

Indiana Healthy Indiana Plan 2.0: Appendices

Prepared for:

Indiana Family and Social Services Administration (FSSA)

Submitted by:

The Lewin Group, Inc.

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Appendix A. Current Basic Member Survey (Full)

DESCRIPTION: This survey applies to individuals currently enrolled in in HIP BASIC, per eligibility data.

CONFIRM AWARENESS OF ENROLLMENT IN HIP BASIC

Q1. The State of Indiana runs an insurance program called the Healthy Indiana Plan (or HIP) for Hoosiers age 19 to 64. Are you enrolled in the “Healthy Indiana Plan” or “HIP” at this time?

- YES
 - NO
 - DON'T KNOW → GO TO CLOSE
- ↓

Q1a. Are you in HIP Basic or HIP Plus?

- BASIC → CONTINUE WITH THE SURVEY, GO TO Q2
- PLUS → CONTINUE WITH THE SURVEY, GO TO Q2
- REFUSED → GO TO Q1B
- DON'T KNOW → GO TO Q1B

Q1b. Based on the information we have, it looks like you are in HIP Basic and pay copayments for services. Is this correct?

- YES → CONTINUE WITH THE SURVEY, GO TO Q2
- NO
- DON'T KNOW → GO TO CLOSE

SATISFACTION WITH HIP

The next set of questions will ask about your satisfaction with the Healthy Indiana Plan.

Q2. Thinking about your overall experience with the Healthy Indiana Plan in the past six months, would you say you are:

- VERY SATISFIED,
- SOMEWHAT SATISFIED,
- NEITHER SATISFIED NOR DISSATISFIED,
- SOMEWHAT DISSATISFIED, OR
- VERY DISSATISFIED?
- DON'T KNOW → GO TO Q3
- REFUSED → GO TO Q3

Q2a. Why are you (FILL IN WITH PREVIOUS RESPONSE)? OPEN-ENDED RESPONSE

- SPECIFY: _____

DO NOT READ LIST BELOW; USE FOR CODING PURPOSES

- CAN'T SEE MY DOCTOR WITH HIP
- DISSATISFACTION WITH CHOICE OF DOCTORS IN HIP
- HIP DOES NOT COVER DENTAL
- HIP DOES NOT COVER VISION/OPTICAL
- HIP DOES NOT COVER PROCEDURE/ MEDICATION
- MANY DOCTORS DO NOT ACCEPT HIP
- DISSATISFIED WITH ADMINISTRATIVE ISSUE(S) OR PROCESS
- DISSATISFACTION WITH A PAYMENT RELATED ISSUE
- CAN'T AFFORD CO-PAY/ TOO HIGH
- CO-PAYMENT / MONTHLY/ ANNUAL PAYMENT TOO HIGH
- LIKE HAVING COVERAGE/ INSURANCE
- LIKE DOCTORS/ HOSPITALS / HEALTH CARE PROVIDERS
- LIKE PAYMENTS / PRICE
- LIKE THE PLAN/ PROVIDER
- LIKE SOME THINGS/ DISLIKE OTHER THINGS
- SOME THINGS NOT COVERED
- DON'T KNOW
- REFUSED
- OTHER REASON NOT LISTED ABOVE: (SPECIFY) _____

Q3. If you ever left HIP, would you try to reenroll if you became eligible for the program again?

- YES
- NO
- DON'T KNOW
- REFUSED

FAST-TRACK PAYMENTS

Q4. When you applied for HIP, did you make a fast track payment?

(IF NEEDED: A fast track payment is made when you complete your application. Fast track payments allow you to get HIP coverage more quickly because you pre-pay your first payment. By making the fast track payment when you apply, it may take less time for your coverage to begin.)

- YES
- NO → GO TO Q4b
- DON'T KNOW
- REFUSED → GO TO Q5

Q4a. Why did you decide to sign-up for the fast track payment option?

- I WANTED MY COVERAGE AND/OR ELIGIBILITY TO BEGIN SOONER
- I THOUGHT IT WAS A REQUIRED PART OF HIP
- I THOUGHT IT WOULD BE EASIER TO PAY THEN (I.E., WOULDN'T HAVE TO MAIL/GO IN-PERSON, ETC.)
- I HAD THE FUNDS AT THE TIME I APPLIED
- OTHER REASON NOT LISTED ABOVE: (SPECIFY) _____
- DON'T KNOW
- REFUSED

Q4b. Why did you decide NOT to sign-up for the fast track payment option?

- I COULDN'T AFFORD TO MAKE THE PAYMENT
- I WASN'T SURE IF I WOULD BE ELIGIBLE
- I DIDN'T UNDERSTAND THE DIFFERENCE BETWEEN FAST TRACK AND THE REGULAR PAYMENT OPTION
- I DIDN'T NEED COVERAGE TO START SOONER
- I WASN'T AWARE OF THE OPTION TO SIGN-UP FOR FAST TRACK AT THE TIME I APPLIED
- OTHER REASON NOT LISTED ABOVE: (SPECIFY)

- DON'T KNOW
- REFUSED

ACCESS

Q5. In the last 6 months, did you make any appointments for a check-up or routine care at a doctor's office or clinic?

- YES → GO TO NEXT QUESTION
- NO → SKIP NEXT QUESTION [Q6]

Q5a. In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?

- NEVER
- SOMETIMES
- USUALLY
- ALWAYS

Q6. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, did you make any appointments to see a specialist?

- YES → GO TO Q6A
- NO → GO TO Q7
- DON'T KNOW → GO TO Q7

Q6a. In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?

- NEVER
- SOMETIMES
- USUALLY
- ALWAYS

Q7. In the last 6 months, did you get any new prescription medicines or refill a prescription?

- YES → GO TO Q7a
- NO → GO TO Q8

Q7a. In the last 6 months, how often was it easy to get your prescription medicine from your health plan?

- NEVER
- SOMETIMES
- USUALLY
- ALWAYS

Q8. In the past six months, have you missed any healthcare appointments, such as doctor's appointments?

- YES → GO TO 8a
- NO
- DON'T KNOW → GO TO Q9
- REFUSED → GO TO Q9

Q8a. What are the reasons you missed an appointment? (ALLOW MULTIPLE RESPONSE OPTIONS)

- COST TOO MUCH
- COULDN'T GET CHILDCARE
- COULDN'T GET TIME OFF FROM WORK
- COULDN'T GET THROUGH ON THE PHONE
- COULDN'T SCHEDULE APPOINTMENT SOON ENOUGH
- DIDN'T GET APPROVAL FROM PLAN
- DIDN'T HAVE TIME
- DIDN'T WANT TO GO
- HOURS OF OPERATION WERE NOT CONVENIENT FOR ME
- NO INSURANCE
- PLACE DID NOT ACCEPT THE INSURANCE COVERAGE
- TAKES TOO LONG TO GET THERE
- TRANSPORTATION PROBLEM
- TOO SICK TO GO
- OTHER REASON, NOT LISTED ABOVE: (SPECIFY)

Q8b. What is the most common reason you missed an appointment?

- _____
- (If respondent chooses more than one option for Q8a above.)

Q9. In the past six months, was there any time when you contacted a doctor's office or clinic, but couldn't get an appointment soon enough so you went to the emergency room instead?

- YES
- NO
- DON'T KNOW
- REFUSED

Q10. When you need to get health care, what is the type of transportation you use most often to get to your visit?

- I DRIVE MYSELF, USING MY OWN VEHICLE
- SOMEONE ELSE (SUCH AS A FRIEND, NEIGHBOR, OR FAMILY) DRIVES ME, USING MY OWN VEHICLE
- SOMEONE ELSE (SUCH AS A FRIEND, NEIGHBOR, OR FAMILY) DRIVES ME, USING THEIR VEHICLE
- I TAKE A TAXI CAB/OR UBER
- I TAKE THE BUS
- OTHER: _____

AWARENESS

Q11. Have you heard of the Healthy Indiana Plan POWER account, which stands for Personal Wellness and Responsibility Account?

- YES
- NO
- DON'T KNOW → GO TO Q13
- REFUSED

Q11a. How did you hear or learn about the POWER account? (MARK ALL THAT APPLY)

- MEMBER HANDBOOK
- SOMEONE FROM THE PLAN CALLED AND EXPLAINED IT TO YOU
- HIP WEBSITE
- YOUR HEALTH PLAN
- YOUR DOCTOR OR HEALTH CARE PROFESSIONAL
- FAMILY/FRIENDS
- NONE OF THESE
- DON'T KNOW
- REFUSED

Q12. Do you have a POWER account as part of your HIP Basic insurance?

- YES
- NO
- DON'T KNOW → GO TO Q13
- REFUSED

Q12a. How often do you check the balance in your POWER account? Would you say ...

- WEEKLY
- A FEW TIMES A MONTH
- MONTHLY
- A FEW TIMES A YEAR BUT NOT EVERY MONTH
- ONCE A YEAR
- NEVER
- DON'T KNOW
- REFUSED

Q13. If you were to get preventive services, such as a cancer screening, do you think the cost would be deducted from your POWER account, if you have enough money available in the account?

- YES
- NO
- DON'T KNOW
- REFUSED

Q14. Has your health plan given you a HIP POWER Account debit card? (IF NEEDED: *This is a card that can be used to spend the money in your POWER account.*)

- YES → GO TO NEXT QUESTION
 - NO
 - DON'T KNOW
 - REFUSED
- GO TO Q15

Q14a. How often do you present the card to a health care provider? Is it...

- EVERY TIME YOU GET CARE
- SOME OF THE TIME
- ONLY FOR SPECIFIC SERVICES
- NEVER
- DON'T KNOW
- REFUSED

Q15. I'm going to read a couple of policies, please indicate whether you think the policy is true or false.

The first policy states: "If you get preventive services suggested by your plan every year and have money left in your POWER account, part of that money will be rolled over to your account for next year."

- TRUE
- FALSE
- DON'T KNOW
- REFUSED

Q16. The second policy states: "If you get the preventive services suggested by your plan and have money left over in your POWER account, this could result in lower payments in the next year."

- TRUE
- FALSE
- DON'T KNOW
- REFUSED

COVERAGE

Indiana offers two HIP programs – HIP Plus and HIP Basic. Based on the information we have, you are currently on HIP Basic. In the next set of questions, I am going to ask you about the differences between HIP Basic and HIP Plus.

Q17. HIP Plus covers services that HIP Basic does not cover, such as dental and vision. It also covers surgery for obesity and treatment of jaw disorders. Did you know that HIP Plus covers these additional services?

- YES
- NO
- DON'T KNOW
- REFUSED

Q18. How important would this additional coverage be to you?

- VERY IMPORTANT
- SOMEWHAT IMPORTANT
- NOT IMPORTANT
- DON'T KNOW
- REFUSED

COPAYMENTS

HIP Basic charges copayments or copays at the time you get most services. (IF NEEDED: Copayments are payments you make at the time you visit your doctor's office, go to the hospital or get prescription drugs.)

Q19. When you need treatment from a doctor or other health professional, do you ask how much the treatment will cost?

- YES
- NO
- DON'T KNOW
- REFUSED

Q20. In the past six months, when you needed treatment from doctors or other healthcare professionals, did they ask you to make a copay?

- ALWAYS
 - SOMETIMES
 - NEVER
 - HAVEN'T NEEDED TREATMENT/BEEN TO A HEALTHCARE PROFESSIONAL
 - DON'T KNOW
 - REFUSED
- GO TO Q23

Q21. Did you make the copay at the time of service?

- ALWAYS → GO TO Q22
- SOMETIMES → GO TO Q22
- NEVER → GO TO Q23
- DON'T KNOW → GO TO Q23
- REFUSED → GO TO Q23

Q22. Were the copays affordable?

- YES
- NO
- DON'T KNOW
- REFUSED

Q23. In the past 6 months, how often were you worried about having enough money to pay your copay?

- ALWAYS
- USUALLY
- SOMETIMES
- RARELY
- NEVER
- DON'T KNOW
- REFUSED

Q24. Did you know that HIP Plus does not require you to pay copays, but does require you to pay in advance for coverage through a monthly or annual payment?

- YES
- NO
- DON'T KNOW
- REFUSED

HIP 2.0 POLICIES

Q25. Do you prefer to pay copayments at the time of service, rather than paying in advance for your coverage through a monthly or annual payment to your POWER account? (IF NEEDED: *POWER account stands for Personal Wellness and Responsibility Account*)

- YES
 - NO
 - DON'T KNOW
 - REFUSED
- GO TO Q27

Q26. Why? OPEN-ENDED RESPONSE

- SPECIFY: _____

DO NOT READ LIST BELOW; USE FOR CODING PURPOSES

- COPAYMENTS ARE CHEAPER
- I DON'T USE A LOT OF SERVICES, SO I DON'T WANT TO PAY IF I DON'T NEED THE SERVICES
- I DON'T HAVE THE MONEY EVERY MONTH
- OTHER: (SPECIFY) _____
- DON'T KNOW
- REFUSED

Q27. Did you know that, if you are in HIP Plus, you can use funds in your POWER account to pay for the first \$2,500 of covered services?

- YES
- NO
- DON'T KNOW
- REFUSED

Q28. Did you know that, if some of the funds in a POWER account are rolled over to the next year, the monthly POWER account contribution will be reduced in the next year?

- YES
- NO
- DON'T KNOW

AFFORDABILITY

Q29. Did you know that, if you do not make your monthly or annual POWER account contribution, you will be moved from HIP Plus to HIP Basic?

- YES
- NO
- DON'T KNOW
- REFUSED

Q30. Our records show that you used to be on HIP Plus but moved to HIP Basic because you *never made* your first monthly or annual POWER account contributions, or because you *stopped making* monthly or annual POWER account contributions. Can you explain why you never made or stopped making contributions for HIP Plus? (ALLOW MULTIPLE RESPONSES)

- CAN'T AFFORD/FEES TOO HIGH
- DON'T NEED ADDITIONAL SERVICES
- DON'T KNOW HOW TO START PAYING ON A MONTHLY BASIS
- PREFER TO PAY COPAYMENTS FOR EACH SERVICE I USE
- DO NOT WANT HIP PLUS OR ADDED BENEFITS
- DON'T PLAN TO BE IN THE PROGRAM VERY LONG
- I ALREADY GOT MY VISION/DENTAL SERVICES, AND DON'T NEED HIP PLUS ANYMORE
- NOT OFFERED THE OPTION TO PAY ON A MONTHLY BASIS
- DON'T UNDERSTAND THE PROGRAM/DIFFERENCES
- NOT REQUIRED TO PAY THE CONTRIBUTION
- FORGOT
- OTHER REASON NOT LISTED ABOVE: (SPECIFY) _____

- DON'T KNOW → GO TO Q31
- REFUSED → GO TO Q31

Q30a. Which of these reasons is the most important? _____

Q31. The state checks your eligibility for HIP once a year. The next time the state checks your eligibility, you can move from HIP Basic to HIP Plus if you make your monthly/annual contributions to your POWER account. Did you know this?

- YES
- NO
- DON'T KNOW
- REFUSED

Q32. Would you rather remain in HIP Basic or move to HIP Plus, knowing that they are different?

- REMAIN IN HIP BASIC
- MOVE TO HIP PLUS
- DON'T KNOW → GO TO Q33
- REFUSED → GO TO Q33

Q32a. Why? OPEN-ENDED RESPONSE

- SPECIFY: _____

Q33. If HIP required you to pay \$5 each month, would you continue to stay enrolled?

- YES → GO TO Q34
- NO → GO TO Q35
- DON'T KNOW → GO TO Q35
- REFUSED → GO TO Q35

Q34. What about \$10? Would you continue to stay enrolled if HIP required you to pay \$10 each month?

- YES
- NO
- DON'T KNOW
- REFUSED

DEMOGRAPHICS

Q35. What is the highest grade or year of school you have completed? (READ ALL OPTIONS)

- GRADES 1 TO 8 (ELEMENTARY SCHOOL)
- GRADES 9 TO 11 (SOME HIGH SCHOOL)
- GRADE 12 OR GED (HIGH SCHOOL GRADUATE)
- COLLEGE/TECHNICAL SCHOOL 1 - 3 YEARS (SOME COLLEGE OR ADDITIONAL TRAINING)
- COLLEGE 4 YEARS OR MORE (COLLEGE GRADUATE)
- NO FORMAL EDUCATION
- DON'T KNOW

**Q36. As of this week, which of the following best describes your employment status?
(READ ALL OPTIONS, ALLOW MULTIPLE RESPONSES)**

- EMPLOYED FOR WAGES
- EMPLOYED FOR LESS THAN 20 HOURS A WEEK
- EMPLOYED FOR 20 OR MORE HOURS A WEEK
- SELF-EMPLOYED
- UNEMPLOYED AND LOOKING FOR WORK
- OUT OF WORK MORE THAN 1 YEAR
- OUT OF WORK LESS THAN 1 YEAR
- A HOMEMAKER
- TAKING CARE OF AN ELDERLY PARENT OR A FAMILY MEMBER WITH A DISABILITY
- A STUDENT
- RETIRED
- UNABLE TO WORK BECAUSE OF A PHYSICAL OR MENTAL HEALTH CONDITION
- SOMETHING ELSE: (SPECIFY) _____
- DON'T KNOW
- REFUSED

CLOSE: Thank you for answering these questions. On behalf of the Healthy Indiana Plan we thank you for participating in this survey. Your answers will help improve

Appendix B. Current Plus Member Survey (Full)

DESCRIPTION: This survey applies to individuals currently enrolled in in HIP PLUS, identified with eligibility data.

CONFIRM ENROLLMENT IN HIP PLUS

Q1. The State of Indiana runs an insurance program called the Healthy Indiana Plan (or HIP) for Hoosiers age 19 to 64. Are you enrolled in the “Healthy Indiana Plan” or “HIP” at this time?

- YES
 - NO
 - DON'T KNOW
- GO TO CLOSE

Q1a. Are you in HIP Basic or HIP Plus?

- BASIC → CONTINUE WITH THE SURVEY, GO TO Q2
- PLUS → CONTINUE WITH THE SURVEY, GO TO Q2
- DON'T KNOW
- REFUSED

Q1b. Based on the information we have, it looks like you are in HIP Plus and make a monthly or annual payment to maintain your coverage. Is this correct?

- YES → CONTINUE WITH THE SURVEY, GO TO Q2
 - NO
 - DON'T KNOW
- GO TO CLOSE

SATISFACTION WITH HIP

The next set of questions will ask about your satisfaction with the Healthy Indiana Plan.

Q2. Thinking about your overall experience with the Healthy Indiana Plan in the past six months, would you say you are:

- VERY SATISFIED
 - SOMEWHAT SATISFIED
 - NEITHER SATISFIED NOR DISSATISFIED
 - SOMEWHAT DISSATISFIED
 - VERY DISSATISFIED
 - DON'T KNOW
 - REFUSED
- GO TO Q3

Q2a. Why are you (FILL IN WITH PREVIOUS RESPONSE)? OPEN-ENDED RESPONSE

- SPECIFY: _____

**DO NOT READ LIST BELOW; USE FOR CODING PURPOSES.
(CHECK ALL THAT APPLY)**

- CAN'T SEE MY DOCTOR WITH HIP
- DISSATISFACTION WITH CHOICE OF DOCTOR'S IN HIP
- HIP DOES NOT COVER DENTAL
- HIP DOES NOT COVER VISION/OPTICAL
- HIP DOES NOT COVER PROCEDURE/ MEDICATION
- MANY DOCTORS DO NOT ACCEPT HIP
- DISSATISFIED WITH ADMINISTRATIVE ISSUE(S) OR PROCESS
- DISSATISFACTION WITH A PAYMENT RELATED ISSUE
- CAN'T AFFORD CO-PAY/ TOO HIGH
- CO-PAYMENT / MONTHLY/ ANNUAL PAYMENT TOO HIGH
- LIKE HAVING COVERAGE/ INSURANCE
- LIKE DOCTORS/ HOSPITALS / HEALTH CARE PROVIDERS
- LIKE PAYMENTS / PRICE
- LIKE THE PLAN/ PROVIDER
- LIKE SOME THINGS/ DISLIKE OTHER THINGS
- SOME THINGS NOT COVERED
- DON'T KNOW
- REFUSED
- OTHER REASON NOT LISTED ABOVE: (SPECIFY) _____

Q3. If you ever left HIP, would you try to reenroll if you became eligible for the program again?

- YES
- NO
- DON'T KNOW
- REFUSED

Q4. When you applied for HIP, did you make a fast track payment?

(IF NEEDED: A fast track payment is made when you complete your application. Fast track payments allow you to get HIP coverage more quickly because you pre-pay your first payment. By making the fast track payment when you apply, it may take less time for your coverage to begin.)

- YES
- NO → **GO TO Q4b**
- DON'T KNOW → **GO TO Q5**
- REFUSED → **GO TO Q5**

Q4a. Why did you decide to sign-up for the fast track payment option?

- I WANTED MY COVERAGE AND/OR ELIGIBILITY TO BEGIN SOONER
- I THOUGHT IT WAS A REQUIRED PART OF HIP
- I THOUGHT IT WOULD BE EASIER TO PAY THEN (I.E., WOULDN'T HAVE TO MAIL/GO IN-PERSON, ETC.)
- I HAD THE FUNDS AT THE TIME I APPLIED
- OTHER REASON NOT LISTED ABOVE: (Specify) _____
- DON'T KNOW
- REFUSED

Q4b. Why did you decide NOT to sign-up for the fast track payment option?

- I COULDN'T AFFORD TO MAKE THE PAYMENT
- I WASN'T SURE IF I WOULD BE ELIGIBLE
- I DIDN'T UNDERSTAND THE DIFFERENCE BETWEEN FAST TRACK AND THE REGULAR PAYMENT OPTION
- I DIDN'T NEED COVERAGE TO START SOONER
- I WASN'T AWARE OF THE OPTION TO SIGN-UP FOR FAST TRACK AT THE TIME I APPLIED
- OTHER REASON NOT LISTED ABOVE: (Specify) _____
- DON'T KNOW
- REFUSED

AFFORDABILITY

Q5. When you need treatment from a doctor or other health professional, do you ask how much the treatment will cost?

- YES
- NO
- DON'T KNOW
- REFUSED

Q6. Do you make a monthly or annual payment to be in HIP?

IF NEEDED, PROBE: Do you pay something each month or once a year to be in HIP? Some call this a monthly or annual contribution and others call it a monthly bill.

- MONTHLY → **GO TO Q7**
- ANNUAL → **GO TO Q7**
- NO I HAVE NOT MADE A MONTHLY/ANNUAL PAYMENT FOR HIP → **GO TO Q14**
- DON'T KNOW → **GO TO Q14**
- REFUSED → **GO TO Q14**

Q7. How much money do you contribute each month/year (depending on answer above) to be in HIP?

\$ | |, | | |. | | |

- DON'T KNOW
- REFUSED

Q8. If HIP required you to pay \$5 more each month, would you continue to stay enrolled?

- YES → **GO TO Q9**
- NO → **GO TO Q10**
- DON'T KNOW
- REFUSED

Q9. What about \$10 more? Would you continue to stay enrolled if HIP required you to pay \$10 each month?

- YES
- NO
- DON'T KNOW

- REFUSED

Q10. In the past 6 months, how often were you worried about having enough money to pay your monthly contribution?

- ALWAYS
- USUSALLY
- SOMETIMES
- RARELY
- NEVER
- DON'T KNOW
- REFUSED

Q11. When you received your bill for your monthly or annual HIP payment, did you get any help with the cost from someone else such as a family member, friend, employer, healthcare provider or charity?

- YES → GO TO Q12
- NO
- DON'T KNOW → GO TO Q13
- REFUSED

Q12. Please tell me yes or no if you received help in making the payments from each of these sources:

- FAMILY MEMBER
- FRIEND
- CHARITY OR RELIGIOUS ORGANIZATION
- A HEALTHCARE PROVIDER SUCH AS A DOCTOR'S OFFICE OR HOSPITAL
- EMPLOYER
- OTHER: (SPECIFY) _____

Q13. Please tell me if you have used each of the following methods to make your payment:

- CASH
- CHECK
- CREDIT CARD
- DEBIT CARD
- OTHER: (SPECIFY) _____
- DON'T KNOW
- REFUSED

ACCESS

Q14. In the last 6 months, did you make any appointments for a check-up or routine care at a doctor's office or clinic?

- YES → GO TO NEXT QUESTION
- NO → SKIP NEXT QUESTION [Q15]
- DON'T KNOW → GO TO Q15

Q14a. In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?

- NEVER
- SOMETIMES
- USUALLY
- ALWAYS

Q15. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, did you make any appointments to see a specialist?

- YES → GO TO NEXT QUESTION
- NO → GO TO Q16
- DON'T KNOW → GO TO Q16

Q15a. In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?

- NEVER
- SOMETIMES
- USUALLY
- ALWAYS

Q16. In the last 6 months, did you get any new prescription medicines or refill a prescription?

- YES → GO TO NEXT QUESTION
- NO → GO TO Q17
- DON'T KNOW → GO TO Q17

Q16a. In the last 6 months, how often was it easy to get your prescription medicine from your health plan?

- NEVER
- SOMETIMES
- USUALLY
- ALWAYS

Q17. In the past six months, have you missed any healthcare appointments, such as doctor's appointments?

- YES
 - NO
 - DON'T KNOW
 - REFUSED
- GO TO Q18

Appendix C. Leaver Survey (Full)

DESCRIPTION: This survey applies to individuals who:

- Were members but left the program for any reason (e.g., moved out of state, received coverage through Medicare)
- Were members with income over 100% FPL who left the program for non-payment of the POWER account contribution

Q1. Think about the new HIP insurance program that started in February 2015. Were you enrolled in HIP insurance earlier this year, in 2015? (NOTE: CLARIFY ONLY 2015)

- YES (CONTINUE)
 NO
 DON'T KNOW → GO TO CLOSE 1

Q2. Just to confirm . . . you are not currently enrolled in HIP at this time. Is that correct?

- YES
 NO – CURRENTLY ENROLLED
 DON'T KNOW → GO TO CLOSE 1
- GO TO Q3

WHY ENROLLMENT ENDED

Q3. What are all the reasons you are no longer enrolled with HIP?
(ACCEPT MULTIPLE RESPONSES, USE LIST FOR CODING)

- I EARNED TOO MUCH/INCREASE IN MY INCOME
- I DIDN'T FINISH MY PAPERWORK IN TIME
- DIDN'T KNOW HOW TO MAKE A MONTHLY PAYMENT
- I COULDN'T PAY MY MONTHLY CONTRIBUTION
- I HAD OTHER INSURANCE AVAILABLE TO ME
- I BECAME PREGNANT WHILE ON HIP
- THEY CHANGED ME TO REGULAR MEDICAID
- I DON'T KNOW WHY THEY TERMINATED MY COVERAGE
- PAYMENT ERROR/MISUNDERSTANDING/CHECKING ACCOUNT PROBLEM/ LOST PAYMENT
- LATE OR FORGOTTEN MONTHLY PAYMENT
- EMPLOYER ERROR RELATED TO PAPERWORK
- GOT MEDICARE
- TRIED TO RE-ENROLL BUT STAFF COULDN'T HELP ME/SYSTEM FAILED/ IT DIDN'T WORK OUT
- TRIED TO RE-ENROLL BUT THEY DIDN'T GET MY PAPERWORK DONE IN TIME
- MOVED / NO LONGER LIVING IN INDIANA
- INCARCERATED
- PROBLEMS WITH APPEALS PROCESS
- HIP PAPERWORK ERROR/MEMBER NEVER RECEIVED PAPERWORK/MEMBER
- SENT PAPERWORK BUT HIP NEVER RECEIVED
- CHANGED MY MIND / DON'T WANT COVERAGE
- OTHER (SPECIFY) _____
- DON'T KNOW
- REFUSED

Q4. Which reason for leaving HIP was the most important? _____
(ASK ONLY IF RESPONDENT PROVIDED MULTIPLE REASONS FOR LEAVING HIP; IF NEEDED RE-READ RESPONDENT'S SELECTIONS FROM ABOVE)

Q5. Did you make a monthly or annual payment when you were in HIP?
(ASK ONLY IF FILE SHOWS RESPONDENT USED TO BE IN HIP PLUS)

- DID NOT MAKE A MONTHLY OR ANNUAL PAYMENT → GO TO Q8
- MONTHLY
- ANNUAL → GO TO Q6
- REFUSED
- DON'T KNOW → GO TO Q8

Q6. Would you say the amount you contributed each month/year was:
(ASK ONLY OF RESPONDENTS WITH DATA FILE ENTRY FOR HIP PLUS)

- WAY TOO MUCH
- A LITTLE TOO MUCH
- THE RIGHT AMOUNT
- BELOW THE RIGHT AMOUNT
- WAY BELOW THE RIGHT AMOUNT
- NEVER MADE A PAYMENT
- DON'T KNOW
- REFUSED

Q7. When you were enrolled in HIP, how often were you worried about having enough money to pay your monthly contribution?
(ASK ONLY OF RESPONDENTS WITH DATA FILE ENTRY FOR HIP PLUS)

- ALWAYS
- USUALLY
- SOMETIMES
- RARELY
- NEVER
- NEVER MADE A PAYMENT
- DON'T KNOW
- REFUSED

Q8. Did you make copayments when you were in HIP?
(ASK ONLY IF FILE SHOWS RESPONDENT USED TO BE IN HIP BASIC)

- YES → GO TO Q9
- NO
- DON'T KNOW → GO TO Q10
- REFUSED

Q9. Would you say your copayments were:
(ASK ONLY OF RESPONDENTS WITH DATA FILE ENTRY FOR HIP BASIC)

- WAY TOO MUCH
- A LITTLE TOO MUCH
- THE RIGHT AMOUNT
- BELOW THE RIGHT AMOUNT
- WAY BELOW THE RIGHT AMOUNT

- NEVER MADE A PAYMENT
- DON'T KNOW
- REFUSED

Q10. Are you aware that, in HIP, if you do not make monthly or annual payments you can be terminated from the program and not allowed to return for six months?
(ASK ONLY OF RESPONDENTS WITH DATA FILE ENTRY FOR FPL ABOVE 100%)

- YES
- NO
- DON'T KNOW
- REFUSED

Q11. Do you have any health insurance coverage right now?

- YES → GO TO Q13
 - NO
 - DON'T KNOW
 - REFUSED
- } → GO TO Q12

Q12. So you are not insured right now, is that correct?

- YES → GO TO Q18
 - NO → CHANGE RESPONSE TO Q11. GO TO Q13
 - DON'T KNOW
 - REFUSED
- } → GO TO Q18

INDIVIDUALS WITH OTHER COVERAGE

Q13. What is your source of insurance coverage?
(ASK ONLY IF YES TO QUESTION 11 ABOUT CURRENTLY HAVING INSURANCE COVERAGE. ACCEPT MULTIPLE RESPONSES)

- A SPOUSE → IF EMPLOYER BOX IS CHECKED, GO TO Q14
- AN EMPLOYER → IF EMPLOYER BOX IS CHECKED, GO TO Q14
- MEDICARE
- MEDICAID OR HOOSIER HEALTHWISE, OR HOOSIER CARE CONNECT
- TRICARE
- VETERAN'S ADMINISTRATION
- AN INDIVIDUAL POLICY
- MARKETPLACE OR TAX CREDIT
- SOME OTHER SOURCE (SPECIFY) _____
- DON'T KNOW
- REFUSED

INDIVIDUALS WITH EMPLOYER COVERAGE

Q14. Do you or your spouse/partner have to pay a portion of the insurance that you get from your employer?

(ASK ONLY IF ANSWER TO QUESTION 13 IS "AN EMPLOYER")

- YES
- NO

- DON'T KNOW
- REFUSED

Q15. In comparison to your previous HIP payments, would you say the amount you contribute to your employer-sponsored coverage each month is...
(ASK ONLY IF ANSWER TO QUESTION 13 IS "AN EMPLOYER" AND Q11 IS "YES – HAS INSURANCE")

- WAY TOO MUCH
- A LITTLE TOO MUCH
- THE RIGHT AMOUNT
- BELOW THE RIGHT AMOUNT
- WAY BELOW THE RIGHT AMOUNT
- DON'T KNOW
- REFUSED

Q16. When you make your monthly or annual payment to your employer this year, will you get any help with the cost from someone else such as a family member, friend, healthcare provider or charity?

(ASK ONLY IF ANSWER TO QUESTION 13 IS "AN EMPLOYER" AND Q11 IS "YES – HAS INSURANCE")

- YES
- NO
- DON'T KNOW
- REFUSED

Q17. If HIP could help you pay for your employer-sponsored insurance, would you sign up for that type of help?

(ASK ONLY IF ANSWER TO QUESTION 13 IS "AN EMPLOYER" AND Q11 IS "YES – HAS INSURANCE")

- YES
- NO
- DON'T KNOW
- REFUSED

ACCESS TO CARE

Q18. Since you left HIP, did you make any appointments for a check-up or routine care at a doctor's office or clinic?

- YES → GO TO NEXT QUESTION
- NO → GO TO Q20
- DON'T KNOW → GO TO Q20
- REFUSED → GO TO Q20

Q19. Since you left HIP, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?

- NEVER
- SOMETIMES
- USUALLY
- ALWAYS

Q20. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. Since you left HIP, did you make any appointments to see a specialist?

- YES → GO TO NEXT QUESTION
- NO → GO TO Q22
- DON'T KNOW → GO TO Q22
- REFUSED → GO TO Q22

Q21. Since you left HIP, how often did you get an appointment to see a specialist as soon as you needed?

- NEVER
- SOMETIMES
- USUALLY
- ALWAYS

Q22. Since you left HIP, did you get any new prescription medicines or refill a prescription?

- YES → GO TO NEXT QUESTION
- NO → GO TO Q24
- DON'T KNOW → GO TO Q24
- REFUSED → GO TO Q24

Q23. Since you left HIP, how often did you get the prescription medicine you needed?

- NEVER
- SOMETIMES
- USUALLY
- ALWAYS

DEMOGRAPHICS

Q24. What is the highest grade or year of school you have completed? (READ ALL OPTIONS)

- GRADES 1 TO 8 (ELEMENTARY SCHOOL)
- GRADES 9 TO 11 (SOME HIGH SCHOOL)
- GRADE 12 OR GED (HIGH SCHOOL GRADUATE)
- COLLEGE / TECHNICAL SCHOOL 1 TO 3 YEARS (SOME COLLEGE OR ADDITIONAL TRAINING)
- COLLEGE 4 YEARS OR MORE (COLLEGE GRADUATE)
- NO FORMAL EDUCATION
- DON'T KNOW

Q25. As of this week which of the following best describes your employment status? (READ ALL OPTIONS, ALLOW MULTIPLE RESPONSES)

- EMPLOYED FOR WAGES
- EMPLOYED FOR LESS THAN 20 HOURS A WEEK
- EMPLOYED FOR 20 OR MORE HOURS A WEEK
- SELF-EMPLOYED
- UNEMPLOYED AND LOOKING FOR WORK
- OUT OF WORK MORE THAN 1 YEAR

- OUT OF WORK LESS THAN 1 YEAR
- A HOMEMAKER
- TAKING CARE OF AN ELDERLY PARENT OR A FAMILY MEMBER WITH A DISABILITY
- A STUDENT
- RETIRED
- UNABLE TO WORK BECAUSE OF A PHYSICAL OR MENTAL HEALTH CONDITION
- SOMETHING ELSE (SPECIFY) _____
- DON'T KNOW
- REFUSED

CLOSE1 Thank you for answering these questions. This survey is meant to be completed by people who are not currently enrolled in the Healthy Indiana Plan or who have left the plan within the past year. If you have any questions about the plan, please call 1-877-438-4479. Thank you and have a good (day/night).

INTERVIEWER: HANG UP. CODE CASE AS INELIGIBLE—DOES NOT MEET SURVEY CRITERIA

CLOSE: Thank you for answering these questions. On behalf of the Healthy Indiana Plan we thank you for participating in this survey. Your answers will help improve the program.

Appendix D. Never Member Survey - Presumptive Eligibility (PE) (Full)

DESCRIPTION: This survey applies to individuals **NOT** currently enrolled in in HIP who were determined eligible for Presumptive Eligibility (PE) but did not complete an application to obtain full coverage. Individuals in this population were identified using eligibility data.

CONFIRM NEVER MEMBER STATUS

Q1. In February 2015 the state introduced an updated version of a Medicaid insurance program called HIP 2.0, sometimes called the “Healthy Indiana Plan.” Prior to this phone call today, had you ever heard about this program before?

- YES
 - NO
 - DON'T KNOW
- GO TO Q3

Q1a. Where did you hear or learn about HIP?

- WEBSITE
- FRIEND OR FAMILY
- HEALTHCARE PROFESSIONAL / DOCTOR'S OFFICE / HOSPITAL, ETC.
- TV
- NEWSPAPER
- RADIO
- BILLBOARDS OR SIGNS
- SIGNS ON BUSES
- MAIL
- HAVE IT AS MY INSURANCE
- SOME OTHER PLACE (SPECIFY)
- DON'T KNOW
- REFUSED

Q2. Do you have any HIP coverage right now?

- YES → **CLOSE**
- NO
- DON'T KNOW
- REFUSED

Q3. Do you have any health insurance coverage right now?

- YES
 - NO
 - DON'T KNOW
 - REFUSED
- GO TO Q4

Q3a. What type of coverage do you have now?
(Select all that apply)

- HIP → **GO TO CLOSE**
- A SPOUSE
- AN EMPLOYER
- MEDICARE

- MEDICAID/HOOSIER HEALTHWISE
- TRICARE
- VETERAN'S ADMINISTRATION
- AN INDIVIDUAL POLICY
- MARKETPLACE
- OTHER (SPECIFY)

PRESUMPTIVE ELIGIBILITY

Q4. At any point in this year did you have temporary Medicaid coverage through presumptive eligibility? (IF NEEDED: To receive this type of coverage, someone at a health care providers' office or hospital would have helped you apply for temporary coverage)

- YES
 - NO
 - DON'T KNOW
 - REFUSED
- } → GO TO Q10
-

Q5. Next, I'm going to read a list of places where someone could have helped you apply for temporary Medicaid coverage. Please tell me which one of these was the location where someone helped you apply for temporary Medicaid coverage.

- A HOSPITAL
- PSYCHIATRIC HOSPITAL
- COMMUNITY MENTAL HEALTH CENTER
- LOCAL HEALTH DEPARTMENT
- A PROVIDER TREATING YOU BECAUSE YOU WERE PREGNANT
- SOME OTHER PLACE (SPECIFY)
- DON'T KNOW
- REFUSED

Q6. That coverage was temporary. To keep it, you had to fill out a longer application by phone, online or in-person. Did you complete an application and obtain full Medicaid coverage after receiving temporary coverage?

- YES → GO TO Q8
 - NO
 - DON'T KNOW
 - REFUSED
- } → GO TO Q8
-

Q7. What are the reasons you didn't complete the full application or obtain full coverage?

- SENT APPLICATION BUT WAS TOLD THAT IT WAS INCOMPLETE
- DIDN'T KNOW OR FORGOT THAT I NEEDED TO COMPLETE AN APPLICATION
- DIDN'T KNOW HOW TO APPLY OR SUBMIT AN APPLICATION
- CHANGED MY MIND ABOUT WANTING HIP COVERAGE
- GOT OTHER INSURANCE
- DIDN'T WANT COVERAGE
- PREFER TO PAY FOR MEDICAL COVERAGE WITHOUT INSURANCE
- DID SUBMIT APPLICATION, BUT FOUND INELIGIBLE

- OTHER (SPECIFY) _____
- DON'T KNOW
- REFUSED

Q8. Did the hospital, health center, doctor or health department that helped you sign up for temporary coverage follow up to remind you to submit a full application?

- YES
- NO
- DON'T KNOW
- REFUSED

Q9. When Temporary Medicaid was set for you, you were enrolled in a health plan to manage your benefits. Did the health plan that you were assigned to for temporary coverage follow up to remind you to submit a full application? (IF NEEDED: By health plan, I mean the company such as Anthem, MDwise, or MHS.)

- YES
- NO
- DON'T KNOW
- REFUSED

FUTURE HIP COVERAGE

Q10. Do you plan to apply for health coverage assistance through Medicaid or HIP in the future? (IF NEEDED: "HIP is Healthy Indiana Plan" – a health insurance program for uninsured Hoosiers that provides coverage for Hoosiers ages 19 to 64.)

- YES → GO TO Q12
- NO
- DON'T KNOW → GO TO Q12
- REFUSED

Q11. Why do you not plan to apply for Medicaid or HIP in the future?

- DON'T KNOW WHERE TO GET APPLICATION
- DON'T KNOW WHERE TO SUBMIT AN APPLICATION:
 - DON'T KNOW WHAT OFFICE TO GO TO
 - DON'T HAVE INTERNET ACCESS
 - DON'T KNOW I CAN APPLY BY PHONE
- DON'T NEED IT, HEALTHY
- DON'T WANT PUBLIC ASSISTANCE
- DIDN'T KNOW ABOUT IT
- DON'T UNDERSTAND IT
- NOT SURE ABOUT ELIGIBILITY / NOT ELIGIBLE
- CAN'T AFFORD PAYMENTS
- HAVE ACCESS TO OTHER INSURANCE
- ALREADY INSURED
- PAY FOR MEDICAL COVERAGE WITHOUT INSURANCE
- JUST GO TO THE EMERGENCY ROOM
- JUST MOVED HERE
- GOING TO MOVE AWAY
- OTHER (SPECIFY)

- DON'T KNOW
- REFUSED

Q12. Some people make a monthly contribution to be in HIP. If HIP required you to pay \$5 each month to be enrolled, would you enroll?

- YES
- NO → GO TO Q14
- DON'T KNOW → GO TO Q14
- REFUSED → GO TO Q14

Q13. What about \$10? Would you enroll if HIP required you to pay \$10 each month?

- YES
- NO
- DON'T KNOW
- REFUSED

ACCESS (CAHPS QUESTIONS)

Q14. In the last 6 months, did you make any appointments for a check-up or routine care at a doctor's office or clinic?

- YES → GO TO NEXT QUESTION
- NO → SKIP NEXT QUESTION [Q16]

Q15. In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?

- NEVER
- SOMETIMES
- USUALLY
- ALWAYS

Q16. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, did you make any appointments to see a specialist?

- YES → GO TO Q17
- NO → GO TO Q18
- DON'T KNOW → GO TO Q18
- REFUSED → GO TO Q18

Q17. In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?

- NEVER
- SOMETIMES
- USUALLY
- ALWAYS

Q18. In the last 6 months, did you get any new prescription medicines or refill a prescription?

- YES → GO TO Q19
- NO → GO TO Q20

Q19. In the last 6 months, how often was it easy to get your prescription medicine from your health plan?

- NEVER
- SOMETIMES
- USUALLY
- ALWAYS

DEMOGRAPHICS

Q20. Including yourself, how many total people (adults and children) are in your household?

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- MORE THAN 8
- DON'T KNOW
- REFUSED

Q21. Please stop me when I read the amount that best describes your family's monthly household income. Would that be

- LESS THAN \$1,000
- MORE THAN \$1,000 UP TO \$1,400
- BETWEEN \$1,400 AND \$1,700,
- BETWEEN \$1,700 AND \$2,000
- BETWEEN \$2,000 AND \$2,300
- BETWEEN \$2,300 AND \$2,700
- BETWEEN \$2,700 AND \$3,000
- BETWEEN \$3,000 AND \$3,400
- MORE THAN \$3,400 PER MONTH
- DON'T KNOW
- REFUSED

Q21. What is the highest grade or year of school you have completed?
(READ ALL OPTIONS)

- GRADES 1 TO 8 (ELEMENTARY SCHOOL)
- GRADES 9 TO 11 (SOME HIGH SCHOOL)
- GRADE 12 OR GED (HIGH SCHOOL GRADUATE)
- COLLEGE / TECHNICAL SCHOOL 1 TO 3 YEARS (SOME COLLEGE OR ADDITIONAL TRAINING)
- COLLEGE 4 YEARS OR MORE (COLLEGE GRADUATE)
- NO FORMAL EDUCATION
- DON'T KNOW

Q22. As of this week, which of the following best describes your employment status (READ ALL OPTIONS, ALLOW MULTIPLE RESPONSES)?

- EMPLOYED FOR LESS THAN 20 HOURS A WEEK
- EMPLOYED FOR 20 OR MORE HOURS A WEEK IN A SINGLE JOB
- EMPLOYED FOR 20 OR MORE HOURS A WEEK IN MULTIPLE JOBS
- SELF-EMPLOYED
- UNEMPLOYED AND LOOKING FOR WORK
- NOT ABLE TO WORK
- FULLTIME HOMEMAKER
- TAKING CARE OF ELDERLY OR DISABLED FAMILY MEMBER
- RETIRED
- SOMETHING ELSE (SPECIFY)
- DON'T KNOW
- REFUSED

CLOSE: Thank you for answering these questions. On behalf of the Healthy Indiana Plan we thank you for participating in this survey. Your answers will help improve the program.

Appendix E. Never Member Survey - Did Not Make PAC (Full)

DESCRIPTION: This survey applies to individuals **NOT** currently enrolled in HIP who applied for HIP coverage but did not make their first Power Account payment/contribution (PAC) and are over 100% of the FPL. Individuals in this population were identified using eligibility data.

CONFIRM NEVER MEMBER STATUS

Q1. In February 2015 the state introduced an updated version of a Medicaid insurance program called HIP 2.0, sometimes called the “Healthy Indiana Plan.” Prior to this phone call today, had you ever heard about this program before?

- YES
 - NO
 - DON'T KNOW
- GO TO Q2

Q1a. Where did you hear or learn about HIP?

- WEBSITE
- FRIEND OR FAMILY
- HEALTHCARE PROFESSIONAL / DOCTOR'S OFFICE / HOSPITAL, ETC.
- TV
- NEWSPAPER
- RADIO
- BILLBOARDS OR SIGNS
- SIGNS ON BUSES
- MAIL
- HAVE IT AS MY INSURANCE
- SOME OTHER PLACE (SPECIFY)
- DON'T KNOW
- REFUSED

Q2. Do you have any HIP coverage right now?

- YES → CLOSE
- NO
- DON'T KNOW
- REFUSED

Q3. Do you have any health insurance coverage right now?

- YES
 - NO
 - DON'T KNOW
 - REFUSED
- GO TO Q4

Q3a. What type of coverage do you have now?
(Select all that apply)

- HIP → GO TO CLOSE
- A SPOUSE
- AN EMPLOYER
- MEDICARE

- MEDICAID/HOOSIER HEALTHWISE
- TRICARE
- VETERAN'S ADMINISTRATION
- AN INDIVIDUAL POLICY
- MARKETPLACE
- OTHER (SPECIFY)

NON-PAYMENT OF PAC

Q4. Did you ever complete an application for HIP?

- YES
- NO → **CONTINUE TO Q7**
- DON'T KNOW
- REFUSED

Q5. Once you complete an application for HIP, you are required to make a payment before your coverage starts. Were you aware of this prior to this call?

- YES
- NO
- DON'T KNOW
- REFUSED

Q6. Did you make your first HIP payment?

- YES → **GO TO CLOSE**
- NO
- DON'T KNOW
- REFUSED

Q6a. What is the main reason you did not make your first payment?

- CAN'T AFFORD/FEES TOO HIGH
- CHANGED MY MIND ABOUT WANTING HIP COVERAGE
- GOT OTHER INSURANCE
- DON'T NEED ADDITIONAL SERVICES
- DON'T KNOW HOW TO START PAYING ON A MONTHLY BASIS
- DO NOT WANT HIP PLUS OR ADDED BENEFITS
- DON'T PLAN TO BE IN THE PROGRAM VERY LONG
- NOT OFFERED THE OPTION TO PAY ON A MONTHLY BASIS
- DON'T UNDERSTAND THE PROGRAM/DIFFERENCES
- NOT REQUIRED TO PAY THE CONTRIBUTION
- FORGOT
- OTHER REASON NOT LISTED ABOVE: (SPECIFY) _____
- DON'T KNOW
- REFUSED

FUTURE HIP COVERAGE

Q7. Do you plan to apply for health coverage assistance through Medicaid or HIP in the future? (IF NEEDED: "HIP is Healthy Indiana Plan" -- a health insurance program for uninsured Hoosiers that provides coverage for Hoosiers ages 19 to 64.)

- YES → GO TO Q9
- NO
- DON'T KNOW
- REFUSED →GO TO Q9

Q8. Why do you not plan to apply for Medicaid or HIP in the future?

- DON'T KNOW WHERE TO GET APPLICATION
- DON'T KNOW WHERE TO SUBMIT AN APPLICATION:
 - DON'T KNOW WHAT OFFICE TO GO TO
 - DON'T HAVE INTERNET ACCESS
 - DON'T KNOW I CAN APPLY BY PHONE
- DON'T NEED IT, HEALTHY
- DON'T WANT PUBLIC ASSISTANCE
- DIDN'T KNOW ABOUT IT
- DON'T UNDERSTAND IT
- NOT SURE ABOUT ELIGIBILITY / NOT ELIGIBLE
- CAN'T AFFORD PAYMENTS
- HAVE ACCESS TO OTHER INSURANCE
- ALREADY INSURED
- PAY FOR MEDICAL COVERAGE WITHOUT INSURANCE
- JUST GO TO THE EMERGENCY ROOM
- JUST MOVED HERE
- GOING TO MOVE AWAY
- OTHER (SPECIFY)
- DON'T KNOW
- REFUSED

Q9. Some people make a monthly contribution to be in HIP. If HIP required you to pay \$5 each month to be enrolled, would you enroll?

- YES
- NO → GO TO Q11
- DON'T KNOW
- REFUSED

Q10. What about \$10? Would you enroll if HIP required you to pay \$10 each month?

- YES
- NO
- DON'T KNOW
- REFUSED

- Q11. In the last 6 months, did you make any appointments for a check-up or routine care at a doctor's office or clinic?**
- YES → GO TO NEXT QUESTION
 - NO → SKIP NEXT QUESTION [Q13]
- Q12. In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?**
- NEVER
 - SOMETIMES
 - USUALLY
 - ALWAYS
- Q13. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, did you make any appointments to see a specialist?**
- YES → GO TO Q14
 - NO → GO TO Q15
- Q14. In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?**
- NEVER
 - SOMETIMES
 - USUALLY
 - ALWAYS
- Q15. In the last 6 months, did you get any new prescription medicines or refill a prescription?**
- YES → GO TO Q16
 - NO → GO TO Q17
- Q16. In the last 6 months, how often was it easy to get your prescription medicine from your health plan?**
- NEVER
 - SOMETIMES
 - USUALLY
 - ALWAYS

DEMOGRAPHICS

Q17. Including yourself, how many total people (adults and children) are in your household?

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- MORE THAN 8
- DON'T KNOW
- REFUSED

Q18. Please stop me when I read the amount that best describes your family's monthly household income. Would that be

- LESS THAN \$1,000
- MORE THAN \$1,000 UP TO \$1,400
- BETWEEN \$1,400 AND \$1,700,
- BETWEEN \$1,700 AND \$2,000
- BETWEEN \$2,000 AND \$2,300
- BETWEEN \$2,300 AND \$2,700
- BETWEEN \$2,700 AND \$3,000
- BETWEEN \$3,000 AND \$3,400
- MORE THAN \$3,400 PER MONTH
- DON'T KNOW
- REFUSED

Q18. What is the highest grade or year of school you have completed? (READ ALL OPTIONS)

- GRADES 1 TO 8 (ELEMENTARY SCHOOL)
- GRADES 9 TO 11 (SOME HIGH SCHOOL)
- GRADE 12 OR GED (HIGH SCHOOL GRADUATE)
- COLLEGE / TECHNICAL SCHOOL 1 TO 3 YEARS (SOME COLLEGE OR ADDITIONAL TRAINING)
- COLLEGE 4 YEARS OR MORE (COLLEGE GRADUATE)
- NO FORMAL EDUCATION
- DON'T KNOW

Q19. As of this week, which of the following best describes your employment status? (READ ALL OPTIONS, ALLOW MULTIPLE RESPONSES)

- EMPLOYED FOR WAGES
- EMPLOYED FOR LESS THAN 20 HOURS A WEEK
- EMPLOYED FOR 20 OR MORE HOURS A WEEK
- SELF-EMPLOYED
- UNEMPLOYED AND LOOKING FOR WORK
- OUT OF WORK MORE THAN 1 YEAR
- OUT OF WORK LESS THAN 1 YEAR

- A HOMEMAKER
- TAKING CARE OF AN ELDERLY PARENT OR A FAMILY MEMBER WITH A DISABILITY
- A STUDENT
- RETIRED
- UNABLE TO WORK BECAUSE OF A PHYSICAL OR MENTAL HEALTH CONDITION
- SOMETHING ELSE (SPECIFY) _____
- DON'T KNOW
- REFUSED

CLOSE: Thank you for answering these questions. On behalf of the Healthy Indiana Plan we thank you for participating in this survey. Your answers will help improve the program.

Appendix F. Provider Survey (Full)

DESCRIPTION: This survey applies to clinicians, practice managers, or others responding on behalf of health care providers that serve HIP members.

OPENING QUESTIONS

Q1. What is your role in the practice?

- OFFICE MANAGER/PRACTICE ADMINISTRATOR
- CLINICIAN
- OTHER (SPECIFY) _____

**Q2. As a provider, which of the following Indiana programs do you participate in?
READ LIST. (SELECT ALL THAT APPLY)**

- HOOSIER HEALTHWISE (HHW)
- HIP → **IF NOT SELECTED, GO TO CLOSE1**
- HOOSIER CARE CONNECT (HCC)
- FEE-FOR-SERVICE (TRADITIONAL MEDICAID)

**Q3. What is your practice setting?
(READ LIST. ALLOW MULTIPLE ANSWER CHOICES)**

- SOLO/INDIVIDUAL PRACTICE
- SINGLE-SPECIALTY GROUP (THIS CAN BE EITHER PRIMARY CARE OR SPECIALISTS)
- MULTI-SPECIALTY GROUP (THIS CAN INCLUDE BOTH PRIMARY CARE AND SPECIALISTS)
- ACUTE CARE HOSPITAL OR PHYSICIAN HOSPITAL ORGANIZATION (PHO)
- FEDERALLY QUALIFIED HEALTH CENTER (FQHC)
- RURAL HEALTH CENTER (RHC)
- OTHER (PLEASE SPECIFY) _____

Q4. Are your providers...? READ LIST

- A PCP (PRIMARY CARE PROVIDER – THAT IS, INTERNAL MEDICINE, FAMILY PRACTICE)
- AN OB/GYN
- OTHER SPECIALIST (SPECIFY : _____)
- NONE OF THE ABOVE

Q5. Did you, as a provider, participate in the original HIP program?

- YES
- NO
- DON'T KNOW
- REFUSED
-

PAYMENT QUESTIONS

Q6a. How does the reimbursement for this program compare to the Medicare program? Would you say it ...? READ LIST
(NOTE: Currently HIP Reimburses at Medicare rates or 130% of the Medicaid rate if a Medicare rate does not exist.)

- REIMBURSES AT THE SAME RATE
 - REIMBURSES AT A HIGHER RATE
 - REIMBURSES AT A LOWER RATE
 - DON'T KNOW
 - REFUSED
- GO TO Q6b
- GO TO Q7

Q6b. Does the reimbursement rate influence your decision to participate in the program?

- YES
- NO
- DON'T KNOW
- REFUSED

Q7. Were you aware that the State has increased Fee-For-Service reimbursement for all Medicaid programs, including non-HIP programs such as Hoosier Healthwise?

- YES
- NO
- DON'T KNOW
- REFUSED

Q8. ASK Q. 8 IF ONLY HIP IS CHECKED IN Q. 2. OTHERWISE, SKIP TO Q. 9a
(ASK ONLY IF RESPONDENT INDICATED THAT PRACTICE ACCEPTS HIP BUT NOT ANY OF THE OTHER MEDICAID PROGRAMS IN Q. 2)

You mentioned that you accept HIP, but not other Medicaid programs. What are your reasons for only accepting HIP?

- THE OTHER PROGRAMS HAVE A LOWER REIMBURSEMENT RATE
- I WAS NOT AWARE OF THE OPTION TO COVER OTHER PROGRAMS
- ADMINISTRATIVE BURDEN
- I USED TO COVER THE OTHER PROGRAMS BUT DON'T ANYMORE
- OTHER (PLEASE SPECIFY): _____

Q9a. With HIP 2.0, some members are responsible for copayments. Do you know how to find out if the patient is required to pay copayments?

- YES → GO TO Q9b
 - NO
 - DON'T KNOW
 - REFUSED
- GO TO Q9c

Q9b. How do you find out if the patient is required to pay a copayment?
(ALLOW MULTIPLE ANSWER CHOICES)

- BY ASKING THE PATIENT
- BY CHECKING ELIGIBILITY VERIFICATION SYSTEM (EVS)
- OTHER (PLEASE SPECIFY: _____)

Q9c. Are you charging copayments to HIP members?

- YES → GO TO Q9d
- NO → GO TO Q11
- DON'T KNOW → GO TO Q11
- REFUSED → GO TO Q11

Q9d. When do HIP members pay copayments?

- AT POINT OF SERVICE → GO TO Q10
- MEMBER IS BILLED → GO TO Q9E

Q9e. Do you pursue collections on unpaid copays?

- YES
- NO
- SOMETIMES
- DON'T KNOW
- REFUSED

Q10. For those HIP members who are required to pay copayments, what percentages of them are making their copayments to you? Would you say it is... (READ LIST)

- LESS THAN 25%
- 26-49%
- 50-74%
- 75-99%
- 100%
- DON'T KNOW

MISSED APPOINTMENTS

Q11. If a member misses an appointment, which of the following are some likely reasons that the member missed it, in your opinion? READ LIST. (CHOOSE ALL THAT APPLY)

- COSTS TOO MUCH
- COULDN'T GET CHILDCARE
- COULDN'T GET TIME OFF FROM WORK
- COULDN'T GET THROUGH ON THE PHONE
- DIDN'T GET APPROVAL FROM HEALTH PLAN
- DIDN'T HAVE TIME
- DIDN'T WANT TO GO
- HOURS OF OPERATION WERE NOT CONVENIENT
- TAKES TOO LONG TO GET THERE
- TRANSPORTATION PROBLEM
- TOO SICK TO GO
- OTHER (PLEASE SPECIFY)
- I DON'T KNOW

Q11a. Which of the reasons that you just mentioned, do you feel is the most common reason for a member to miss an appointment?

- COSTS TOO MUCH
- COULDN'T GET CHILDCARE
- COULDN'T GET TIME OFF FROM WORK
- COULDN'T GET THROUGH ON THE PHONE
- DIDN'T GET APPROVAL FROM HEALTH PLAN
- DIDN'T HAVE TIME
- DIDN'T WANT TO GO
- HOURS OF OPERATION WERE NOT CONVENIENT
- TAKES TOO LONG TO GET THERE
- TRANSPORTATION PROBLEM
- TOO SICK TO GO
- OTHER (PLEASE SPECIFY)
- I DON'T KNOW

Q12. When members missed appointments, do you feel that it had an impact on members receiving preventive care?

- YES
- NO
- SOMETIMES
- DON'T KNOW
- REFUSED

Q13. When members missed appointments, do you feel that it had an impact on members' overall quality of care?

- YES → GO TO Q14
- NO → GO TO Q15
- SOMETIMES → GO TO Q14
- DON'T KNOW → GO TO Q15
- REFUSED → GO TO Q15

Q14. How has it impacted members' quality of care? [Free response]

PRESUMPTIVE ELIGIBILITY

Q15. Are you a qualified Presumptive Eligibility provider?

- YES → GO TO Q16
- NO → GO TO Q20
- DON'T KNOW → GO TO Q20
- REFUSED → GO TO Q20

Q16. Which of the following types of Presumptive Eligibility processes do you conduct? (READ LIST, SELECT ALL THAT APPLY)

- PE FOR PREGNANT WOMEN (PEPW) ONLY
- HOSPITAL PE (HPE)
- REGULAR PE (PE)
- DON'T KNOW
- REFUSED

Q17. Thinking about the Presumptive Eligibility (PE) process, how would you rate the overall effectiveness of the PE process at eliminating gaps in health care coverage? Would you say you rate it ...? (READ LIST)

- VERY EFFECTIVE
- SOMEWHAT EFFECTIVE
- NOT THAT EFFECTIVE
- NOT EFFECTIVE AT ALL
- DON'T KNOW
- REFUSED

Q18. Do you track how many people who signed up for Presumptive Eligibility coverage went on to complete an application?

- YES
- NO
- DON'T KNOW
- REFUSED

Q19. What would you say is the success rate of your PE members getting full HIP coverage? Would you say it is ... (READ LIST)

- LESS THAN 25%
- 25-49%
- 50-74%
- 75-99%
- 100%
- DON'T KNOW

OVERALL THOUGHTS ON HIP

Q20. How do you feel HIP will impact your overall revenues? Do you feel it will... (READ LIST)

- INCREASE OVERALL REVENUES
- DECREASE OVERALL REVENUES
- KEEP THEM THE SAME, HAVE NO EFFECT ON OVERALL REVENUES
- DON'T KNOW
- REFUSED

Q21. How do you feel HIP will affect health or health care overall in Indiana? Do you feel it will... (READ LIST)

- MAKE IT BETTER
- MAKE NO DIFFERENCE
- MAKE IT WORSE
- DON'T KNOW
- REFUSED

Q22. Some Hoosier Healthwise adults moved into HIP. Have these changes had any impact on your organization's uncompensated care, charity care or bad debt?

- YES – GO TO Q.22a
- NO – STAYED THE SAME – GO TO Q.23
- DON'T KNOW – GO TO Q.23
- REFUSED – GO TO Q.23

Q22a. How have these changes impacted your uncompensated care, charity care or bad debt? (Free response)

Q23. Since HIP started in February 2015, have you seen a decline in...

a. The number of patients without insurance

- YES – NUMBER OF PATIENTS WITHOUT INSURANCE DECLINED
- NO – NUMBER OF PATIENTS WITHOUT INSURANCE INCREASED
- NO – NUMBER OF PATIENTS WITHOUT INSURANCE STAYED THE SAME
- DON'T KNOW

b. The number of requests for charity care cases that the practice receives

- YES – IT DECREASED
- NO – IT INCREASED
- NO – IT STAYED THE SAME
- DON'T KNOW

c. The instances of Bad Debt

- YES – IT DECREASED
- NO – IT INCREASED
- NO – IT STAYED THE SAME
- DON'T KNOW

> CLOSE1< Thank you for answering these questions. May I please confirm the following information? This survey is meant to be completed by clinicians or practice managers who provide services to HIP members. If you have any questions about HIP please call 1-877-438-4479. Thank you and have a good (day/night).

INTERVIEWER: HANG UP. CODE CASE AS INELIGIBLE—DOES NOT MEET SURVEY CRITERIA

CLOSE: Thank you for answering these questions. On behalf of the Healthy Indiana Plan we thank you for participating in this survey. Your answers will help improve the program.

Appendix G. Survey Sampling Approach

To provide information on individual experiences with the Healthy Indiana Plan (HIP) 2.0, Indiana surveyed current HIP 2.0 members, previous members (leavers), never members, and providers. The surveys were administered in December 2015 and January 2016. The surveys cover a range of topics that address aspects such as access to care, affordability, and member and provider understanding of the program.

Current Member survey sampling strategy

A sample was randomly selected from the total number of HIP 2.0 members. *Table G1*, below, outlines the total number of members, number of members selected into the sample, target number of responses, and number of completed responses for each category.

The total number of members represents the universe of HIP 2.0 members (n=264,018) as of August 26, 2015. A sample of this universe was selected (n=11,000), for whom data was sent to the survey firm, AIRvan Consulting, for data collection. This sample was selected to ensure that the target number of responses were completed based upon expected survey response rates. A target number of completed responses was constructed to maintain the proportion of members in each category in the universe of HIP 2.0 members. That is, the survey design and collection process was based on a quota-based sample where the number of completed surveys was designed to have similar proportions of respondents to the universe of HIP 2.0¹ members along the dimensions of state-provided NEMT coverage, as well as participation in the HIP Plus and HIP Basic plans.

Ultimately, 600 current members comprised the survey sample. This number exceeded our initial target of 550 as AIRvan Consulting oversampled to ensure that quotas for each of the NEMT categories were met. The target sample sizes for the survey were determined in order to detect large differences across populations in aggregate – greater than 10 percentage points – using standard levels of statistical confidence. These differences were deemed substantial from a policy perspective for populations of interest in aggregate (e.g., all members with Plus coverage versus those with Basic coverage).² However, the ability to detect statistically significant differences for subgroup analyses, which would rely on smaller subsets of the overall sample, would be lower.³

¹ The sample was selected based on the HIP 2.0 population at a point in time in August 2015. Reference to universe of HIP 2.0 beneficiaries for any sample projections refer to this point in time population.

² Response to Recent Communications from CMS (10/29/15) and Mathematica Policy Research (10/27/15), Submitted by Lewin Group to Joseph Moser on 11/05/2015. Sample sizes determined using a .05 level of significance 80% power.

³ Detectable differences determined using an assumed response proportion of .10. Detectable differences increase greatly as this assumed proportion increases.

Table G1. Summary of Current Member Sample Sizes from Survey Analysis Plan

Survey	Detail	Total Number of Members	Number of Members Selected into Sample	Target Number of Completed Responses	Actual Number of Completed Responses
Current Member	Plan Selection - Total	264,018	11,000	550	600
	<i>HIP Plus</i>	183,021	7,637	385	420
	<i>HIP Basic</i>	80,997	3,363	165	180
	Transportation Coverage – Total	264,018	11,000	550	600
	<i>Receive State-provided NEMT</i>	120,320	5,192	260	286
	<i>Do not receive State-provided NEMT</i>	143,698	5,808	290	314

AIRvan Consulting randomly selected participants in each of the categories to be surveyed (survey protocol detailed below). Once 400 current member surveys were conducted, the number of interviews conducted within each category in relation to target completion numbers was assessed. A two-stage sampling approach was employed in which AIRvan Consulting was then asked to oversample specific categories of members to meet the target number for completed categories.

As discussed above, the member survey was targeted at two sets of non-mutually exclusive groups: HIP Basic and HIP Plus members, and those who were eligible and ineligible for transportation benefits (non-emergency medical transportation or NEMT). *Table H1* illustrates the target completed responses for each group and shows how all four were met given the existing distribution of HIP Plus and HIP Basic members with and without transportation benefits.

Previous Member (Leaver) Survey Sampling Strategy

The goal of the previous member (leaver) survey was to obtain information from those who were no longer HIP members. The survey included questions about why they left HIP, their knowledge of POWER accounts, and how they accessed care after leaving HIP. The evaluators identified previous members using enrollment data collected on August 26, 2015. There were two groups of individuals selected for inclusion in the leaver sample: those who left the program for any reason (such as moving away from Indiana or receiving coverage through Medicare) and those with incomes at or above 100% FPL who left HIP for non-payment of POWER account contributions. There was a total sample of 1,887 leavers, which consisted of 988 individuals who left the program for any reason and 890 who left for non-payment of POWER account contributions. The target completed response was 125, and 130 responses were collected. A total of 55 responses were collected from those who left due to change in eligibility, and 75 responses were collected from those who left due to not making a POWER account contribution.

Table G2 outlines the number of leavers included in the universe population, the number selected to survey, and the number of completed responses.

Table G2. Distribution of Sampled HIP 2.0 Previous Members by Type

Survey	Detail	Total Number of Leavers	Total Number of Leavers Selected into Sample	Target Number of Completed Responses	Actual Number of Completed Responses
Leavers	Left due to change in eligibility	8,569	988	125	55
	Left due to having income at or above 100% and not making a POWER account contribution	890	890		75
	TOTAL	9,459	1,887	125	130

Never-Member Sampling Strategy

The goal of the never-member survey was to obtain information from those who were eligible for HIP but did not enroll. The never members consisted of individuals from the following groups: 1) Those who applied for HIP coverage and were conditionally approved, had income at or above 100% FPL, and did not make their first POWER account contribution; and 2) those determined eligible through the presumptive eligibility (PE) process but did not complete an application to obtain full coverage. Evaluators identified these individuals using eligibility data.

As this population was difficult to contact, it was not surprising to observe a low response rate. The initial goal was to complete 125 total surveys of never members; however, the amount of effort required to complete only 51 surveys was much greater than anticipated. The available data for individuals who did not make their first POWER account contributions, for example, contained phone numbers without any names or additional information. AIRvan Consulting contacted 940 (out of a total universe of 5,190) individuals who completed the PE process and collected 50 responses. AIRvan Consulting contacted 114 (out of a total universe of 121) individuals who did not become HIP members because they did not make their first POWER account contribution, and only one (1) response was collected. This response was later determined to be invalid due to inconsistencies in the way the individual answered certain questions.

Table G3 outlines the number of never members included in the universe population, the number selected to survey, and the number of completed responses.

Table G3. Distribution of Sampled HIP 2.0 Never-members by Type

Survey	Detail	Total Number of Never-members	Total Number of Never-members Selected into Sample	Target Number of Completed Responses	Actual Number of Completed Responses
Never-members	Conditionally approved but did not make POWER account contribution in first month (income at or above 100% FPL)	121	121	125	1
	Completed Presumptive Eligibility (PE) process but did not complete full application	5,190	5,190		50
	TOTAL	5,311	5,311 ⁴	125	51

Provider survey sampling strategy

The goal of the Provider Survey was to obtain information from providers who treat HIP 2.0 members. The survey included questions about overall impressions of HIP, missed appointments, the presumptive eligibility process, and collection of copayments. The survey also gauged providers' knowledge of HIP 2.0 reimbursement rates and asked if it affected their decision to participate in HIP 2.0.

Table G4 outlines the total number of providers and actual number of completed responses by provider type groupings used in the analysis.

Table G4. Distribution of Sampled HIP 2.0 Providers by Type

Survey	Detail	Total Number of Providers	Actual Number of Completed Responses
Provider	FQHC + RHC	42 (FQHCs)	24
	Hospitals	848	45
	Office-based	45,058	156
	Total	45,948	225

The total number of providers represents the universe of providers (n=45,948) as of August 15, 2015, including federally qualified health centers (FQHCs), rural health centers (RHCs), hospitals, and physician practices in Indiana. Indiana sent Lewin a list of all providers in the state. A sample of the provider universe was selected (n=1,750), for whom data was sent to the provider survey firm, Bingle Research, for data collection. The sample selection criteria were restricted to providers whose addresses are in Indiana or surrounding states (i.e., Michigan, Ohio, Kentucky,

⁴ Although 5,311 never-members were selected into the sample, valid contact information was only available for 1,061 of these individuals.

and Illinois) and treated HIP 2.0 patients. We excluded the following provider types and related specialties:

- Pediatrics
- Mental health
- School corporation
- Pharmacy
- DME/medical supply
- Transportation provider
- Dentist
- Laboratory
- First Step program
- Case management
- Hearing aid dealer
- Waiver provider
- Non-billing waiver case manager

Pediatric providers were excluded as HIP 2.0 covers only persons age 19 – 64. The other provider groups were excluded because they would be unlikely to be familiar with missed appointments or the availability of NEMT services. Providers eligible for inclusion into the surveyed sample included: (1) acute care hospitals, (2) psychiatric hospitals, (3) counseling and mental health centers, (4) rural health care centers (RHCs), (5) federally qualified health centers (FQHCs), (6) local health departments, (7) solo/individual practices, (8) single-specialty practices, and (9) multi-specialty practices. Due to small numbers for some of the provider types, we did not end up sampling all of these provider types.

To increase participation and alert providers that a survey was going to be conducted, all of the providers received a letter from Joseph Moser, Medicaid Director of Indiana FSSA. A copy of the letter is in *Appendix I*.

Ultimately, 225 providers comprised the survey sample; 96.4 percent were located in Indiana, while a small sample (n=8) came from surrounding states. All FQHCs (n=42) were targeted to be in the sample, as the FQHC client mix favors Medicaid members, including HIP 2.0. Half of the FQHCs in Indiana were ultimately sampled. For the purpose of analysis, survey responses from FQHCs (n=21) and RHCs (n=3), are combined. The other 1,708 records were selected via simple random sample from the remaining pool of providers.

It should also be noted that Bingle Research interviewed primarily administrative⁵ and financial staff⁶ (88.0 percent), while clinicians⁷ and auxiliary clinical staff⁸ comprised approximately 5.3 percent and 6.7 percent, respectively. Survey questions were intended to be answered by those most familiar with the office environment and patient issues as a whole.

Respondents were asked in which field they practice and were classified as primary care providers if they responded “primary care,” “family practice,” or “OB/GYN.” All other providers

⁵ Includes office managers / practice administrators and administrative assistants

⁶ Includes financial and insurance staff

⁷ Includes physicians and nurses

⁸ Includes medical assistants, patient navigators, and community outreach staff

were classified as specialists. Bingle Research approximated a 2:1 ratio of primary care to specialty care providers.

Respondents were also asked to identify their practice setting as either: (1) solo/individual practice, (2) single-specialty group, (3) multi-specialty group, (4) hospital, (5) federally qualified health center or rural health center, or (6) other. Respondents were able to select more than one option. For analysis purposes, mutually exclusive categories of practice setting were created as follows: (1) FQHC/RHC, (2) hospital, and (3) office practice. The “hospital” category was comprised of all respondents who selected “hospital” as a response, even if they also selected another response option. Next, if a non-hospital provider said they were an FQHC, even if they also selected another response option, they were categorized as an FQHC. The remaining respondents who identified as an RHC, even if they also selected another response option, were classified as an RHC. All FQHCs and RHCs were combined into one category due to the small number of RHCs in the sample (n=3). Lastly, the “office practice” category was comprised of solo/individual practices (n=68), single-specialty groups (n=36), and multi-specialty groups (n=52).

Table G5 shows the distribution of completed survey responses by the provider settings outlined above. As noted in the sampling section, this survey was not designed to be conducted with a representative sample. Rather, the survey focused on provider groups, such as FQHCs, that disproportionately serve HIP and Medicaid members. The majority of respondents (69 percent) practiced in an office-based setting.

As mentioned above, respondents were also asked to identify if providers in their practice were: (1) primary care providers (inclusive of internal medicine and family practice), (2) OB/GYNs, (3) other specialists (specified in open responses), or (4) none of the above. Respondents were able to select more than one response because some worked at practices with more than one type of provider. Three mutually exclusive categories of providers were developed based upon responses: (1) primary care only, (2) specialty care only, and (3) primary care and specialty care. For the purpose of analysis, primary care providers and OB/GYNs were combined into one category. Please note that these designations only applied to respondents identified as office practices. *Table H5* shows the distribution of type of care provided among office-based practices. The majority of respondents (56 percent) practiced in primary care.

Table G5. Provider Survey Respondents in Office-Based Practices, by Type of Care Provided

Type of Care Provided	Number	Proportion
Primary care	87	56%
Specialty care	48	31%
Both primary care and specialty care	21	13%
Total number of respondents	156	100%

Table G6 shows the distribution of providers by region, with the majority of respondents practicing in the southern region of Indiana (26 percent). Provider regions were identified by the area code of the phone number used to contact the provider.

Table G6. Provider Survey Respondents, by Region

Region	Number	Proportion
Northwest	39	17%
North central	30	13%
Northeast	28	12%
Central	27	12%
South	58	26%
Indianapolis area	35	16%
Neighboring states	8	4%
Total number of respondents	225	100%

Member and provider survey protocol

The survey firms conducting both the *member* and *provider* surveys used computer-assisted telephone interviewing (CATI) to collect data. This telephone methodology provides for interviewer assistance with complicated skip patterns, unaided responses, and consistency in evaluation and limitations of sample bias. Additionally, it provides for expedient collection of the data, allows for better sample control, and can provide more in-depth and complete data than other types of data collection methodologies. Prior to starting the interviewing, a thorough briefing was conducted with all interview and supervisory personnel assigned to the project. During the briefing, interviewers conducted practice interviews and were monitored by supervisory staff.

CATI was used to set quotas for each category of HIP membership or provider type for the respective surveys. The survey firms then randomly identified participants in each of the categories. When the quota (i.e., total number of interviews) was reached in a category, no additional attempts to reach individuals were made in that category. The CATI system pulled a random selection from the sample for each quota group. Any phone numbers found inactive (i.e., instances where it would not be possible to call again) were flagged and were not included in additional contact attempts during the survey period. Inactive phone numbers include: disconnected numbers, wrong numbers, a response of “no such person lives here,” those who refused to start the survey, and those who started but were “qualified refusals.” Qualified refusals were those who stayed on the phone long enough to answer the qualifying questions, but refused or dropped off at some point and did not complete the survey. All “live” numbers such as those at which a busy signal or answering device was reached would be eligible to be called again until the quota for each membership category was filled.

To maximize response rate, calling took place between 9 am and 9 pm on weekdays, and 10 am to 9 pm on weekends for the member survey. Calling took place between 8 am and 5 pm on weekdays during business hours for the provider survey. Any individual who was interested in taking the survey, but who could not participate at the time he or she was initially reached, was given the option of a callback at a specific time. The CATI system would then initiate a call at the scheduled time. If the person was available, the interview would be conducted. If there was no answer, the number would be placed in the “live” category with the potential to be called back.

Appendix H. The Member and Leaver Survey Weighting Methodology

The Indiana HIP program evaluation sampling design is a two phase sampling design that can be treated as a stratified sample. The first phase was a sample of 11,000 members and a census of 1,956 leavers. For the members, the sample was stratified such that the number of claims in each plan and NEMT status was proportional to the universe frequencies. For the leavers, the sample was divided into those that left by disenrollment and those that left for other reasons. These combinations of plans and NEMT status define the strata for this design. In the second phase, sample was taken from each stratum. Since the sampling in the second phase was nested within each stratum, all members within each stratum had the same probability of being sampled, thus all members in each strata had the same final probability of both being selected in the first phase and second phase of the sample. As such, we can treat the sample as a one stage stratified design.

Sampling Weights

All members/leavers within a stratum were sampled with the same probability. Hence, all individuals in a given strata had the same raw sampling weights. *Table H1* below shows the universe size, sample size and raw sampling weights for the seven strata (five member strata and two leaver strata).

Table H1. Raw Weights by Stratum

Description	Total Universe Members	Total Sample Members	Raw Weight
Regular Basic - NEMT	316	2	158.000
Regular Basic - No NEMT	29,220	86	339.767
Regular Plus - No NEMT	114,478	228	502.096
State Basic - NEMT	51,461	92	559.359
State Plus - NEMT	67,690	192	352.552
Leavers - Disenrolled	890	75	11.867
Leavers - Other	8,569	55	155.800

We should note that utilizing these sampling weights would be a very typical and acceptable approach for purposes of analysis. However, we recognize that the sample is quite small, which exposes the sample to a greater risk of being skewed on key characteristics that might be correlated with differing responses to topics addressed in the survey. As such, we identified three dimensions, or partitions, that the sample should be benchmarked to in order to make sure estimates are not skewed due to distribution of the raw sample. This benchmarking, commonly referred to calibration, modifies weights such that the calibrated weighted totals of a key dimension project to the known universe totals of that dimension. When calibrated weights are constructed such that these constraints are met, the sample is said to be balanced with respect to these dimensions.

Table H2 below shows the distribution of the universe as well as the distribution for the sample when using the raw sampling weights across the key dimensions of age, gender, and federal poverty level. We conducted t-tests to identify statistically significant differences between the

projected and universe distributions of age, gender, and FPL using the raw sampling weights. While significance appeared only a few times when using a multivariate adjusted (Bonferroni) 0.05 level of significance, the point estimates varied enough to warrant calibration to these dimensions.

Raking

The simplest, most straightforward approach to calibration would be to benchmark the sample to every level of age, gender, and FPL combination. However, given the small nature of the sample, clearly many of these calibration universe totals would have no corresponding sample to project to. A possible fix for this would be to subjectively collapse these groupings until the sample size permits for calibration, but as one can see from *Table H2* and *Table H3*, such collapsing would likely obscure some of the sampling skew that can only be observed at the more granularly defined groupings of age and FPL. This is a common problem for calibration strategies, and the process of Raking was constructed for this very reason. Raking iteratively calibrates the sample to one dimension at a time, and continues this process until weights converge to a point where all desired dimensions project to the universe totals with a singular weight.

Table H2. Projections by Stratum and Level

	Regular Basic - NEMT			Regular Basic - No NEMT			Regular Plus - No NEMT			State Basic - NEMT			State Plus - NEMT		
	% Uni	% Samp	% Proj	% Uni	% Samp	% Proj	% Uni	% Samp	% Proj	% Uni	% Samp	% Proj	% Uni	% Samp	% Proj
Age															
19-25	56.6%	100.0%	100.0%*	28.1%	25.6%	28.1%*	14.4%**	11.0%**	14.4%*	29.9%**	20.7%**	30.2%*	18.3%**	11.5%**	18.3%*
26-35	36.7%	0.0%	.	32.6%	31.4%	32.6%*	24.4%	22.8%	24.4%*	42.5%	42.4%	42.9%*	35.1%	38.5%	35.1%*
36-45	6.6%	0.0%	.	19.3%	15.1%	19.3%*	21.7%**	17.1%**	21.7%*	21.0%	28.3%	21.2%*	26.5%	24.5%	26.5%*
46-55	0.0%	0.0%	.	14.1%	18.6%	14.1%*	23.5%	24.6%	23.5%*	5.6%	8.7%	5.7%*	14.7%**	19.8%**	14.7%*
56-64	0.0%	0.0%	.	5.9%	9.3%	5.9%*	15.9%**	24.1%**	15.9%*	0.9%	0.0%	.	5.4%	5.7%	5.4%*
65+	0.0%	0.0%	.	0.1%	0.0%	.	0.1%	0.4%	0.1%*	0.0%	0.0%	.	0.0%	0.0%	.
Gender															
Female	100.0%	100.0%	100.0%*	59.7%	64.0%	59.7%*	62.4%**	71.9%**	62.4%*	82.3%	84.8%	82.3%	76.7%**	83.9%**	76.7%
Male	0.0%	0.0%	.	40.3%	36.0%	40.3%*	37.6%**	28.1%**	37.6%*	17.7%	15.2%	17.7%	23.3%**	16.1%**	23.3%
% FPL															
<25	35.1%	100.0%	100.0%	50.5%	44.2%	50.5%	35.7%	34.6%	35.9%	85.3%	83.7%	85.3%	78.6%	78.6%	78.6%
25-49.9	17.1%	0.0%	.	11.3%	17.4%	11.4%	10.9%	13.2%	11.0%	3.6%**	8.7%**	3.6%	4.3%**	2.1%**	4.3%
50-74.9	23.4%	0.0%	.	17.8%**	25.6%**	17.8%	16.7%	14.9%	16.9%	3.9%	2.2%	3.9%	5.4%	4.2%	5.4%
75-99.9	18.0%	0.0%	.	18.1%**	11.6%**	18.1%	18.6%	17.5%	18.7%	3.2%	3.3%	3.2%	5.1%**	2.6%**	5.1%
100-137.9	4.4%	0.0%	.	2.2%	1.2%	2.2%	17.5%	19.7%	17.6%	2.2%	1.1%	2.2%	4.9%**	11.5%**	4.9%
>138	1.9%	0.0%	.	0.1%	0.0%	.	0.6%	0.0%	.	1.7%	1.1%	1.7%	1.6%	1.0%	1.6%

* Categories where the projected number of members using the final weight is not exactly equal to the total number of members in the universe

** Categories where the T test performed on the difference between the raw weight projected and universe distributions was significant

Notes: “% Universe” refers to projections using calibrated weights. “% Sample” refers to projections using the raw sampling weight derived from the sample.

Table H3. Final Projections for Leavers by Stratum and Level

	Disenrolled			Other		
	% Uni	% Samp	% Proj	% Uni	% Samp	% Proj
Age						
19-25	14.0%	16.0%	14.0%*	26.8%	27.3%	26.2%*
26-35	26.9%	29.3%	26.9%*	32.2%	27.3%	31.4%*
36-45	21.2%	18.7%	21.2%*	19.1%	18.2%	18.6%*
46-55	22.1%	20.0%	22.1%*	14.3%	12.7%	14.0%*
56-64	15.7%	16.0%	15.7%*	6.9%	12.7%	6.7%*
65+	0.0%	0.0%	.	0.7%	1.8%	3.1%*
Gender						
Female	71.1%	68.0%	71.1%*	64.9%	63.6%	65.7%*
Male	28.9%	32.0%	28.9%*	35.1%	36.4%	34.3%*
% FPL						
<25	30.0%	36.0%	30.7%	89.2%**	94.5%**	94.6%
25-49.9	0.0%	.	.	1.8%	1.8%	1.9%
50-74.9	0.3%	1.3%	0.3%	2.9%	0.0%	.
75-99.9	0.0%	.	.	2.9%	1.8%	3.1%
100-137.9	67.4%	62.7%	69.0%	2.8%	0.0%	.
>138	2.2%	0.0%	.	0.4%	1.8%	0.4%

* Categories where the projected number of members using the final weight is not exactly equal to the total number of members in the universe

** Categories where the T test performed on the difference between the raw weight projected and universe distributions was significant

Appendix I. Survey Notification Letters Sent to Members and Providers

Letter Sent to Members



[Case ID]

[casename]

[Address Line 1]

[Address Line 2]

Dear [casename],

We are writing to ask for your help with a survey about your experience with the new Healthy Indiana Plan or “HIP 2.0.” Your answers will help us improve the program.

Your point of view is important to us. In the next few weeks you may get a phone call from someone asking about your health care. Our phone call should take less than fifteen minutes.

Your name was picked randomly from a list of all people who receive health care through HIP 2.0. You can choose to answer the questions or not. If you decide not to answer questions, it will NOT affect any HIP 2.0 benefits you receive.

Your answers to the survey will be kept private, and will be used only to help understand experiences with HIP 2.0.

Your opinion matters to us. We hope that you will talk with us. We want to learn more about what you think of your health care in Indiana. If you have any questions regarding the content or purpose of the survey, please contact Shannon Curtis Kellogg at 317-872-0784. If you have questions about HIP 2.0, please call 1-877-GET-HIP-9.

Thank you for your time.

Sincerely,

[Signature Block]

Joseph Moser

Medicaid Director

Letter Sent to Providers



[Date]

[Provider Name and Address]

Dear [Provider Name],

We are writing to encourage you to participate in an important telephone survey for the state of Indiana. As you may know, Indiana has implemented the new Healthy Indiana Plan (or “HIP 2.0”). The state is working with The Lewin Group and Bingle Research to conduct phone interviews with providers across the state in order to understand your experience with HIP 2.0.

Your participation in this interview process is a critical component of Indiana’s evaluation of the HIP 2.0 Initiative. Indiana will use the data collected from these surveys to help understand the impact of the HIP 2.0 program.

In the next few weeks, someone from The Lewin Group or Bingle Research may contact you to conduct the interview or to set up an interview time most convenient for your schedule. Interviews will be conducted over the phone and may be with the practice administrator or office manager. Our phone call should take about ten minutes. Results will be reported in a non identifiable, aggregated form that will ensure your full confidentiality. **Data on your individual practice** will not be shared with anyone besides the evaluation team, and will not be used for any purposes other than the evaluation of this initiative.

If you have any questions regarding the content or purpose of the survey, please contact us at 317-927-7004. If you have questions about HIP 2.0, please call 1-877-GET-HIP-9.

Thank you in advance for your participation in this important process.

Sincerely,

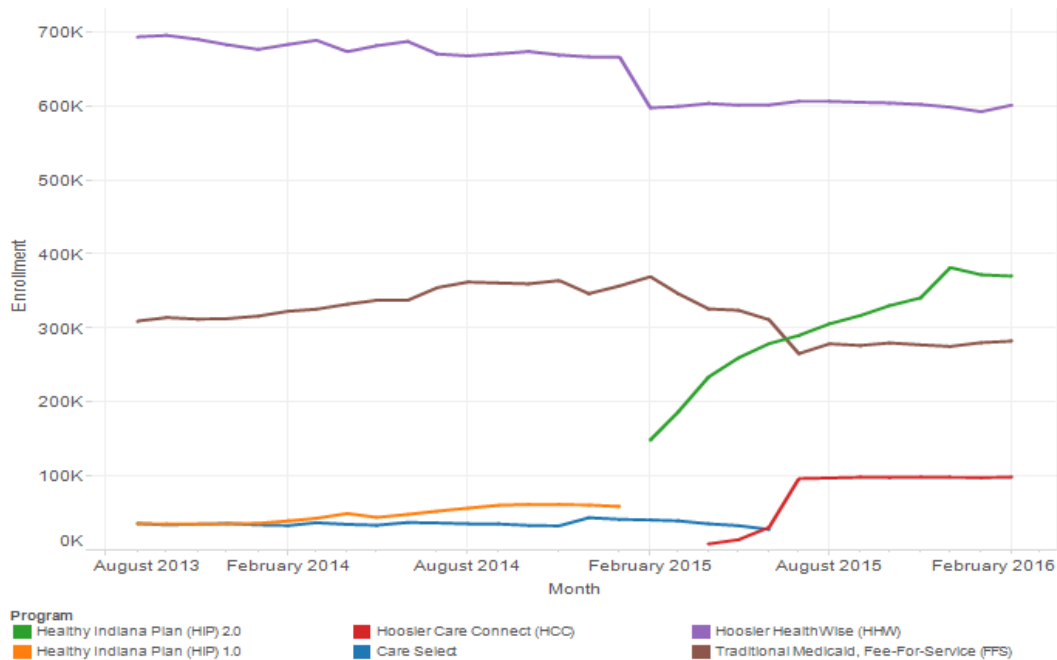
[Signature Block]

Joseph Moser
Medicaid Director

Appendix J. Enrollment in State of Indiana Sponsored Healthcare Programs

Monthly enrollment data on the total number of Indiana residents enrolled in State Sponsored Healthcare Programs as of February 2016. This includes individuals enrolled in HIP, Hoosier Healthwise, Hoosier Care Connect and traditional Medicaid.

Figure K1. Enrollment in State of Indiana Healthcare Programs



Enrollment Table (Monthly)

	Healthy Indiana Plan (HIP) 2.0	Healthy Indiana Plan (HIP) 1.0	Hoosier Care Connect (HCC)	Care Select	Hoosier HealthWise (HHW)	Traditional Medicaid, Fee-For-Service (FFS)
February 2016	370,342		97,840		602,158	282,322
January 2016	372,231		97,510		593,180	280,255
December 2015	381,990		97,733		599,366	275,124
November 2015	340,924		97,755		602,986	277,330
October 2015	330,486		97,673		605,046	279,825
September 2015	316,959		97,858		605,945	276,426
August 2015	305,716		96,889		607,329	278,697
July 2015	290,058		96,004		607,221	265,314
June 2015	278,910		29,928	27,160	602,450	311,270
May 2015	259,607		13,193	32,287	602,043	324,175
April 2015	233,893		7,535	34,731	604,336	325,980
March 2015	186,210			38,778	600,245	346,746
February 2015	148,275			39,985	598,465	369,648
January 2015		58,239		40,872	667,380	357,118
December 2014		60,274		43,050	667,433	346,661
November 2014		60,758		32,000	670,148	364,482
October 2014		60,969		32,652	674,751	359,926
September 2014		59,944		34,429	671,651	361,130
August 2014		56,035		34,785	668,849	362,358
July 2014		51,945		35,892	671,431	354,882
June 2014		47,583		36,638	688,410	337,641
May 2014		43,453		32,860	682,677	337,700
April 2014		48,721		33,974	674,553	332,421
March 2014		42,264		36,248	689,939	325,630
February 2014		38,704		32,523	684,547	322,901
January 2014		35,428		33,319	677,619	316,254
December 2013		34,823		35,105	683,913	312,785
November 2013		34,352		34,352	691,146	312,227
October 2013		34,560		33,361	696,582	314,234
September 2013		35,109		35,138	694,715	309,561

Source: Medicaid Monthly Enrollment Reports from the Family and Social Services Administration Website <http://in.gov/fssa/ompp/4881.htm>.

Appendix K. Identification of Primary and Specialty Care Services

In order to effectively evaluate type of service outcomes for Indiana's HIP benefits, Lewin had a need for consistent definitions for primary care and specialty care. For both, primary care and specialty care, a visit was identified using the combination of member and date of service. Visits were identified for both primary care and specialty care using claims that were paid and non-voided professional medical claims. Additional criteria were specific to primary care or specialty care.

For additional criteria specific to primary care, Lewin chose to use the national standard definition established by the Centers for Medicare & Medicaid Services (CMS) for Medicare claims processing for primary care claims under the Affordable Care Act as indicated in the *CMS Manual System, Pub 100-04 Medicare Claims Processing, Transmittal 2161, Change Request 7060*. CMS specifies a limited set of services eligible to be counted as primary care, based on evaluation and management (E&M) current procedural terminology (CPT) codes. CMS also specifies a set of providers to identify as delivering primary care; including, family practitioners, general practitioners, geriatric practitioners, internists, general internists, pediatricians, general pediatricians, pediatric nurse practitioners, family nurse practitioners, nurse practitioners (other), and physician assistants. Because of the nature of working with a Medicaid population, Lewin also included providers with specialties of obstetrics/gynecology, obstetric nurse practitioner, rural health clinic (RHC), and federally qualified health clinic (FQHC). Additionally, by definition primary care is not referral or specialty care, so claims with referring providers were excluded from consideration as primary care.

Specialty care was defined as services requiring a referral for medical services rendered by a physician in an office, clinic, or mental health setting. Allied health professionals (i.e. physical therapists, paramedics, etc.) were excluded, as were the primary care specialties indicated above. The claims had to have a referring provider or the provider had to be a psychiatrist in order to be counted as specialty care. This was consistent with the way specialty care benefits were administered to HIP recipients.