in response to budget neutrality concerns; these might include, but are not limited to, capitation rates, other risk sharing arrangements, the benefit package, eligibility requirements, and/or sunset provisions.

2. State Financing Issues

To support a coverage expansion, the State needs to identify state funds to finance it. Politically, using the Indiana general budget was not viable, and previous discussions about funding an expansion signaled that a hospital tax was not feasible. As a result, the State proposed, and CMS approved, a three-prong strategy to HIP financing: (1) a redirection of a portion of DSH funding to support the expansion, (2) revenues from a new cigarette tax, and (3) enrollee contributions. The State's strategy included the following components:

1. CMS approved the redirection of up to 25 percent of its $200 million annual federal DSH allotment, or $50 million, to the expansion
2. On April 29, 2007, the Indiana General Assembly passed a cigarette tax increase, effective July 1, 2007, to generate the state funds needed to draw down the $50 million in diverted federal DSH funds
3. Monthly contributions to POWER accounts by members (up to 50 percent of these contributions could be made by employers or other private entities on behalf of HIP enrollees)

To provide context for the analysis, we will begin by presenting an analysis of how program financing was apportioned across the three main financing sources. We will present the five-year financing plan within the context of a pie chart, so it is visually clear whether DSH or the tobacco tax revenues represented the biggest proportion of program financing (as we know already that POWER accounts will represent the smallest contribution to financing).

The diversion of DSH funds may be subject to political issues that arise during the course of the demonstration and we will track these issues to inform other state reform initiatives. Pressure to reduce the size of the diversion may be mounted if the safety net hospitals believe or have evidence that HIP has had a negative effect on their financial status. Our analyses of Goal 2 will be instrumental in identifying and verifying the issues hospitals face, particularly safety net hospitals, as HIP matures.

Although Indiana is relying on generating $50 million through the new cigarette tax, these revenues are subject to sales fluctuations. A study conducted in 2006 on the predicted effects of such a tax in Indiana indicated that a 25 cent tax increase would lead to a reduction in teen smokers and in pregnant smokers, increase the likelihood of quit attempts, and possibly avoid over 11,000 smoking-related deaths [25]. This study noted that a tax at this level would only decrease sales by 3 percent, while generating $144 million in new excise and sales tax revenues [25], [26]. However, because a federal cigarette tax of 62 cents per pack was signed into law in February 2009, and took effect in April 2009, cigarette tax revenues may fall short of expectations [27].[20] The 2006 study indicated that a $1.00 per pack increase—which is nearly the cost of the federal and state taxes taken together—would decrease sales over 10 percent [25].

To date, the State's expenditures on HIP in the first year remain well below cigarette tax revenues and expenditures are unlikely to exhaust dedicated revenues in the short term, in part because the tax went into effect six months before HIP began enrolling people, giving the fund time to build up a reserve. We will continue to monitor trends in the revenue patterns throughout the demonstration as part of the implementation analysis to assess whether the cigarette tax was an effective mechanism for financing a program such as HIP. The analysis may also offer lessons for other states, and even for federal reform, about financing coverage through cigarette taxes.

Relative to DSH funds and cigarette tax revenues, the third financing mechanism, monthly contributions enrollees make to their POWER accounts, will represent a small segment of Indiana's financing for HIP. Nevertheless, it is an important mechanism because it measures the ability and willingness of enrollees to pay for their health care costs. However, this source of revenue has some inherent risks. During the first program year, about 35 percent of enrollees were not required to make a monthly contribution to their POWER accounts. These enrollees either had no income or they were already spending 5 percent of family income on premiums and co-payments for family members covered by Medicaid or CHIP. Using data from Anthem for

[20] The decline in revenue may be offset by the enhanced federal medical assistance percentage (FMAP) rates implemented under the American Recovery and Reinvestment Act (ARRA) [2].

calendar year 2008, Milliman estimates that about 26 percent of caretaker enrollees and 52 percent of non-caretaker enrollees did not make contributions [20].

Using either Milliman quarterly financial reports or the POWER account information reported by the health plans, we will examine monthly and annual trends in POWER account revenues to understand any fluctuations in this revenue source and what the fluctuations mean for the State's fiscal management of the program.

3. Key Analytical Issues and Limitations

The biggest challenge to the analysis of HIP financing issues will be to summarize and synthesize the information so it is useful for other state reform efforts. Indiana will have real-time information on the fiscal status of the program through its own analyses of financial information and through the work of the program's actuary, Millman. Our challenge will be to determine when changes are made to HIP in response to program fiscal issues, which changes are not but affect the fiscal health of the program, and pinpointing the timing of both kinds of changes. For example, when we interviewed Rob Damler of Milliman, Indiana's actuarial consultant, in July 2009, we learned that the state was in discussions with the plans to convert the risk contracts to administrative services only contracts for non-caretaker adults, retroactive to January 2009, and to raise rates for caretaker adults (who will remain in capitated contracts). Also, the ESP disease classes are being re-visited. When changes like these occur, we need to verify with the state whether they were in response to budget neutrality concerns or some other issue.

Programmatic changes made in response to financing issues that arise can have far-ranging effects and are likely to occur throughout the demonstration. Moreover, they are not limited to changes made by the State, but could include plan changes as well. For example, if some enrollees are put under administrative services contracts, plans do not have the same incentives to manage care, which could lead to changes in the costs for care. It is incumbent upon us as the evaluator to stay informed of such changes and to consider the totality of their impact on the program's financial status.

In the end, we want policymakers to understand what it means to finance this type of program with the combination of (1) a fixed fund (DSH funds), (2) funds subject to federal actions and other incentives that may affect the actual amount available (cigarette tax), and (3) funds tied to the number of program enrollees (monthly contributions). We believe our reporting on the issue will serve to supplement the State's internal assessment of HIP financing issues. Our contribution will focus on providing a qualitative assessment and descriptive reporting of the facts so that other state reform efforts may learn from Indiana's experience implementing an expansion for a population typically not eligible for public insurance coverage.

IV. REPORTING AND SCHEDULE

Through various formats, we will report findings from the HIP evaluation. In this chapter, we discuss the types of reports planned at this time.[21]

A. Reporting

1. CMS Annual Reports

As a condition of Indiana's Section 1115 Medicaid demonstration waiver, CMS requires OMPP to submit an annual report summarizing progress throughout the year.[22] Mathematica will draft those annual reports as part of this evaluation.

The annual reports for CMS will address the four following questions:

1. To what extent did HIP achieve its performance goals?
2. What lessons were learned?
3. What were program outcomes?
4. Was the program cost-effective?

Each report will follow the outline already agreed to by OMPP and CMS. The report will be organized primarily around providing information about progress toward each OMPP goal, as well as meeting other CMS reporting requirements.

Because the CMS reports are due to CMS 120 days after the end of the year, we will deliver a draft report to OMPP approximately 60 days after the end of each calendar year.[23] Two months between the end of a program year and a draft report will not allow enough time for receipt of all records for services provided during the year. As a result, the analyses of service records for the prior program year will be preliminary and will include all records we can abstract and analyze at the time. If project resources allow, we will update these analyses when we submit the final version of the report.

During the 60-day period between submission of the draft and submission of the final report to CMS, OMPP can review the report and provide feedback to Mathematica staff, and

[21] A separate dissemination plan will be submitted to OMPP that describes more specific plans for reporting, such as proposed topics for white papers, as well as disseminating evaluation findings.

[22] If OMPP and CMS decide to end the demonstration during the last year and not apply for an extension, the last report will be a final report and will provide a comprehensive discussion of the evaluation results. Otherwise, the last report to CMS will be an interim report.

[23] Because Mathematica was not hired until April 2009, the first annual CMS report was not submitted to OMPP until June 2009.

Mathematica will refine the report based on feedback received from OMPP. After the report is submitted to CMS, the Mathematica team will be ready to revise and refine it a second time to incorporate comments and feedback from CMS.

2. OMPP Annual Technical Reports

Each year, we will provide an annual report designed to meet the information needs of OMPP. This report will build upon and expand the information reported in the CMS annual reports and provide more methodological detail.

- We plan to submit the draft OMPP annual reports in ***June*** of the following year for years 2 through 5 of the evaluation, approximately three months after we submit the draft CMS annual report. In year 1 we submitted this report in August 2009 (approximately five months after our contract started).
- We will revise each report to reflect OMPP's comments and feedback on the draft. We will submit a revised report within 30 days of receiving comments from OMPP.
- Cindy Collier will lead the development of the executive summary for each report to ensure that it is easy to read and effectively communicates the report's key messages.

3. Other Deliverables

a. White Papers

We will create a series of white papers, up to four each year depending on the project resources, designed for publication in professional journals. Each paper will focus on a specific topic of current interest to OMPP, policymakers, and the research community. The results will be presented in the context of previous research on the topic and will indicate how the effects of HIP advance knowledge about state health care reform efforts.

Topics will be developed each year, to allow us to focus on the current issues of greatest interest. We will use a two-stage process to develop topics. In the first stage, Mathematica will propose a list of broad topics (for example, enrollment, provider impacts, financial analysis, and service utilization) for discussion. In the second stage, about two to four months before a draft white paper is due, Mathematica and OMPP will discuss and agree upon the exact content of the paper. At that time, Mathematica will draft an outline for the paper, for OMPP's approval. After receiving approval for the paper, work will begin. Different senior members of the team will take the lead for each paper, depending on the topic, and they will be supported by more junior staff to ensure we produce papers on schedule.

b. News Releases

The project team will provide OMPP with news releases that describe the project's findings for a nontechnical audience. Cindy Collier will lead our development of all communication materials, and will work closely with OMPP staff to ensure that the state's needs are met.

c. PowerPoint Slides for Technical Audiences

We will develop PowerPoint slides that provide information about HIP and the results of our research for presentations to technical audiences, such as researchers familiar with other state efforts to extend Medicaid coverage to working-age adults or those who follow the development of Medicaid initiatives to promote value-based purchasing or allow people to buy into Medicaid coverage. Slides will include an appropriate mix of explanatory text, tables, and graphs. Slides for technical audiences may also present information about methodology, data, and the theoretical underpinnings of the analyses.

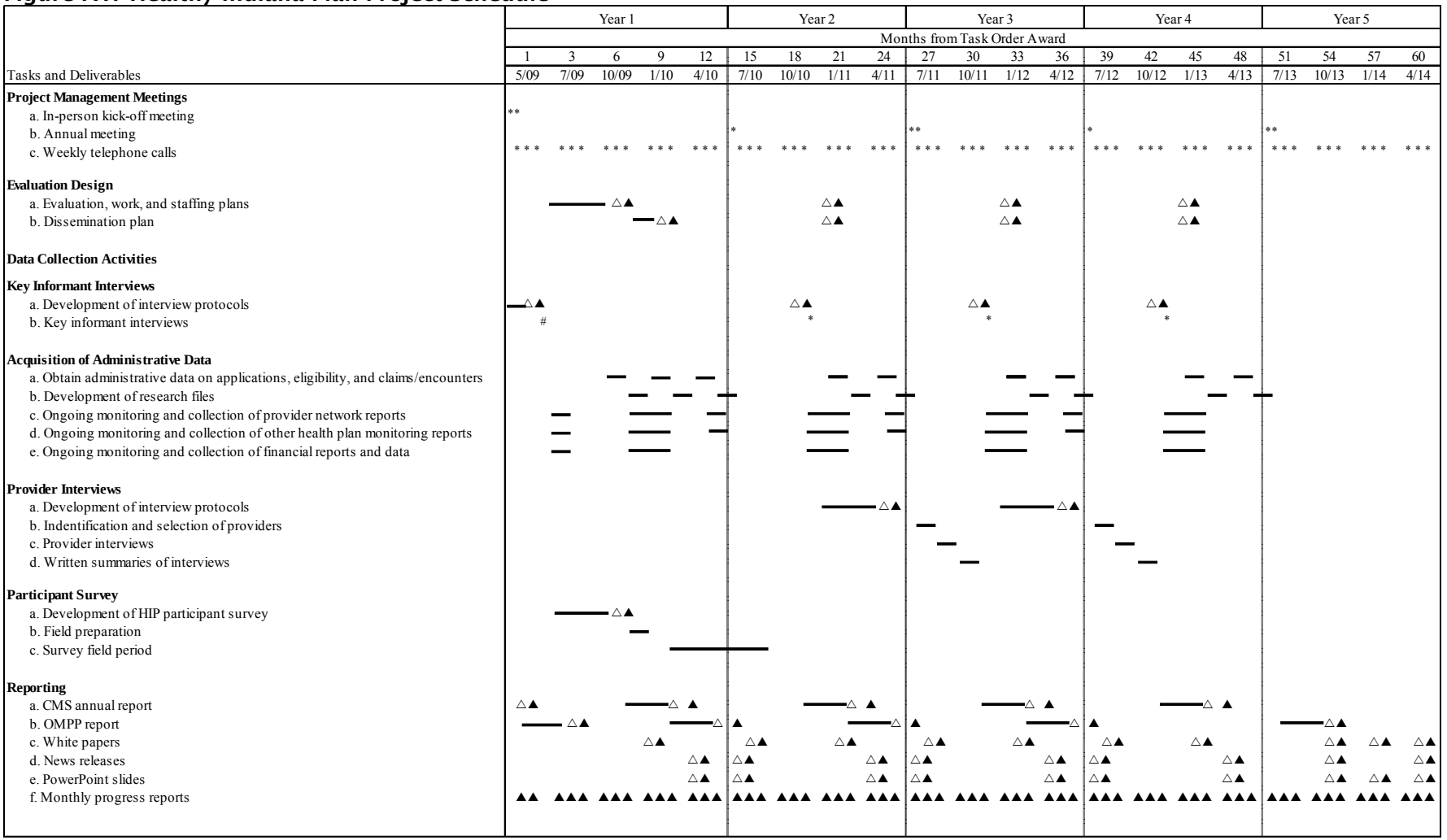
d. PowerPoint Slides for General Audiences

We will also provide PowerPoint slides for presentations to general, nontechnical, audiences. These slides will provide the same basic information as the slides for technical audiences, but they will be accessible for general audiences such as legislators, providers, and consumer advocates. Cindy Collier, who has considerable experience distilling information for general audiences, will lead the development of these slides.

B. Schedule

Figure IV.1 provides the current schedule for the project, and includes the timing for all project deliverables.

Figure IV.1 Healthy Indiana Plan Project Schedule



△ Draft deliverable
▲ Final deliverable
* Teleconference
* * In-person meeting
In-person interviews

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APPENDIX A

HIP ENROLLEE SURVEY

2010 Survey of
Healthy Indiana Plan Participants

Draft Dated: December 22, 2009

General Administrative Notes / CATI PROGRAMMING ASSUMPTIONS:

- A **test file will be requested in November of 2009** to enable programmers to review the file layout and prepare the necessary specifications for the sample prep that is to follow throughout the field period. Once created, these same specifications will be used each month the sample is received (5 times).

- **Sample will be drawn on a monthly basis and sent to statisticians for review and sampling with a unique identification numbers assigned to each piece of sample**. From there, the file will be sent to Hong Zhang, programming liaison to distribute to the applicable IS team members for review and preparation to load into CAPI. The time span between receipt of file from Indiana and loading to CATI for dialing will be 4 weeks, to allow time for statisticians to identify the cases selected for inclusion in the study and CAI programmers to prep, load, and test the sample for CATI.

- **Once activated / loaded in CATI, each replicate will be available for dialing for 12 weeks**. Sample will be managed on face sheets – with each replicate being assigned a separate color for ease of identification. The replicate's close out date will be clearly marked on the face sheet. We will not be utilizing the SMS or the front-end of CATI for sample management or locating purposes. A "release number" will be assigned to each of the 5 cohorts and this variable will be loaded into CATI. At the end of 12 weeks, all non-completed cases will no longer be dialed.

- There will be **two groups of sample** – "new enrollees" and "established enrollees" – a variable identifying each group should be included in the sample prep. All skips and fills in CATI will be driven off Respondent's answer to question A4 – not what is recorded in the sample file (as sample ages, some new enrollees may become ESTABLISHED enrollees). However, if a respondent does not reply to A4 (DK / REF) – we will use the information provided in the sample as a back-up for the appropriate skip patterns.

- On a monthly basis (starting April 2010) completed cases for the previous month will be identified for a report which will generate the **honorarium checks**, produced by Lucy Tindall. The variables at the end of the survey (address / contact information confirmation) will be used for this report.

- CATI is to be designed in **English only,** approximately 30 minutes in length. Non-English speakers will be coded as language barrier. **No proxies** will be allowed for administration.

- Throughout the instrument, special instructions for CATI programming are listed in all caps – designated by the identifier "CATI: …."

<INTRO> Hi, my name is ___ and I am calling on behalf of the Healthy Indiana Health Insurance Plan. May I please speak with [FILL BENEFICIARY NAME]?

THIS IS BENEFICIARY	1	CONTINUE TO **INFCONS**
BENEFICIARY COMES TO PHONE	2	CONTINUE TO **INFCONS**
NOT AVAILABLE AT THIS TIME	3	ASK FOR BEST TIME TO REACH, SET CALLBACK, TERMINATE
HUDI	4	CODE AS HUDI, DOCUMENT WHERE IN SCRIPT HU TOOK PLACE
BENEFICIARY TOO SICK / IS IMPAIRED AND CANNOT COMPLETE INTERVIEW	5	CODE AS UNABLE TO COMPLETE – IMPAIRMENT
REFUSAL	6	TERMINATE, CODE AS REFUSAL, DOCUMENT REASON

<INFCONS> We are calling today because the State of Indiana's Office of Medicaid Policy and Planning has sponsored a survey to better understand the experiences of people who are enrolled in the Healthy Indiana Plan. Your name was scientifically selected at random from a list of all the current enrollees.

If you qualify for the survey – we will mail you a check for $20 after completing the interview to thank you for your time. The interview will take about 30 minutes to complete. Your name and contact information will not be linked to any of your answers to these questions. Participation is voluntary, you may skip any questions you do not wish to answer or that make you feel uncomfortable.

I would like to continue now unless you have any questions …

NO QUESTIONS	1	CONTINUE TO SECTION A
ANSWERED QUESTIONS	2	CONTINUE TO SECTION A
REFUSED	3	TERMINATE CALL, DOCUMENT REASON FOR REFUSAL

SECTION A: HEALTH INSURANCE COVERAGE

The first questions are about your health insurance coverage.

A1. The State of Indiana runs an insurance program called the Healthy Indiana Plan (HIP) for Hoosiers ages 19 to 65. Are you enrolled in the insurance plan known as "the Healthy Indiana Plan" at this time?

YES	1	→ SKIP TO A2
NO	2	
DON'T KNOW	d	
REFUSED	r	

A1a. Have you ever been enrolled in the Healthy Indiana Plan?

YES	1	
NO	2	→ SKIP TO CLOSE1
DON'T KNOW	d	→ SKIP TO CLOSE1
REFUSED	r	→ SKIP TO CLOSE1

A1b. Why did you leave the plan?

COULDN'T AFFORD IT ANYMORE	1	▸ SKIP TO CLOSE1
DIDN'T NEED IT ANYMORE	2	▸ SKIP TO CLOSE1
FORGOT TO RE-ENROLL	3	▸ SKIP TO CLOSE1
GOT INSURANCE THROUGH MY SPOUSE	4	▸ SKIP TO CLOSE1
GOT INSURANCE THROUGH AN EMPLOYER	5	▸ SKIP TO CLOSE1
GOT MEDICARE	6	▸ SKIP TO CLOSE1
NOT ABLE TO SEE DOCTOR OF MY CHOICE	7	▸ SKIP TO CLOSE1
NOT SATISFIED WITH PLAN	8	▸ SKIP TO CLOSE1
TRIED TO RE-ENROLL BUT STAFF COULDN'T HELP ME / SYSTEM FAILED / IT DIDN'T WORK OUT	9	▸ SKIP TO CLOSE1
TRIED TO RE-ENROLL BUT THEY DIDN'T GET MY PAPERWORK DONE IN TIME	10	▸ SKIP TO CLOSE1
TOO COMPLICATED	11	▸ SKIP TO CLOSE1
TOO MUCH PAPERWORK	12	▸ SKIP TO CLOSE1
OTHER -	95	▸ SKIP TO CLOSE1
SPECIFY:_____		
DON'T KNOW	d	▸ SKIP TO CLOSE1
REFUSED	r	▸ SKIP TO CLOSE1

<CLOSE1> Thank you for answering these questions. This interview was designed to be completed by people who are currently members of the Healthy Indiana Plan. If you have any questions about the plan, please call 1-877-438-4479. Thank you and have a good day / night.
[FOR ALL AT CLOSE 1 = CATI: TERMINATE, CODE CASE AS "NOT CURRENTLY ENROLLED"].

A2. Some questions in the survey are only for men or women, so I am required to ask - are you male or female?

MALE	1
FEMALE	2
DON'T KNOW	d
REFUSED	r

A3. Because some of my questions are only for certain age groups, what month and year were you born?

CATI: ALLOWABLE RANGE = 01-12

MONTH	1
DON'T KNOW	d
REFUSED	r

YEAR	1
DON'T KNOW	d
REFUSED	r

CATI: USING AGE IN MONTHS AND YEARS – CALCULATE AGE AS OF DATE OF INTERVIEW. THIS AGE, IN YEARS, WILL BE USED FOR SUBSEQUENT SKIP PATTERNS FOR OTHER ITEMS WITHIN THE INSTRUMENT. IF AGE IN YEARS IS D OR R – THEN USE AGE FROM SAMPLE INFORMATION FOR SUBSEQUENT SKIPS.

A4. How long have you been covered by the "Healthy Indiana" Plan?
IF NEEDED: If you have been enrolled more than once, how long have you been enrolled this most recent time?

CATI: IF MONTHS, RANGE = 01-12; IF YEARS, RANGE = 01 TO 64

MONTHS	1	→ SKIP TO A5
YEARS	2	→ SKIP TO A5
DON'T KNOW	d	
REFUSED	r	

A4a. Have you been covered for more or less than 5 months, that is since [FILL MONTH 5 MONTHS PRIOR TO INTERVIEW DATE] OF (2009/ 2010)?

MORE THAN 5 MONTHS	1
LESS THAN OR EQUAL TO 5 MONTHS	2
DON'T KNOW	d
REFUSED	r

CATI: IF ITEM A4a = "R" OR "D", THEN FOLLOW SKIP PATTERN FOR ENROLLEE STATUS QUESTIONS USING DATA PROVIDED IN SAMPLE FILE.

A5. **ASK ONLY OF NEW ENROLLEES (A4= ≤5 MONTHS), ELSE SKIP TO A8.**

Just before you enrolled in the "Healthy Indiana" Plan, how many months or years in a row were you **without health insurance**?

IF R PROVIDES MONTHS AND YEARS – CONVERT RESPONSE TO ALL MONTHS – EXAMPLE: ONE AND A HALF YEARS = 18 MONTHS.

				CATI: IF MONTHS, RANGE = 01-12; IF YEARS, RANGE = 01 TO 64

MONTHS	1
YEARS	2
DON'T KNOW	d
REFUSED	r

A6. What was the main reason you were without any health insurance during this period? (CHECK ONLY ONE)

	1
COVERAGE STOPPED, NO LONGER ELIGIBLE	
DID NOT KNOW HOW TO GET COVERAGE	2
DIDN'T THINK I WAS ELIGIBLE	3
DIDN'T THINK I NEEDED IT	4
DIDN'T WANT STIGMA OF PUBLIC INSURANCE	5
FAILED TO REAPPLY OR RE-DETERMINE ELIGIBILITY	6
FORGOT TO PAY THE PREMIUM	7
IMMIGRATION CONCERNS	8
TOO EXPENSIVE / COULDN'T AFFORD HEALTH INSURANCE	9
JUST MOVED TO THE AREA	10
LOST MY JOB – LOST HEALTH INSURANCE BENEFITS	11
PREVIOUS COVERAGE CANCELLED	12
SPOUSE'S INSURANCE WAS DROPPED	13
UNEMPLOYED – DID NOT HAVE INSURANCE	14
OTHER REASON - (SPECIFY): _____	95
DON'T KNOW	d
REFUSED	r

CATI: RANGE FOR OTHER – SPECIFY = 250 CHARACTERS

A7. When you enrolled in the Healthy Indiana Plan, was it because you were sick or injured and needed medical care?

YES	1	
NO	2	→ SKIP TO A8
DON'T KNOW	d	→ SKIP TO A8
REFUSED	r	→ SKIP TO A8

A7a. What was the **sickness** or **injury** that caused you to enroll in the Healthy Indiana Plan?

SPECIFY: _____(CATI: RANGE FOR OTHER – SPECIFY = 250 CHARACTERS)	95
DON'T KNOW	d
REFUSED	r

A8. Which Healthy Indiana health plan are you enrolled with at this time, is it: Anthem, MDwise, the Enhanced Services Plan, or some other plan? (CHECK ONLY ONE).

IF NEEDED: If you have been enrolled in different plans over the years, please tell me which plan you are with at this time.

ANTHEM	1
MDWISE (Med-Wise)	2
ENHANCED SERVICES PLAN (ESP)	3
OTHER PLAN	4
DON'T KNOW	d
REFUSED	r

SECTION B. HEALTH AND DISABILITY STATUS

The next set of questions asks about your health in general at this time and about specific health-related conditions.

B1. In general, would you say that your health now is . . .

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

B2. Compared to one year ago, how would you rate your health in general now? Is it …

Much better than one year ago	1
Somewhat better than one year ago	2
Same as one year ago	3
Somewhat worse than one year ago	4
Much worse than one year ago	5
DON'T KNOW	d
REFUSED	r

B3. In general, would you say that your **mental health** is …

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

B4. Have you smoked 100 cigarettes in your entire life?

YES	1	
NO	2	→ SKIP TO B5
DON'T KNOW	d	→ SKIP TO B5
REFUSED	r	→ SKIP TO B5

B4a. Do you <u>now</u> smoke cigarettes every day, some days, or not at all?

EVERYDAY	1
SOME DAYS	2
NOT AT ALL	3
DON'T KNOW	d
REFUSED	r

B4b. Have you tried to quit smoking in the last six months?

YES	1
NO	2
DON'T KNOW	d
REFUSED	r

B4c. In the last six months, has a **doctor or other health provider** advised you to quit smoking?

YES	1
NO	2
DON'T KNOW	d
REFUSED	r

B5. How tall are you without shoes?

		FEET / METERS

FEET	1
METERS	2
DON'T KNOW	d
REFUSED	r

		INCHES / CENTIMETERS

INCHES	1
CENTIMETERS	2
DON'T KNOW	d
REFUSED	r

B6. About how much do you weigh without shoes? CONFIRM – Just so I make sure I am entering this correctly, is that in pounds or kilograms?

POUNDS	1
KILOGRAMS	2
DON'T KNOW	d
REFUSED	r

B7. Next I am going to read some medical conditions that some people may experience in their lifetime. For each, please tell me whether you have ever been told by a **doctor or other health professional** that you had this condition or not.

Has a doctor or other health professional ever told you that you had …	**CHECK ONLY ONE …**			
	Y	N	DK	REF
a. coronary heart disease?	1	2	7	8
b. a heart attack, also called myocardial infarction or MI?	1	2	7	8
c. a stroke or TIA? A TIA is a transient ischemic attack which is sometimes referred to as a mini-stroke.	1	2	7	8
d. emphysema?	1	2	7	8
e. chronic bronchitis? Please do not include isolated instances of acute bronchitis.	1	2	7	8
f. cancer or a malignancy of any kind?	1	2	7	8
g. asthma?	1	2	7	8
h. [IF FEMALE ADD: Other than in pregnancy, …] diabetes or sugar diabetes?	1	2	7	8
i. a mental or emotional health condition?	1	2	7	8

B8. Have you ever been told by a doctor, nurse, or other health professional that you have **high blood pressure** or **hypertension**?

YES	1	
YES – ONLY IN PREGNANCY	2	→ SKIP TO SECTION C
TOLD I WAS BORDERLINE OR PRE-HYPERTENSIVE	3	→ SKIP TO SECTION C
NO	4	→ SKIP TO SECTION C
DON'T KNOW	d	→ SKIP TO SECTION C
REFUSED	r	→ SKIP TO SECTION C

B8a. Are you currently taking medicine for your high blood pressure?

YES	1
NO	2
DON'T KNOW	d
REFUSED	r

SECTION C: RECENT EXPERIENCE WITH HEALTH CARE

Now I'm going to ask you some questions about your recent experiences with health care.

CATI: IF NEW ENROLLEE (A4≤ 5 MONTHS) CONTINUE TO C1.
IF ESTABLISHED ENROLLEE (A4> 5 MONTHS – SKIP TO C11).

ASK C1 THROUGH C10 OF NEW ENROLLEES ONLY:

C1. The next questions ask about your health care experiences in the six months before you were enrolled in the Healthy Indiana Plan (HIP). In the six months before you enrolled in the Healthy Indiana Plan (HIP), did you visit **any** doctor's office, health clinic, hospital, or other place because you were sick or you needed advice about your health?

YES	1	
NO	2	→ SKIP TO C2
DON'T KNOW	d	→ SKIP TO C2
REFUSED	r	→ SKIP TO C2

C1a. In the six months before you enrolled in the Healthy Indiana Plan (HIP), what type of place did you go to most often? Was it a . . . (CHECK ONLY ONE).

IF R ONLY WENT TO A COUPLE OF LOCATIONS, ASK FOR PLACE VISITED ON MOST RECENT VISIT.

Private doctor's office,	1
Clinic or health center,	2
Hospital emergency room, or	3
Some other type of place? (SPECIFY): _____	95
DON'T KNOW	d
REFUSED	r

C2. A **personal doctor or nurse** is a health provider who knows you well and is familiar with your health history. This can be a general doctor, a specialist doctor, a nurse practitioner, or a physician assistant. In the 6 months before you enrolled in HIP, did you have **one person** you thought of as your **personal doctor or health care provider**?

IF "NO," ASK: Was there more than one or is there no person you thought of as your personal doctor or health care provider?

Yes, only one	1	
More than one	2	
No	3	→ SKIP TO C3
DON'T KNOW	d	→ SKIP TO C3
REFUSED	r	→ SKIP TO C3

C2a. Now that you are in the Healthy Indiana Plan (HIP), can you continue to see this doctor(s) or health care providers, or do you have to see someone new?

YES, CONTINUE TO SEE THIS / THESE DOCTOR(S)	1
NO – MUST SEE SOMEONE NEW	2
I CAN SEE ONE / SOME BUT NOT OTHERS	3
DON'T KNOW	d
REFUSED	r

C3. In the six months <u>before</u> you enrolled in the Healthy Indiana Plan (HIP), did you see a doctor or health care professional for **preventive care**, such as a check-up, shots, or physical examination?

YES	1	
NO	2	→ SKIP TO C4
DON'T KNOW	d	→ SKIP TO C4
REFUSED	r	→ SKIP TO C4

C3a. In the six months before you enrolled in the Healthy Indiana Plan (HIP), when you saw your doctor or other health care professional for **preventive care**, how long, in general, did you have to wait to get an appointment?

Less than or equal to 2 weeks	1
More than 2 weeks but less than or equal to 4 weeks, or	2
More than 4 weeks	3
DON'T KNOW	d
REFUSED	r

C4. In the six months before you enrolled in the Healthy Indiana Plan (HIP), was there any time that you needed to see a doctor or other health care professional for **preventive care** such as a checkup or physical examination **but did not go**?

YES	1	
NO	2	→ SKIP TO C5
DON'T KNOW	d	→ SKIP TO C5
REFUSED	r	→ SKIP TO C5

C4a. During that time, what was the **main** reason you did not see a doctor or other health care professional for the **preventive** care you needed? (CHECK ONLY ONE)

COST TOO MUCH	1
COULDN'T GET CHILDCARE	2
COULDN'T GET TIME OFF FROM WORK	3
COULDN'T GET THROUGH ON THE PHONE	4
COULDN'T SCHEDULE APPOINTMENT SOON ENOUGH	5
DIDN'T GET APPROVAL FROM PLAN	6
DIDN'T HAVE TIME	7
DIDN'T WANT TO GO	8
HOURS OF OPERATION WERE NOT CONVENIENT FOR ME	9
NO INSURANCE	10
PLACE DID NOT ACCEPT THE INSURANCE COVERAGE	11
TAKES TOO LONG TO GET THERE/ TRANSPORTATION PROBLEM	12
OTHER (SPECIFY): _____	95
DON'T KNOW	d
REFUSED	r

C5. In the six months before you enrolled in the Healthy Indiana Plan (HIP), did you have an illness, accident, or injury?

YES	1	
NO	2	→ SKIP TO C6
DON'T KNOW	d	→ SKIP TO C6
REFUSED	r	→ SKIP TO C6

C5a. In the six months before you enrolled in the Healthy Indiana Plan (HIP), how many times did you see a **doctor or other health professional** about any illness, accident, or injury you had?

				CATI: RANGE = 0-9999

DON'T KNOW	d
REFUSED	r

C5a1. ASK IF C5a > 0, ELSE SKIP TO C5b. In the six months before you enrolled in the Healthy Indiana Plan (HIP), when you saw your doctor or other health care professional for any **illness, accident, or injury**, how long, in general, did you have to wait to get an appointment?

Less than or equal to 24 hours	1
More than 24 but less than or equal to 48 hours	2
More than 48 hrs but less than or equal to 1 week, or	3
More than 1 week	4
DON'T KNOW	d
REFUSED	r

C5b. During that time, was there any time that you needed to see a doctor or other health care professional because of an illness, accident, or injury but **did not go**?

YES	1	
NO	2	→ SKIP TO C6
DON'T KNOW	d	→ SKIP TO C6
REFUSED	r	→ SKIP TO C6

C5b1. During that time, what was the **main** reason you did not see a doctor or other health care professional because of your illness, accident, or injury?

CONDITION CLEARED UP	1
COST TOO MUCH	2
COULDN'T GET CHILDCARE	3
COULDN'T GET TIME OFF FROM WORK	4
COULDN'T GET THROUGH ON THE PHONE	5
COULDN'T SCHEDULE APPOINTMENT SOON ENOUGH	6
DIDN'T GET APPROVAL FROM PLAN	7
DIDN'T THINK I WAS SICK ENOUGH	8
DIDN'T HAVE TIME	9
DIDN'T WANT TO GO	10
HOURS OF OPERATION WERE NOT CONVENIENT FOR ME	11
NO INSURANCE	12
PLACE DID NOT ACCEPT THE INSURANCE COVERAGE	13
TAKES TOO LONG TO GET THERE/ TRANSPORTATION PROBLEM	14
OTHER (SPECIFY): _____	95
DON'T KNOW	d
REFUSED	r

C6. In the six months before you enrolled in the Healthy Indiana Plan (HIP), did you see a **specialist**, such as a heart, lung or respiratory specialist, a digestive or urinary tract specialist, someone who treats diabetes, or other doctor who takes care of special parts of the body?

YES	1	
NO	2	→ SKIP TO C7
DON'T KNOW	d	→ SKIP TO C7
REFUSED	r	→ SKIP TO C7

C6a. In the six months before you enrolled in the Healthy Indiana Plan (HIP), how many visits did you make to see specialist(s)?

				CATI: RANGE = 01-9999

DON'T KNOW	d
REFUSED	r

C6b. In the six months before you enrolled in the Healthy Indiana Plan (HIP), when you saw a **specialist**, how long, in general, did you have to wait to get an appointment?

Less than or equal to 4 weeks	1
More than 4 week but less than or equal to 6 weeks	2
More than 6 weeks	3
DON'T KNOW	d
REFUSED	r

C7. In the six months before you enrolled in the Healthy Indiana Plan (HIP), was there any time when you needed to see a specialist but **did not go**? IF NEEDED: By specialist we mean a doctor who takes care of special parts of the body, such as a heart, lung or respiratory specialist, a digestive or urinary tract specialist, someone who treats diabetes, or other doctor who takes care of special parts of the body?

YES	1	
NO	2	→ SKIP TO C8
DON'T KNOW	d	→ SKIP TO C8
REFUSED	r	→ SKIP TO C8

C7a. During that time, what was the **main** reason you did not see a specialist?

CONDITION CLEARED UP	1
COST TOO MUCH	2
COULDN'T GET CHILDCARE	3
COULDN'T GET TIME OFF FROM WORK	4
COULDN'T GET THROUGH ON THE PHONE	5
COULDN'T SCHEDULE APPOINTMENT SOON ENOUGH	6
DIDN'T GET APPROVAL FROM PLAN	7
DIDN'T THINK I WAS SICK ENOUGH	8
DIDN'T HAVE TIME	9
DIDN'T WANT TO GO	10
HOURS OF OPERATION WERE NOT CONVENIENT FOR ME	11
NO INSURANCE	12
PLACE DID NOT ACCEPT THE INSURANCE COVERAGE	13
TAKES TOO LONG TO GET THERE/ TRANSPORTATION PROBLEM	14
OTHER (SPECIFY): _____	95
DON'T KNOW	d
REFUSED	r

C8. In the six months before you enrolled in the Healthy Indiana Plan (HIP), did you need any prescription drugs?

YES	1	
NO	2	→ SKIP TO C9
DON'T KNOW	d	→ SKIP TO C9
REFUSED	r	→ SKIP TO C9

C8a. In the six months before you enrolled in the Healthy Indiana Plan (HIP), on average, how many prescriptions did you fill a month?

CATI – ALLOWABLE RANGE = 0 TO 9999.

DON'T KNOW	d
REFUSED	r

C8b. In the six months before you enrolled in the Healthy Indiana Plan (HIP), was there a time you needed a prescription drug but you **did not get it**?

YES	1	
NO	2	→ SKIP TO C9
DON'T KNOW	d	→ SKIP TO C9
REFUSED	r	→ SKIP TO C9

C8b1. During that time, what was the **main** reason you did not get the prescription drug?

CONDITION CLEARED UP	1
COST TOO MUCH	2
COULDN'T GET CHILDCARE	3
COULDN'T GET TIME OFF FROM WORK	4
DID NOT GET APPROVAL FROM PLAN	5
DID NOT THINK I WAS SICK ENOUGH	6
DID NOT HAVE TIME	7
DID NOT WANT TO GO	8
HOURS OF OPERATION WERE NOT CONVENIENT FOR ME	9
I DON'T TAKE PRESCRIPTION MEDICATIONS	10
NO CONVENIENT PLACE TO PICK UP THE PRESCRIPTION	11
NO INSURANCE	12
PHARMACY DID NOT HAVE CONVENIENT HOURS OF OPERATION	13
PLACE DID NOT ACCEPT THE INSURANCE COVERAGE	14
TAKES TOO LONG TO GET THERE/ TRANSPORTATION PROBLEM	15
OTHER (SPECIFY): _____	95
DON'T KNOW	d
REFUSED	r

C9. In total, how many trips did you make to the **emergency room** in the six months before you enrolled in the Healthy Indiana Plan (HIP)?

CATI – ALLOWABLE RANGE = 0 TO 9999.

DON'T KNOW	d
REFUSED	r

C9a. **IF C9 > 0, ASK. ELSE SKIP TO C10.** In the six months before you enrolled in the Healthy Indiana Plan (HIP), was there been any time when you contacted a doctor's office or clinic, but couldn't get an appointment soon enough so you went to the emergency room instead?

YES	1
NO	2
DON'T KNOW	d
REFUSED	r

C10. How many times were you **hospitalized** in the six months before you enrolled in the Healthy Indiana Plan (HIP)? Please only include times where you spent the night at the hospital.

CATI – ALLOWABLE RANGE = 0 TO 9999.

DON'T KNOW	d
REFUSED	r

C10a. **ASK IF C10 = >0, ELSE SKIP TO C21**. In the six months before you enrolled in the Healthy Indiana Plan (HIP) how many nights did you spend in the hospital in **total**?

CATI – ALLOWABLE RANGE = 0 TO 9999.

DON'T KNOW	d
REFUSED	r

ALL NEW ENROLLEES: SKIP TO C21

ALL NEW ENROLLEES SKIP TO C21, **ITEMS C11 THROUGH C21 OF ESTABLISHED ENROLLEES ONLY:**

C11. The next questions ask about your health care experiences in the past six months. During the past six months, did you visit **any** doctor's office, health clinic, hospital, or other place because you were sick or you needed advice about your health?

YES	1	
NO	2	→ SKIP TO C12
DON'T KNOW	d	→ SKIP TO C12
REFUSED	r	→ SKIP TO C12

C11a. What type of place did you go to **most often**? Was it a . . . (CHECK ONLY ONE)

IF R ONLY WENT TO A COUPLE OF LOCATIONS, ASK FOR PLACE VISITED ON MOST RECENT VISIT.

Private doctor's office,	1
Clinic or health center,	2
Hospital emergency room, or	3
Some other type of place? (SPECIFY): _____	95
DON'T KNOW	d
REFUSED	r

C12. A **personal doctor or nurse** is a health provider who knows you well and is familiar with your health history. This can be a general doctor, a specialist doctor, a nurse practitioner, or a physician assistant. Do you have **one person** you think of as your **personal doctor or health care provider**?

IF "NO," ASK: Is there more than one or is there no person you think of as your personal doctor or health care provider?

Yes, only one	1
More than one	2
No	3
DON'T KNOW	d
REFUSED	r

C13. In the past six months, did you see a doctor or health care professional for **preventive care**, such as a check-up, shots, or physical examination?

YES	1	
NO	2	→ SKIP TO C14
DON'T KNOW	d	→ SKIP TO C14
REFUSED	r	→ SKIP TO C14

C13a. In the past six months, when you saw your doctor or other health care professional for **preventive care**, how long, in general, did you have to wait to get an appointment?

Less than or equal to 2weeks	1
More than 2 weeks but less than or equal to 4 weeks, or	2
More than 4 weeks	3
DON'T KNOW	d
REFUSED	r

C14. During the past six months, was there <u>any</u> time that you needed to see a doctor or other health care professional for **preventive care** such as a checkup or physical examination **but did not go**?

YES	1	
NO	2	→ SKIP TO C15
DON'T KNOW	d	→ SKIP TO C15
REFUSED	r	→ SKIP TO C15

C14a. During that time, what was the **main** reason you did not see a doctor or other health care professional for the **preventive** care you needed? (CHECK ONLY ONE)

COST TOO MUCH	1
COULDN'T GET CHILDCARE	2
COULDN'T GET TIME OFF FROM WORK	3
COULDN'T GET THROUGH ON THE PHONE	4
COULDN'T SCHEDULE APPOINTMENT SOON ENOUGH	5
DIDN'T GET APPROVAL FROM PLAN	6
DIDN'T HAVE TIME	7
DIDN'T WANT TO GO	8
HOURS OF OPERATION WERE NOT CONVENIENT FOR ME	9
NO INSURANCE	10
PLACE DID NOT ACCEPT THE INSURANCE COVERAGE	11
TAKES TOO LONG TO GET THERE / TRANSPORTATION PROBLEM	12
OTHER (SPECIFY): _____	95
DON'T KNOW	d
REFUSED	r

C15. In the past 6 months, did you have an illness, accident, or injury?

YES	1	
NO	2	→ SKIP TO C16
DON'T KNOW	d	→ SKIP TO C16
REFUSED	r	→ SKIP TO C16

C15a. In the past 6 months, how many times did you see a **doctor or other health professional** about <u>any</u> illness, accident, or injury you had?

				CATI: RANGE = 0-9999

DON'T KNOW	d
REFUSED	r

C15a1. **IF C15a > "0", ASK, ELSE SKIP TO C16:**
In the last six months, when you saw your doctor or other health care professional for any **illness, accident, or injury**, how long, in general, did you have to wait to get an appointment?

Less than or equal to 24 hours	1
More than 24 but less than or equal to 48 hours	2
More than 48 hrs but less than or equal to 1 week, or	3
More than 1 week	4
DON'T KNOW	d
REFUSED	r

C15b. During the past six months, was there any time that you <u>needed</u> to see a doctor or other health care professional because of an illness, accident, or injury but **did not go**?

YES	1	
NO	2	→ SKIP TO C16
DON'T KNOW	d	→ SKIP TO C16
REFUSED	r	→ SKIP TO C16

C15b1. During that time, what was the **main** reason you did not see a doctor or other health care professional because of your illness, accident, or injury?

CONDITION CLEARED UP	1
COST TOO MUCH	2
COULDN'T GET CHILDCARE	3
COULDN'T GET THROUGH ON THE PHONE	4
COULDN'T GET TIME OFF FROM WORK	5
COULDN'T SCHEDULE APPOINTMENT SOON ENOUGH	6
DIDN'T GET APPROVAL FROM PLAN	7
DIDN'T THINK I WAS SICK ENOUGH	8
DIDN'T HAVE TIME	9
DIDN'T WANT TO GO	10
HOURS OF OPERATION WERE NOT CONVENIENT FOR ME	11
NO INSURANCE	12
PLACE DID NOT ACCEPT THE INSURANCE COVERAGE	13
TAKES TOO LONG TO GET THERE/ TRANSPORTATION PROBLEM	14
OTHER (SPECIFY): _____	95
DON'T KNOW	d
REFUSED	r

C16. During the past six months, did you see a **specialist**, such as a heart, lung or respiratory specialist, a digestive or urinary tract specialist, someone who treats diabetes, or other doctor who takes care of special parts of the body?

YES	1	
NO	2	→ SKIP TO C17
DON'T KNOW	d	→ SKIP TO C17
REFUSED	r	→ SKIP TO C17

C16a. In the past 6 months, how many visits did you make to see specialists?

				CATI: RANGE = 01-9999

DON'T KNOW	d
REFUSED	r

C16b. In the last six months, when you saw a **specialist**, how long, in general, did you have to wait to get an appointment?

Less than or equal to 4 weeks	1
More than 4 week but less than or equal to 6 weeks	2
More than 6 weeks	3
DON'T KNOW	d
REFUSED	r

C17. During the past six months, was there any time when you <u>needed</u> to see a <u>specialist</u> but **did not go**? IF NEEDED: By specialist we mean a doctor who takes care of special parts of the body, such as a heart, lung or respiratory specialist, a digestive or urinary tract specialist, someone who treats diabetes.

YES	1	
NO	2	→ SKIP TO C18
DON'T KNOW	d	→ SKIP TO C18
REFUSED	r	→ SKIP TO C18

C17a. During that time, what was the **main** reason you did not see a specialist?

CONDITION CLEARED UP	1
COST TOO MUCH	2
COULDN'T GET CHILDCARE	3
COULD NOT GET THROUGH ON THE PHONE	4
COULDN'T GET TIME OFF FROM WORK	5
COULDN'T SCHEDULE APPOINTMENT SOON ENOUGH	6
DIDN'T GET APPROVAL FROM PLAN	7
DIDN'T THINK I WAS SICK ENOUGH	8
DIDN'T HAVE TIME	9
DIDN'T WANT TO GO	10
HOURS OF OPERATION WERE NOT CONVENIENT FOR ME	11
NO INSURANCE	12
PLACE DID NOT ACCEPT THE INSURANCE COVERAGE	13
TAKES TOO LONG TO GET THERE/ TRANSPORTATION PROBLEM	14
OTHER (SPECIFY): _____	95
DON'T KNOW	d
REFUSED	r

C18. In the past six months, did you need any prescription drugs?

YES	1	
NO	2	→ SKIP TO C19
DON'T KNOW	d	→ SKIP TO C19
REFUSED	r	→ SKIP TO C19

C18a. In the past 6 months, on average, how many prescriptions did you fill a month?

CATI – ALLOWABLE RANGE = 0 TO 9999.

DON'T KNOW	d
REFUSED	r

C18b. During the past six months, was there a time you needed a prescription drug but you **did not get it**?

YES	1	
NO	2	→ SKIP TO C19
DON'T KNOW	d	→ SKIP TO C19
REFUSED	r	→ SKIP TO C19

C18b1. During that time, what was the **main** reason you did not get the prescription drug?

CONDITION CLEARED UP	1
COST TOO MUCH	2
COULDN'T GET CHILDCARE	3
COULDN'T GET TIME OFF FROM WORK	4
DID NOT GET APPROVAL FROM PLAN	5
DID NOT THINK I WAS SICK ENOUGH	6
DID NOT HAVE TIME	7
DID NOT WANT TO GO	8
HOURS OF OPERATION WERE NOT CONVENIENT FOR ME	9
I DON'T TAKE PRESCRIPTION MEDICATIONS	10
NO CONVENIENT PLACE TO PICK UP THE PRESCRIPTION	11
NO INSURANCE	12
PHARMACY DID NOT HAVE CONVENIENT HOURS OF OPERATION	13
PLACE DID NOT ACCEPT THE INSURANCE COVERAGE	14
TAKES TOO LONG TO GET THERE/ TRANSPORTATION PROBLEM	15
OTHER (SPECIFY): _____	95
DON'T KNOW	d
REFUSED	r

C19. In total, how many trips did you make to the **emergency room** in the past six months?

CATI – ALLOWABLE RANGE = 0 TO 9999.

DON'T KNOW d
REFUSED r

C19a. **ASK IF C19 = >0, ELSE SKIP TO C20**. During the past six months, was there any time when you contacted a doctor's office or clinic, but couldn't get an appointment soon enough so you went to the emergency room instead?

YES	1
NO	2
DON'T KNOW	d
REFUSED	r

C20. How many times were you **hospitalized** in the past six months? Please only include times where you spent the night at the hospital.

CATI – ALLOWABLE RANGE = 0 TO 9999.

DON'T KNOW d → SKIP TO C21
REFUSED r → SKIP TO C21

C20a. ASK IF C21 = >0, ELSE SKIP TO C21. In the past six months, how many nights did you spend in the hospital in **total**?

CATI – ALLOWABLE RANGE = 0 TO 9999.

DON'T KNOW d
REFUSED r

↓ BOTH GROUPS OF ENROLLEES MERGE TOGETHER HERE ↓

C21. My next questions are about preventative care. About how long has it been since you last visited a doctor for a **routine check up**? A routine check-up is a general physical exam, not an exam for a specific injury, illness, or condition.

Within the past 3 months,	1
Within the past year (More than or equal to 3 months but less than or equal to 12 months ago),	2
Within the past 2 years (More than 1 year less than or equal to 2 years ago),	3
Within the past 5 years (More than 2 years but less than 5 years ago),	4
5 or more years ago, or	5
Never	6
DON'T KNOW	d
REFUSED	r

C22. Blood cholesterol is a fatty substance found in the blood. When did you last have your **blood cholesterol** checked? Was it …

Within the past 3 months,	1
Within the past year (More than or equal to 3 months but less than or equal to12 months ago),	2
Within the past 2 years (More than 1 year less than or equal to 2 years ago),	3
Within the past 5 years (More than 2 years but less than 5 years ago),	4
5 or more years ago, or	5
Never	6
DON'T KNOW	d
REFUSED	r

C23. Glucose or sugar is a substance found in your blood. Have you ever had your **blood glucose** or **sugar** tested by a health care provider to see if you have diabetes?

YES	1	
NO	2	→ SKIP TO C24
DON'T KNOW	d	→ SKIP TO C24
REFUSED	r	→ SKIP TO C24

C23a. When was the last time your blood glucose or sugar level was measured by a health care provider?

Within the past 3 months,	1
Within the past year (More than or equal to 3 months but less than or equal to 12 months ago),	2
Within the past 2 years (more than 1 year less than or equal to 2 years ago),	3
Within the past 5 years (more than 2 years but less than 5 years ago), or	4
5 or more years ago	5
DON'T KNOW	d
REFUSED	r

C24. **ASK ONLY IF AGE IS ≥ 50**, **ELSE SKIP TO C25.** Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of cancer and other health problems. Have you ever had either of these exams?

YES	1	
NO	2	→ SKIP TO C25
DON'T KNOW	d	→ SKIP TO C25
REFUSED	r	→ SKIP TO C25

C24a. How long has it been since you had a sigmoidoscopy or a colonoscopy? IF HAD BOTH, PROBE FOR WHICH ONE WAS DONE MORE RECENTLY.

Within the past 3 months,	1
Within the past year (more than or equal to 3 months but less than or equal to 12 months ago),	2
Within the past 2 years (more than 1 year less than or equal to 2 years ago),	3
Within the past 5 years (more than 2 years but less than 5 years ago), or	4
5 or more years ago	5
DON'T KNOW	d
REFUSED	r

C25. **ASK ONLY IF GENDER = MALE AND AGE IS ≥ 39; ELSE SKIP TO C26.**

Now I will ask about prostate screening. Two tests used in prostate cancer screening include a **Prostate-Specific Antigen Test**, also called a "**PSA"** test, which is a blood test and a **digital rectal exam**, in which a doctor, nurse, or other health professional places a gloved finger into the rectum to feel the size, shape, and hardness of the prostate gland. Have you ever had either of these tests?

YES	1	
NO	2	→ SKIP TO C26
DON'T KNOW	d	→ SKIP TO C26
REFUSED	r	→ SKIP TO C26

C25a. How long has it been since you had a either the **Prostate-Specific Antigen Test** / "**PSA"** test or the **digital rectal exam**? IF HAD BOTH, PROBE FOR ONE WHICH WAS DONE MORE RECENTLY.

Within the past 3 months,	1
Within the past year (More than or equal to 3 months but less than or equal to 12 months ago),	2
Within the past 2 years (more than 1 year less than or equal to 2 years ago),	3
Within the past 5 years (more than 2 years but less than 5 years ago), or	4
5 or more years ago	5
DON'T KNOW	d
REFUSED	r

C26. **ASK ONLY IF GENDER = FEMALE AND YEAR OF BIRTH IS ≥ 35, ELSE SKIP TO C27.** My next questions are about breast and cervical cancer. A **mammogram** is an x-ray of each breast to look for breast cancer. Have you ever had a mammogram?

YES	1	
NO	2	→ SKIP TO C27
DON'T KNOW	d	→ SKIP TO C27
REFUSED	r	→ SKIP TO C27

C26a. How long has it been since your last mammogram?

Within the past 3 months,	1
Within the past year (more than or equal to 3 months but less than or equal to 12 months ago),	2
Within the past 2 years (more than 1 year less than or equal to 2 years ago),	3
Within the past 5 years (more than 2 years but less than 5 years ago), or	4
5 or more years ago	5
DON'T KNOW	d
REFUSED	r

C27. **ASK ONLY IF GENDER = FEMALE, ELSE SKIP TO SECTION D.** A **PAP test** is a test for cancer of the cervix. Have you ever had a PAP test, also known as a PAP smear?

YES	1	
NO	2	→ SKIP TO C28
DON'T KNOW	d	→ SKIP TO C28
REFUSED	r	→ SKIP TO C28

C27a. How long has it been since your last PAP test?

Within the past 3 months,	1
Within the past year	2
(More than or equal to 3 months but less than or equal to 12 months ago),	
Within the past 2 years (more than 1 year less than or equal to 2 years ago),	3
Within the past 5 years (more than 2 years but less than 5 years ago), or	4
5 or more years ago	5
DON'T KNOW	d
REFUSED	r

C28. **ASK ONLY IF GENDER = FEMALE <u>AND</u> AGE = 19 TO 25 YEARS OLD, ELSE SKIP TO SECTION D.**

In the past <u>12 months</u>, have you been tested by a doctor or other health care professional for **Chlamydia**, which is a sexually transmitted disease?

YES	1
NO	2
DON'T KNOW	d
REFUSED	r

SECTION D: SATISFACTION WITH HIP & USE OF POWER ACCOUNTS

My next questions ask about your overall satisfaction with the Healthy Indiana Plan and your experiences with the POWER Account feature in the plan.

D1. Thinking about your overall experience with the Healthy Indiana Plan so far, would you say you are:

Very Satisfied	1	→ SKIP TO D2
Somewhat Satisfied	2	→ SKIP TO D2
Neither Satisfied nor Dissatisfied	3	→ SKIP TO D2
Somewhat Dissatisfied, or	4	
Very Dissatisfied	5	
DON'T KNOW	d	→ SKIP TO D2
REFUSED	r	→ SKIP TO D2

D1a. Can you tell me why you are dissatisfied? IF NEEDED: Any other reasons why you are dissatisfied in your experience with HIP so far? PROBE: Anything else?

SPECIFY: _____	95
DON'T KNOW	d
REFUSED	r

D2. Are there any **health-related services** you need which are not covered by HIP?

YES	1	
NO	2	→ SKIP TO D3
DON'T KNOW	d	→ SKIP TO D3
REFUSED	r	→ SKIP TO D3

D2a. What are the health-related services you need which are not covered by HIP? PROBE: Any others? (CHECK ALL THAT APPLY).

INTERVIEWER: DO NOT READ THE CATEGORIES OUT LOUD

DENTAL SERVICES	1
DIAGNOSTIC EXAMS	2
FAMILY PLANNING	3
INPATIENT HOSPITAL STAYS	4
MENTAL HEALTH COVERAGE FOR INPATIENT / OUTPATIENT TREATMENT, AND SUBSTANCE ABUSE TREATMENT	5
PRESCRIPTION MEDICATIONS	6
PREVENTIVE SERVICES - ANNUAL EXAMS	7
PREVENTIVE SERVICES – CANCER SCREENING	8
VISION RELATED SERVICES	9
OTHER HEALTH-RELATED SERVICE NOT LISTED ABOVE	10

D3. Do you have a **POWER Account** (which stands for Personal Wellness and Responsibility Account) through the Healthy Indiana plan? IF NEEDED: This account is valued at $1,100 per adult to pay for initial medical costs. This is similar to a health savings account (HSA) and is used to fund the deductible.

YES	1	
NO	2	→ SKIP TO SECTION E
DON'T KNOW	d	→ SKIP TO SECTION E
REFUSED	r	→ SKIP TO SECTION E

D4. Do you feel you have been given **enough information** to be able to understand the POWER Account feature of this plan?

YES	1
NO	2
DON'T KNOW	d
REFUSED	r

D5. If you wanted to **learn more** about the HIP program, such as what it covers, or how the POWER account feature works, how would you find the information you wanted? PROBE: Who would you contact or where would you go for the information? (CHECK ALL THAT APPLY) INTERVIEWER: DO NOT READ CATEGORIES ALOUD.

ASK DOCTOR OR OTHER MEDICAL PROFESSIONAL	1
ASK FAMILY MEMBER OR FRIEND	2
CALL HIP	3
CALL MY HEALTH PLAN (MDWISE, ANTHEM, ESP)	4
CHECK WEBSITE FOR MY HEALTH PLAN (MDWISE, ANTHEM, ESP)	5
CHECK HIP WEBSITE OR STATE WEBSITE	6
CONTACT LOCAL SOCIAL SERVICE OFFICE	7
WOULD NOT CHECK – WOULD JUST GO GET THE SERVICE(S)	8
DON'T KNOW	d
REFUSED	r

D6. Have you visited <u>either</u> your health plan's website or the State of Indiana's website **to find information** about HIP?

YES	1	
NO	2	→ SKIP TO D7
DON'T KNOW	d	→ SKIP TO D7
REFUSED	r	→ SKIP TO D7

D6a. How <u>helpful</u> was the website you visited (for giving you the information you wanted)? Was it:
IF R VISITED BOTH SITES AND ONE WAS MORE HELPFUL THAN ANOTHER – ASK R TO BASE RESPONSE ON THE SITE WHERE HE / SHE SPENT MORE TIME.

Very helpful	1
Somewhat helpful	2
Not very helpful	3
Not at all helpful	4
DON'T KNOW	d
REFUSED	r

D7. Are there any health-related services the HIP program wants you to get each year?

YES	1	
NO	2	→ SKIP TO D8
DON'T KNOW	d	→ SKIP TO D8
REFUSED	r	→ SKIP TO D8

D7a. What are the health-related services the HIP program wants you to in the next year? PROBE: Any others? **(CHECK ALL THAT APPLY)**

DO NOT READ THESE CATEGORIES ALOUD – IF R SAYS "I DON'T NOT KNOW, CODE AS DON'T KNOW WITHOUT PROBING WITH RESPONSE CATEGORIES BELOW.

BLOOD GLUCOSE SCREEN	1
CHOLESTEROL SCREEN	2
FLU SHOT	3
MAMMOGRAM	4
PAP TEST / PAP SMEAR	5
PHYSICAL EXAM / ROUTINE CHECK UP	6
SIGMOIDOSCOPY AND COLONOSCOPY	7
TETANUS SHOT	8
TEST FOR CHLAMYDIA	9
DON'T KNOW	d
REFUSED	r

D7b. What happens if you do not get the health-related services HIP wants you to get in the next year?

I DON'T GET TO ROLL OVER THE POWER ACCOUNT BALANCE AND MY MONTHLY CONTRIBUTIONS DON'T DECLINE	1
I KEEP ADDING TO MY POWER ACCOUNT WITHOUT LOSING ANY NEXT YEAR	2
I LOSE THE MONEY – THE STATE / THE HEALTH PLAN TAKES IT BACK	3
MONEY GOES TO MY HEALTH CARE PROVIDER	4
MY CONTRIBUTION ROLLS OVER BUT THE STATE'S DOES NOT	5
NOTHING HAPPENS	6
THEY GIVE ME MY MONEY BACK (ACCOUNT BALANCE COMES BACK TO ME)	7
OTHER - SPECIFY: _____	95
DON'T KNOW	d
REFUSED	r

D8. How much money do you contribute to your POWER account each month? RECORD IN DOLLARS AND CENTS.

$ [ ][ ][ ][ ] . [ ][ ] CATI: DOLLAR RANGE = 0-9999, CENTS RANGE 00-99

DOLLARS	1	
CENTS	2	
DON'T KNOW	d	→ SKIP TO D9
REFUSED	r	→ SKIP TO D9

D8a. Would you say the amount you contribute to your POWER account each month is:

Way too much – cannot afford this	1
A little too much – it is a stretch to afford this	2
The right amount	3
Below the right amount – could afford a little more	4
Way below the right amount – could afford a lot more	5
DON'T KNOW	d
REFUSED	r

D9. Once HIP tells you **how much you are required to pay** into your POWER Account – is there any way to have this amount reduced?

YES – WAYS TO REDUCE	1	
NO – NO WAY TO REDUCE OR CHANGE IT	2	→ SKIP TO D10
DON'T KNOW	d	→ SKIP TO D10
REFUSED	r	→ SKIP TO D10

D9a. What are the things that can happen to make someone's monthly contribution **go down**?
(CHECK ALL THAT APPLY)
INTERVIEWER: DO NOT READ CATEGORIES OUT LOUD

GET PREVENTATIVE CARE REQUIRED	1
HAVE MONEY LEFT OVER	2
EARN / MAKE LESS MONEY / INCOME GOES DOWN	3
MORE CHILDREN IN HOOSIER HEALTH WISH	4
MAKE AN APPEAL / ASK HIP	5
EMPLOYER PAYS FOR SOME OF IT	6
DON'T KNOW	d
REFUSED	r

D10. How much is the balance in your POWER account at this time? IF NEEDED: Your best guess is fine.

$ [ ][ ][ ][ ] . [ ][ ] CATI: DOLLAR RANGE = 0-9999, CENTS RANGE 00-99

DOLLARS	1	
CENTS	2	
DON'T KNOW	d	→ SKIP TO D11
REFUSED	r	→ SKIP TO D11

D11. How often do you check the balance in your POWER Account?

WEEKLY	1
A FEW TIMES A MONTH	2
MONTHLY	3
A FEW TIMES A YEAR BUT NOT EVERY MONTH	4
ONCE A YEAR	5
NEVER	6
DON'T KNOW	d
REFUSED	r

D12. What happens when the money in your POWER account **runs out** before the end of the year when you must renew your eligibility for the program?

I CAN'T GET ANY MORE CARE	1
I HAVE TO START PAYING FOR ALL MY CARE	2
NOTHING HAPPENS	3
STATE PAYS FOR IT	4
OTHER - SPECIFY: _____	95
DON'T KNOW	d
REFUSED	r

D13. I am going to read a list of medical services. For each, if you were to use the service, tell me whether you think the **cost** would be deducted from your POWER account (if you have enough money available in the account).

	CHECK ONE FOR EACH ROW			
	Y	N	DK	REF
a. Inpatient hospital stays	1	2	d	r
b. family planning	1	2	d	r
c. mental health coverage for inpatient / outpatient treatment, and substance abuse treatment	1	2	d	r
d. prescription medications	1	2	d	r
e. preventive services - annual exams	1	2	d	r
f. preventive services – cancer screening	1	2	d	r

D14. **IF NEW ENROLLEE, ASK - ELSE, SKIP TO D14.** Do you think having this POWER account will make you more likely, just as likely, or less likely to seek medical treatment when needed?

MORE LIKELY	1
JUST AS LIKELY	2
LESS LIKELY	3
DON'T KNOW	d
REFUSED	r

D15. **IF ESTABLISHED ENROLLEE, ASK, ELSE SKIP TO SECTION E:** Has this POWER account made you more likely, just as likely, or less likely to seek medical treatment when needed?

MORE LIKELY	1
JUST AS LIKELY	2
LESS LIKELY	3
DON'T KNOW	d
REFUSED	r

D16. **IF ESTABLISHED ENROLLEE, ASK**: When you are seeking treatment from a doctor or other health professional, do you ask how much it will cost you or what the deduction will be from your POWER account **before** you get the treatment?

YES	1	
NO	2	→ SKIP TO SECTION E
DON'T KNOW	d	→ SKIP TO SECTION E
REFUSED	r	→ SKIP TO SECTION E

D16a. Why is that? IF NEEDED: Why is it that you (ask how much it will cost you / what the deduction from the POWER Account will be) before getting treatment? Why is that helpful information to you?

SPECIFY: _____	95
DON'T KNOW	d
REFUSED	r

CATI: SET ALLOWABLE NUMBER OF CHARACTERS FOR OE TEXT TO CAP AT 500.

SECTION E: DEMOGRAPHICS

The last set of questions are about you and your household in general. This information will help us compare the opinions and experiences of different groups of people who participate in the Healthy Indiana Plan (HIP).

E1. What is the **highest** grade or year of school you have **completed**?

NO FORMAL EDUCATION	1
GRADES 1-8 (ELEMENTARY)	2
GRADES 9-11 (SOME HIGH SCHOOL)	3
GRADE 12 OR GED (HIGH SCHOOL GRADUATE)	4
COLLEGE 1-3 YEARS (SOME COLLEGE)	5
COLLEGE 4 YEARS OR MORE (COLLEGE GRADUATE)	6
DON'T KNOW	d
REFUSED	r

E2. Are you Hispanic or Latino?

YES	1
NO	2
DON'T KNOW	d
REFUSED	r

E3. Which one or more of the following would you say is your race? (CHECK ALL THAT APPLY):

White	1
Black or African American	2
Asian	3
Native Hawaiian or Other Pacific Islander	4
American Indian or Alaska Native	5
DON'T KNOW	d
REFUSED	r

E4. Are you currently: (CHECK ALL THAT APPLY)

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

E5. Are you currently receiving **SSI**, otherwise known as Supplemental Security Income?

YES	1
NO	2
DON'T KNOW	d
REFUSED	r

E6. Are you currently receiving **SSDI**, otherwise known as Social Security Disability Insurance?

YES	1
NO	2
DON'T KNOW	d
REFUSED	r

E7. What is your current marital status? Are you …

Married?	1
Divorced?	2
Widowed?	3
Separated?	4
Never Married?	5
DON'T KNOW	d
REFUSED	r

E8. Do you have a spouse or adult partner living with you?

YES	1	
NO	2	→ SKIP TO E9
DON'T KNOW	d	→ SKIP TO E9
REFUSED	r	→ SKIP TO E9

E8a. Is your spouse or adult partner ... (CHECK ALL THAT APPLY)

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

E9. How many people are <u>currently living with you</u> in your household? Please include children, babies, and anyone else living with you. Do <u>not</u> include yourself.
[INTERVIEWER: IF R LIVES ALONE, ENTER "0"]

|__|__| NUMBER – CATI: ALLOWABLE VALUES = 00-99

DON'T KNOW	d
REFUSED	r

E10. **ASK IF E9 IS >0, ELSE SKIP TO E11.** How many of these people living with you in your household are under age 18?

|__|__| NUMBER - CATI: ALLOWABLE VALUES = 00-99

DON'T KNOW	d
REFUSED	r

E11. **ASK IF E9 IS >0, ELSE SKIP TO E13**. Are <u>any</u> members of your household currently enrolled in "<u>Hoosier Health Wise</u>"?

YES	1
NO	2
DON'T KNOW	d
REFUSED	r

E12. Are any members of your household currently enrolled in "Care Select"?

YES	1
NO	2
DON'T KNOW	d
REFUSED	r

E13. What was your total household income in the past 12 months, before taxes? Please include any income you and other family members may have received from jobs, public assistance, interest, or any other sources.

RECORD IN WHOLE DOLLARS

INTERVIEWERS: IF R IS UNABLE TO RECALL INCOME FOR PAST 12 MONTHS, ASK FOR INCOME LAST MONTH AND IF R FEELS THAT INCOME WAS TYPICAL FOR THE PAST 12 MONTHS, MULTIPLY THAT NUMBER BY 12 FOR ANNUAL INCOME.

_____	TOTAL DOLLARS IN PAST 12 MONTHS	→ SKIP TO E14
DON'T KNOW	d	
REFUSED	r	

E13a. Which of the following categories best describes your total household income in the past 12 months, before taxes? Please stop me when I get to the right category . . .

Less than $10,000,	1
$10,001 up to $20,000,	2
$20,001 up to $30,000,	3
$30,001 up to $40,000,	4
$40,001 up to $50,000, or	5
More than $50,000 last year before taxes?	6
DON'T KNOW	d
REFUSED	r

E14. About **how long** have you lived in Indiana?

IF MOVED BACK AND FORTH, PROBE: Please think about the most recent time you returned to Indiana.
IF LESS THAN 1 YEAR, RECORD NUMBER OF MONTHS, IF LESS THAN 1 MONTH – ROUND UP TO 1 MONTH.

		CATI: ALLOWABLE RANGE = 1-12 MONTHS OR 1 TO 64 YEARS

ENTIRE LIFE	99
MONTHS	1
YEARS	2
DON'T KNOW	d
REFUSED	r

E15. Finally, as I mentioned in the beginning of the interview, we will mail you a check for $20 to thank you for your time. I would like to confirm the spelling of your name and your mailing address.

	↓ **CORRECTIONS, IF NEEDED**: ↓
CONFIRM SPELLING OF FIRST NAME	
CONFIRM SPELLING OF LAST NAME	
CONFIRM ADDRESS 1	
CONFIRM ADDRESS 2	
CONFIRM CITY:	
CONFIRM STATE:	
CONFIRM ZIP CODE.	

<CLOSING> Thank you for completing this interview. We appreciate your time and your willingness to provide this information to help us better understand the experiences of people like yourself across the State.

You should receive your check for $20 within four to six weeks. If you have any questions about the Healthy Indiana Plan, please call 1-877-GET-HIP9. Thank you and have a good day / night.

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