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HIP 2.0 PROGRAM EVALUATION

TEAM 2

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Introduction & Evaluation Questions

SCOPE OF THE EVALUATION

As third party program evaluators, the team aims to objectively evaluate Healthy Indiana Plan 2.0 (HIP 2.0), a health insurance program for qualified individuals. The team will evaluate whether or not HIP 2.0 will improve care for its enrollees. The evaluation will take a broad approach and analyze the program's intended effects across all levels of coverage and Personal Wellness and Responsibility (POWER) Account plan levels to determine whether or not HIP 2.0 improves enrollees' access to care services. However, the evaluation will not include an analysis of the individual programs within the Request for Proposal (RFP) including the Emergency room copy and retroactive coverage evaluations.

FEATURES OF THE EVALUATION

The target population of this program evaluation includes everyone who is not newly eligible and enrolled for HIP 2.0 under Medicaid benefits in Indiana. These individuals are non-disabled and between the ages of 19 and 64 years old. The evaluators define "not newly eligible" as targets who were enrolled under HIP 1.0 and are now covered under the HIP 2.0 plan. These individuals are also considered stakeholders of the program. Additional relevant stakeholders include the State of Indiana (evaluation sponsor), users of the program, program developers and staff, the state Medicaid program, and Centers for Medicaid & Medicare Services (CMS).

The State of Indiana called for and funded the evaluation of HIP 2.0. The purpose of the evaluation is formative in nature. Clearly outlined in the RFP, the state is interested in determining if the program is meeting the intended goals set out when the program started. The formative evaluation will allow for the program to use the information presented in the evaluation to make necessary changes to improve HIP 2.0. For this reason, the relationship between program developers/staff and evaluators is collaborative and participatory. This relationship will allow for truthful and honest sharing of information between staff and the evaluation team. The State set guidelines and metrics for which the evaluation could be based on. The evaluators will work together with the State to determine which components of the evaluation are meaningful and feasible to focus on given the constraints outlined in the following section. Because of this relationship, the team hopes that the program developers will be more willing to share resources and divulge program information to the evaluators. In order to ensure that communication between program staff and evaluators is strong, the team intends on holding quarterly meetings to check in and discuss the progress of the

evaluation. Although the program itself is participatory and formative in nature, the evaluators have agreed that this evaluation is not one of empowerment.

TIMELINE & CONSTRAINTS

The evaluation will begin three months before HIP 2.0 is implemented to address the questions outlined in the needs assessment. Gathering information about HIP 1.0 prior to the launch of HIP 2.0 provides the evaluators with the opportunity to gather accurate answers for analyzing. The evaluation will continue for an additional year after the initial three months to analyze HIP 2.0 progress for a total evaluation timeframe of fifteen months. The evaluation will focus on proximal outcomes of the improvement of care access between HIP 1.0 to HIP 2.0.

The evaluation will strike a balance between scientific and pragmatic, meaningful and useful. It will be scientific because the evaluators will use stratified random sampling for survey sample and pragmatic because the primary resource for data collection is the HIP 2.0 website. This will reduce the burden on program staff and avoid them from becoming overwhelmed by too many questions. The evaluation will be meaningful as the evaluation focuses on access to care and directly involves improving lives of Hoosiers. As for useful, any state can use this evaluation to determine if their state should implement a similar program, or the evaluation can be used in the future to compare data with a new version of HIP.

SUMMARY OF EVALUATION QUESTIONS

The evaluation will focus on the differences between HIP 1.0 and HIP 2.0 healthcare with four sections of evaluation questions: Needs Assessment, Program Theory, Process and Outcomes. The Needs Assessment aims to learn more about the target population to help understand what their needs are and how well HIP 1.0 is meeting those needs as well as what needs are not being met with HIP 1.0 in terms of care access. The Program Theory evaluation questions aim to ascertain the idea behind HIP 2.0. Mainly, the evaluators hope to determine how the program intends on keeping enrolled individuals engaged with the POWER accounts and learn how the theory behind providing HIP 2.0 insurance will alter patient behavior in terms of healthcare use and improve access to good quality care. The Process evaluation section focuses on HIP 2.0 and how well the evaluators implemented the ideas behind the theory evaluation questions. The Outcome section focuses on members' usage and satisfaction of HIP 2.0, specifically regarding POWER accounts and their feasibility.

USE OF THE EVALUATION

The audience for the evaluation encompasses program developers, the State of Indiana, Medicaid at the state and federal level, and policy groups (Mathmatica, Kaiser House Foundation, etc.). The target population is not part of the audience because it is a higher level evaluation in which members of the target population have no interest in; members are not making the decision to enroll in HIP 2.0 based on this evaluation. The evaluation is intended for primary use by the program staff themselves to improve program design and change how services are provided to patients. The secondary use of the evaluation is for the state, other states and the federal level to use as a model, comparison, or alternative.

Needs Assessment Plan & Justification

NEEDS ASSESMENT OVERVIEW

Assessing the needs behind the HIP 2.0 target population will be completed using HIP 1.0 administrative data, survey data and Census data. The data collected from these methods will be used to ascertain the needs of the target population and provide answers to the corresponding evaluation questions detailed in Appendix A.

METHODS OF DATA COLLECTION & JUSTIFICATION

External sources:

Because most of the data will be taken from HIP 1.0, the only external source is the ACS (American Community Survey), a part of the US Census data. This information will help the evaluators get a sense of the target population's home living situation such as approximate access to internet (physical address locations based off of HIP 1.0 data), education levels and languages spoken at home. It will help address the needs assessment questions 5a, 5b, and 5c.

Internal sources:

The first main source of data collection for the target population will be taken from the HIP 1.0 data. Indiana has tracked the enrollment of HIP 1.0 since its inception and the evaluators can gather: income levels, addresses, phone numbers, health statuses, and target population size. With this information, program evaluators can determine who was meeting the appropriate standards, such as attending mandatory appointments per year, who missed POWER payments and which members fell in and out of the HIP 1.0 program. This will help predict those members who might be problematic or will be helped, if at all, by the

new HIP 2.0 POWER account levels. This information will address the needs assessment questions 1, 4, 5d, 5e, 5f and 6.

The second source of data collection will be HIP 2.0 Enrollment, Redetermination, and Conversion document which covers HIP 2.0 basics and the changes and rollover process from HIP 1.0 to HIP 2.0. The document will address the POWER account changes from HIP 1.0 to HIP 2.0 which will help determine the correct survey questions to ask members concerning their feasibility of the new contributions (HIP 2.0) and member knowledge about HIP 2.0.

The final source of data will be collected from a stratified random survey. The survey will capture services that were not covered under HIP 1.0 that members feel should be included in HIP 2.0., i.e. how has HIP 1.0 not met the needs of the target population? It will assess the POWER account monthly payment feasibility. In HIP 1.0 there is one POWER account and this survey will ask questions pertaining to POWER account payment feasibility (subjective to member on a sliding scale from 1-10). The survey will also cover the target population's transportation, access to current health services, and other barriers to accessing doctors where providers are accepted. By assessing the condition of those who need HIP 1.0 and HIP 2.0, the program evaluators can determine how accessible healthcare services are, access to information about HIP 2.0 and office services (for those without internet access), and other health care services including access to prescriptions. The last metric the survey will measure is the satisfaction with HIP 1.0; this is a critical factor in deciding why there is a need for HIP 2.0 and if this need is addressed. See appendix A for sample survey questions specifically pertaining to barriers to access and satisfaction with HIP 1.0 and needs assessment questions 2, 3, 4, 5g and 5h.

The evaluators will use a stratified random sample for the survey for the target population because it ensures that each member of the population will have an equal chance of being selected. Since the evaluators already know the size of the population, an equal number will be chosen from each group to compare data across strata as opposed to a weighted stratified sample which provides evaluators with population estimates. The evaluators will choose to stratify based on income level because POWER accounts are directly linked to income levels. This method has the potential for under representation (for example only 15% of the target population is in the 100%-138% FPL). This data will be used later for the process theory section where the evaluators will determine whether POWER account levels are feasible and how feasible the contribution payments are for members. A survey was chosen over a focus group because it is more cost effective and it will provide the program evaluators with a representative population. The risk of accuracy might be prevalent

because in a stratified sample, where there is comparison across strata, there are inherent differences between the strata-income levels.

The survey will be mailed to the target population and the appropriate sample size for the survey will be determined by power analysis calculations. This mode was chosen because the target population is lower income and may have limited access to internet to complete an online survey. A mail survey will be more accessible for this population and will provide the members with more time to fill out survey resulting in a higher response rate. Consumer Assessment of Healthcare Providers and System (CAHPS) is a part of the US Department of Health & Human Services which provides helpful resources for health plan surveys and design. The program evaluators will use this site as an aid in the design of survey questions to ensure the creation of easy to understand questions that are not misleading or loaded. For example, a question could be: "Are you satisfied with HIP 1.0?"

There is concern for reliability with the survey around noise associated with personal health survey questions. This specifically is a concern with questions concerning health habits: smoking, diabetes and eating well, and heart condition and exercise. The evaluators are aware of this noise but are aware of the greater reliability than focus groups. Most of the other questions regarding education and needs should be reliable because they would presumably want their healthcare to improve so members will answer honestly.

The evaluators also realize there will be under-coverage. Under-coverage indicates a population that is inaccurately under-represented in the sample. This will include the following members in the sample population:

- Proportion of the population of those who have HIP 1.0 and will have HIP 2.0
    - Dis-enroll in the program
    - Have contact with the program
    - Make POWER account contributions (ex. Stays in the HIP Plus and does not get bumped down to HIP Basic or vice versa)

This under-coverage will also include those who are enrolled in HIP 1.0, switch to Healthwise Hoosier and then return to HIP 1.0. Pregnant women and children have access to Healthwise Hoosier but after they have the child they will be a switched to HIP 1.0. The evaluators will need to address the proportion of the population who are pregnant but this might be difficult to determine. Therefore, it is possible that this population will also have an under-coverage bias.

SYNTHESIS OF DATA COLLECTED

The data received from mail or phone will be added to an excel spreadsheet. This data will be coded by common problems for open-ended questions and by which letter they choose in a multiple choice selection question. The data will then be aggregated by each code and the evaluators will make tables and charts to present that information to the stakeholders. The evaluators will take into account those who do not respond and include them as the proportion who don't respond and based on this data the evaluators can determine if a stratified random sample was the appropriate choice for survey data and use this information for the process theory and process outcome evaluation stage. This process will include hiring a data entry and analyst, preferably an intern to keep costs low.

TIMELINE

After acquiring data from HIP 1.0 and designing the survey, the survey should be sent out within the first month. The member will be alerted via phone that a survey will be arriving in the mail within a week before it is sent. A couple weeks after it is sent, there will be a reminder postcard to fill out the survey and end with a follow-up phone call (for those who haven't responded) where the evaluators will remind and ask the members to fill out the survey. This process should take a total of two months. There will be a short hiatus for surveying after the program begins before the process and outcome evaluation surveys will be sent out to prevent beneficiaries from feeling overwhelmed or annoyed[1].

Program Theory Evaluation Plan & Justification

PROGRAM THEORY OVERVIEW

Assessing and evaluating the theory behind Healthy Indiana Plan 2.0 will be done through a series of data collection methods including internal and external document reviews, and program developer interviews. The data collected from these methods will be used to ascertain the theory and provide answers to the corresponding evaluation questions detailed in Appendix B. The data sources intended on hypothesizing the answers to the evaluation questions and the analysis associated with those questions will provide a complete picture of the idea behind HIP 2.0.

[1] "Response Rate on Mail Surveys." *Prairie Research Associates*. PRA Inc. Web. 03 Apr. 2016. http://www.pra.ca/resources/pages/files/technotes/rates_e.pdf

METHODS OF DATA COLLECTION & JUSTIFICATION

Internal sources:

The program's website will be utilized as the main source to ascertain the program theory for HIP 2.0[2]. The website can provide evaluators and program stakeholders with answers related to the service provision and service utilization evaluation questions. This website presents information relating to POWER account usage and access, provider lists, insurance plans to enroll, program services, etc. Any questions related to the access of information or interaction of the program that go unanswered will be directed towards the HIP Representative in the Live Chat component on the program's website.

External sources:

Mathmatica Policy Research, Inc. conducted an evaluation of HIP 1.0 after the first two years of inception~~being in place~~[3]. This resource can be utilized to understand and gather evidence for the evaluation questions relating to the POWER accounts, specifically. Another potential source of information could be reports other states have published based on their own Medicaid expansion programs. Identifying states who took an approach similar to HIP 2.0 would be the primary step followed by examining the trends and outcomes these states have achieved. Perhaps, this research can give some indication of potential and achievable successes for HIP 2.0 in the near future. Additional useful resources to conduct literature reviews include the Kaiser Family Foundation website and Health Affairs. Doing this literature review will enable the program evaluators to determine if the idea behind HIP 2.0 is sound, realistic and feasible to achieve, and will produce the intended consequences it hopes to achieve. Conducting literature reviews of these external sources can help program evaluators and stakeholders understand the theory behind impact of the program and hopefully answer questions in section III of appendix B, specifically numbers 3, 4, 5, 7 and 10.

Key Informant Interviews:

The program evaluators will hold individual informational interviews via telephone with the program developers to gather answers to questions not easily found in document reviews and questions relating to impact theory in the appendix. Specifically, interviewing program developers will allow the evaluators to understand the intended behavioral changes in the targets as a result of enrolling in HIP 2.0 and other questions within impact theory including 1, 3, 4, and 10. Because this program is dealing with low-income

[2] The following link can be used to access the HIP 2.0 webpage: http://www.in.gov/fssa/hip/

[3] This resource can be found at http://www.mathematica-mpr.com/~/media/publications/PDFs/health/healthyIndiana_Irvin.pdf

beneficiaries, another important component to ask about in these interviews are related to the access of information about HIP 2.0. It cannot be assumed that all beneficiaries will have steady access to the internet and for that reason, the evaluators find it most important to focus on how the targets are intended to access information about HIP 2.0 and use POWER accounts. All information that the third party evaluators are unable to gather from document reviews of internal and external sources will be shifted towards the interviews. Due to the complex nature of the healthcare industry and the business of insurance, the evaluators find it best to focus their efforts on individual interviews with program developers rather than focus groups. These over the phone interviews are intended to be conversational and casual in nature to ensure reduce any barriers program staff may have in answering the questions truthfully.

Since there is a year's worth of time to conduct the entire program evaluation, it is important to spend a considerable amount of time ascertaining the program theory from program developers to ensure a solid understanding of what the program intends to achieve and how it plans on doing so. Although interviews can be time consuming and transcribing this information can be taxing, interviews will provide a wealth of information on such a complex issue that cannot necessarily be captured in a survey.

SYNTHESIS OF DATA COLLECTED

Because synthesizing qualitative data can be difficult, the program evaluators have determined to use a variety of methods to synthesize information gathered in the program theory evaluation. Program evaluators aim to identify themes in the data gathered to present them in a summarized manner. Within the summary of themes, program evaluators may identify and highlight notable quotes found in the data collection process. The use of highly organized prose, diagrams (cause and effect or pathway of targets through the program), and/or infographics can be beneficial synthesis tools for the audience to understand the pathway through the program from service provision to impact (from proximal to distal intended outcomes).

TIMELINE

In an effort to be as cost efficient as possible, the program evaluators will attempt to answer as many of the evaluation questions listed in Appendix B using methods the internal and external source review first. Then, interviews will be conducted to either strengthen weak answers the evaluators have found and to answer the difficult questions previously mentioned in the methods section.

Process Evaluation Plan & Justification

PROCESS EVALUATION OVERVIEW

To evaluate the process taking place under HIP 2.0, two main data collection methods will be utilized: 1) analysis of administrative data and 2) data collection through the use of mail surveys. The data collected from these two methods will help answer a set of process evaluation questions (Appendix C) ~~derived~~ to better understand the process of both service provision, how HIP 2.0 is actually provided, as well as service utilization, how the target population actually interacts with HIP 2.0. This evaluation looks to specifically understand how the program supports targets (evaluation questions 1, 3, 5 and 7 under Service Provision) and how targets engage themselves with the overall program and their individual POWER account (evaluations questions 1, 4, 5, 6 and 7 under Service Utilization).[4]

METHODS OF DATA COLLECTION & JUSTIFICATION

Member Surveys:

Qualitative data collected from members through the use of surveys will help capture the perspectives of HIP 2.0 members that were once enrolled in HIP 1.0. These qualitative perspectives will support the quantitative data collected and further enhance the understanding of the program's actual process.

Two population groups will be surveyed~~:~~, Current Members and Previous Members. The description of each survey population, the overall purpose of the survey, and sample question can be found in Appendix D. There will only be a handful of questions relevant to the Process Evaluation, and therefore will be included in the member surveys conducted within the Impact Evaluation. Survey questions will address the following issues:

- Support in receiving quality care,
- Increase in healthcare access,
- Barriers and/or problematic circumstances impacting enrollment or engagement, and
- Defining engagement with HIP 2.0 and POWER account.

Participants for both survey samples will be selected by utilizing a stratified randomization method. Surveys will be administered by written text, on paper, via mail. There will also be a follow-up phone call reminder to elicit participation and avoid a high non-response rate. This chosen mode is most appropriate for the target population as it allows the members to respond at a convenient time for them, as well as data to be

[4] Appendix E

collected via a communication method that is reliable, easy to use and accessible to all levels of income. Furthermore, this mode is the least expensive and fits the limited budget.

Administrative Data:

Quantitative data collected from member eligibility, application and enrollment data will provide a clear picture of member activity within HIP 2.0. This quantitative clarification will indicate what services are being utilized and the socio-demographic makeup of the individuals interacting or not interacting with any aspect of the program. Data from these two areas will address the following issues:

- Types of healthcare services being utilized across income level and HIP coverage level,
- Coverage level and coverage bias of current and previous members,
- Coverage level and dollar amount of active POWER accounts across income level,
- Enrolment in HIP 2.0 for target population, and
- Defining engagement with HIP 2.0 and POWER account.

SYNTHESIS OF DATA COLLECTED

Data will be synthesized according to its type. The quantitative data collected through the analysis of member eligibility, application and enrollment data will be presented through infographics. The qualitative data collected through the use of surveys will, for the most part, be coded through a binary system (1 for yes and 0 for no). The coded data will then be presented in the exact format as the quantitative data.

There are two exceptions to this binary code process, 1) any qualitative data collected related to evaluation question 7 under Service Provision, and 2) any qualitative data collected related to evaluation question 1 and part 1 of question 4 under Service Utilization. For the indicated exception under Service Provision, changed access to health services will be coded on a rating system of -3 to 3. Once coded, the data will be presented in the exact format as the quantitative data. For the indicated exceptions under Service Utilization the qualitative data will be synthesized into themes. The themes will then be presented in written format with an indication of whether it matched the theory themes.

Outcome Evaluation Plan & Justification

OUTCOME EVALUATION OVERVIEW

The outcome evaluation will combine the use of qualitative and quantitative data to assess the effectiveness of HIP 2.0 improving care for the aforementioned target population. Evaluators will utilize existing external and internal data on measures of quality, access to care, health outcomes and member satisfaction to serve as

baseline data. Then they will gather and review many of the same data metric used in the analysis of HIP 1.0, to collect data on the treatment group. The data collected from these various sources will allow evaluators to understand if HIP 2.0 is improving care and access for the target population of this evaluation.

OUTCOME EVALUATION STRATEGY

Analysis of outcomes requires a counterfactual, the outcomes of what would have been in the absence of HIP 2.0. The missing counterfactual for this case is as follows: What would the outcomes of access to healthcare been for those individuals, who are not newly eligible and enrolled for HIP 2.0 under Medicaid benefits in Indiana that are non-disabled and between the ages of 19-64 years old, if HIP 2.0 never existed but everything else remained the same. The evaluation questions proposed in Appendix F will be utilized to further address the missing counterfactual.

To estimate the missing counterfactual, evaluators will utilize the observational identification strategy, specifically the pre-post analytical design. The treatment group are the "current members", those who have been identified as the target population in this evaluation. The control group are "non-members", those who were enrolled in HIP 1.0 but choose to drop out of HIP 1.0 and never enrolled in HIP 2.0. Evaluators will use the previous year's internal and external survey that analyzed HIP 1.0 as the pre-test. The evaluation team will then conduct their own surveys utilizing similar metrics from pre-test surveys on those individuals in the treatment group. This newly conducted survey will serve as the post-test.

This strategy is utilized because evaluators have no control over who is assigned to the program and thus are not able to randomly assign individuals to the program. In order to use other analytical designs, there would need to be a program similar to HIP 1.0 and the population would have to have similar characteristics to Hoosiers. Due to the political debate around Medicare expansion this is not plausible, as there is no program in the country even remotely similar to HIP 1.0. Additionally the control group would have to have the same characteristics as Hoosiers; such as same level of health literacy, same access to doctors, and same economic environment.

Even though this investigative design is the most feasible option, it does have several threats. Selection biases exist because there could be something systemically different between those who drop out of HIP 1.0 and those who proceed to enroll in HIP 2.0. For example, individuals could become employed and receive health insurance benefits from their employer. Therefore, the systemic difference between the treatment and control group could possibly be that the control group is employable. Another threat would be maturation bias; even

though the difference is only a year, individuals could become wiser with age within that time frame. Secular bias also could occur due to the utilization of surveys from the previous year as the pre- test. An event or legal decision could have occurred within that year that yielded a political or economic shift, which could have caused an unrelated change in program participation.

METHODS OF DATA COLLECTION & JUSTIFICATION

External Sources:

The CAHPS Survey ask consumers and patients to report on and assess their experiences with healthcare. The survey produces the following measures about patient experience that evaluators find relevant to assess in the outcomes evaluation: rating of plan overall, ability to get care quickly, provider communication, scheduling of care, and other relevant CAHPS indicators.

Internal Sources:

Administrative data refers to internal participant-level data produced from member activity. This data includes POWER Account contributions, out-of-pocket payments and third-party contributions. Additionally, member application and enrollment data will be used to understand the size and socio-demographic makeup of HIP 1.0 enrollees. Member Data from HIP enrollment figures will be used to identify and measure key member metrics as monthly and annual enrollment counts, the length of time individuals remain in the program, and other related member information.

In addition to administrative data, each state is required by federal law to report encounter data to Centers for Medicare & Medicaid Services. This data provides details about an insured person's interaction with the health care system including "encounters" such as clinic visit and drug prescriptions. All the data provided by the states is de-identified. Evaluators will utilize this data to collect information about how HIP enrollees use care, the type of care they receive, and their diagnoses.

A third internal source is the Managed Care Entities (MCE). "MCE is a health care delivery system organized to managed cost, utilization and quality."[5] There are three MCEs contracted with the state of Indiana to serve the HIP population: Managed Health Services, Anthem, and MDWise. These MCE maintain participant level records on monthly POWER account contributions usage of POWER account funds, and

[5] "Managed Care." *Managed Care*. Web. 31 Mar. 2016. <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html>.

annually calculate and record qualification for rollover of POWER accounts. This data can be linked with data sources to provide analyses of the relationship between POWER Account usage and health care utilization, compare utilization across various member based plans, as well as compare utilization differences between HIP 1.0 and HIP 2.0 members.

Member Surveys:

Surveys will play vital role in this aspect of the evaluation and will be utilized in addressing question in the process theory section of this evaluation. Participants will be selected utilizing the same stratified randomization method used under the Process Evaluation. Previous members will be used as a comparison group. The structure of these surveys will utilize metrics from the Internal and External surveys used to analyze the control group.

The surveys will cover the following topics:

- Health status overall, including physical and mental health status, and chronic conditions.
- Access to care such as attending personal doctor during the previous six month.
- Utilization of care, including preventive and specialty care, prescription medications and emergency room visits during the previous 6 months or 13 months.
- Satisfaction with HIP 2.0.
- Demographic traits such as gender, age, race/ethnicity, education, household size, household income, and employment status.
- Cost Sharing, payments of copays, and perceptions on affordability.

Evaluators will consider the following:

- Encourage survey participation by reaching out to participants prior to mailing the actual survey, and explaining to potential survey participants what they might expect and the importance of their participation.
- Mail hard copies of the survey and follow up with a phone calls to remind individuals to complete the survey.
- To capture a larger and more representative sample, surveys will be offered in both English and Spanish. Spanish is the second most commonly spoken language after English.
- Financial incentives will be considered to ensure the hard-to-reach participants are not being under-represented.

SYNTHESIS OF DATA COLLECTED

The evaluation will utilize a series of univariate, bivariate, and multivariate analysis to test the hypotheses associated with the goals of the HIP 2.0 and the related evaluation questions. Appendix G is an example of the metrics from each data source that will be utilized to address the evaluation of the outcomes.

Strengths and Limitations

OVERVIEW

The evidence provided through this evaluation will be collected over multiple methods: interviews, surveys, and secondary documentation. Depending on the method used, the corresponding evidence with either strengthen or limit our understanding of how the program is truly operating and preforming. Below is an evaluation of both the strengths and limitations of the overall program evaluation design.

STRENGTHS

All aspects of the program evaluation design include and evaluation of secondary documentation. This method ensures more accurate evidence due to the fact that the majority of these sources are quantitative in nature. By having concrete data with definitive results, this evaluation will not suffer from incorrect coding. Moreover, quantitative data tends to be much more easily understood and synthesized. This is especially important when evaluating data from secondary sources for the Outcome Evaluation.

The collaboration aspect of interviews will provide strong and accurate evidence, as these methods allow the evaluators to build trust with the staff members involved. The monthly check-ins with program staff over the course of the entire program evaluation will foster and build trust between the program and the evaluators. This trust will lead to strong evidence and answers to the interview questions.

The use of surveys to acquire supporting evidence functions as a way to assure strong and accurate evidence. The use of stratified random sampling allows for the collection of a representative sample, adding to the strength of the evidence gathered. Without stratification, the surveys utilized in the Needs Assessment, Process Evaluation and Outcome Evaluation could have been randomly unlucky. Due to eligibility and enrollment requirements, the evaluators have additional information about income level and program level, which have been used to stratify against and ensure all groups have been represented.

LIMITATIONS

Much of our evidence collected via secondary documentation could skew our understanding of reality because the motive or process of collection is not known. The secondary documentation collected within the Needs Assessment and Outcome Evaluation suffers from lack of control. We have no control over ensuring data quality, no control in what is asked or measured, and no control of how data is coded and/or processed. An example would be missing data for HIP 1.0, such as race and demographics, which would make it difficult

to draw conclusive judgements about the gaps and fulfillment of those gaps across systematically different populations.

The wide range of qualitative data taken throughout the evaluation design could limit the representativeness and accuracy of such evidence. In the Program Theory evaluation, during the interviews, the program evaluators may attempt to use highly organized prose and select key quotes that may not be an accurate representation. Any information coded from these responses could lead the evaluation in the wrong direction and prohibit the evaluation from being helpful.

A limitation to the evidence collected from the surveys is the high probability that selection bias is at play. Because all the surveys in this program evaluation design are completed voluntarily and through the mail, there may be large systematic differences between those individuals that complete the surveys and those that do not. Furthermore, the data derived from the Process and Outcome surveys is self-reported. There is no system currently in place to review and fact check answers. Due to these issues, there is a possibility that synthesized data is skewed and inaccurate.

Conclusion

Very brief wrap up and summary of the whole thing. About a paragraph should be fine.

Appendix A: Needs Assessment

I. NEEDS ASSESSENT EVALUATION QUESTIONS

1. How many individuals, couples and family parents were enrolled in HIP 1.0? (i.e. the extent of the need)
2. What services are not being covered/insured under HIP 1.0? (i.e. the nature of the need) To what extent was the target population using the different modes of service in HIP 1.0?
3. How longstanding has the need for a HIP 1.0 expansion been going on for?
4. How affordable would the program be for the target population?
5. What are the circumstances for those in need? Our target population will be low income- how will this impact:

   Access to Medicaid programs:

   a) Their access to internet
   b) Their language barriers
   c) Educational components- their knowledge of healthcare, understanding of savings, and access to this information
   d) How their incomes vary from month to month

   Health care needs:

   a) What is the current health status of target population?
   b) How many deal with chronic health conditions?
   c) What percentage of the target population suffers from diabetes/obesity?
   d) Their transportation access and accessibility
6. Of those enrolled in HIP 1.0, who is not utilizing the health services? What are the barriers preventing this eligible population from receiving and accessing current services?

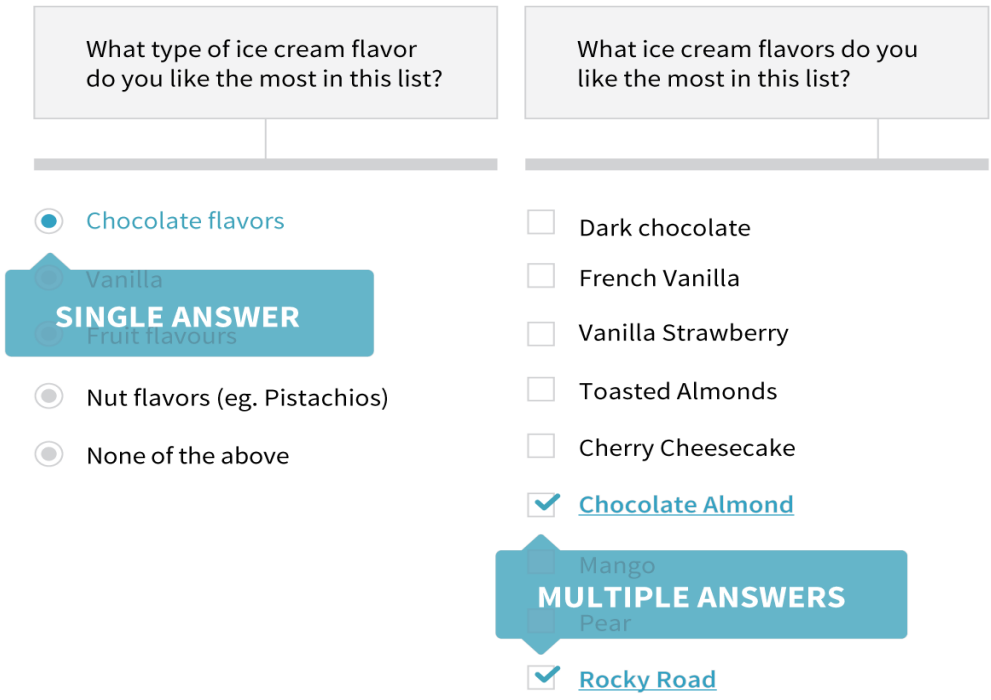
II. SURVEY QUESTIONS

Satisfaction with HIP 1.0: Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate your health care in the last six months? Using a slider scale, members can make a mark on a scale of 0 to 10.

The other questions on the survey will be asked using boxes of options, multiple choice, with four or five options and another box where they can write their own answer.

Some of the questions, such as income will be asked in a single answer format (see Figure 1 below on left) and some such as what about healthcare is satisfactory and what about it isn't will be asked using a multiple answer format (see figure 1 below on the right). Barriers to access will have a list like the second multiple choice where the members can choose all that apply concerning access to the program information, transportation and other barriers where they have the option to explain their choices beside the boxes.

FIGURE 1.



Example question: "Which of the following describes your income level?"

Example questions: "What about the HIP 1.0 experience do you like the most? Choose as many options that apply[6].

[6] Law, Ginette. "Data Design." *Data Design.* Web. 03 Apr. 2016. https://infoactive.co/data-design/ch04.html

Appendix B: Program Theory Evaluation Questions

I. SERVICE PROVISION:

1. How does the program intend to support patients to receive quality care?
2. How does the program intend on informing eligible targets to enroll in the POWER accounts?
3. How does the program intend on getting enrollees actively involved and engaged with the POWER accounts?
4. How does the program intend on keeping track of individuals' POWER accounts?
5. Which types of healthcare services does the program intend on covering? Do they vary based on HIP coverage levels?
6. How does the program intend on informing enrollees about non-emergent ER usage and their responsibility for payment? How does the program intend on informing enrollees of what is considered appropriate use of the ER?

II. SERVICE UTILIZATION:

1. How are the targets supposed to enroll in HIP 2.0? Is it intended to be automatic?
2. How are targets intended to obtain information regarding which providers see patients who are covered under HIP 2.0?
3. With patients who don't have access to internet to see the HIP 2.0 website, what is the plan for them to receive information on HIP 2.0?
4. How is interacting/engaging with the program being defined by HIP 2.0?
5. What is the theorized way in which beneficiaries will use the POWER accounts?
6. People who are eligible for Medicaid benefits because they have limited assets and low income. How does the program intend on patients putting in money to these POWER accounts if they have low income to begin with?
7. How much are enrollees intended to us HIP services? How is usage intended to be measured? (By asking about usage, the evaluators can then analyze how the program described usage and how it is being measured. Then, in the outcome evaluation, usage can be measured to determine if there is under or over usage.)

III. IMPACT THEORY:

1. If people are enrolled in HIP 2.0 as intended, what is supposed to happen?

2. What are the intended benefits for participants to shift from HIP 1.0 to HIP 2.0?
3. How do they theorize that providing HIP 2.0 insurance will change patient behavior? What about enrollees' patterns of healthcare usage is supposed to change?
4. How is the program intended to increase access to healthcare for the individual and increased access to services for the family?
5. What's the theory behind increasing access to care? Does giving people HIP 2.0 insurance lead patients to seek high value care?
6. What is the theorized role of personal responsibility in access and utilization of healthcare services?
7. Is there supposed to be a net savings in healthcare spending for these beneficiaries as a result of the POWER accounts? What is hypothesized to cause this to occur?
8. How is the inclusion of POWER account levels intended to increase access and utilization of care services for enrollees?
9. How are targets intended to access their doctors? What types of doctors will enrollees now be able to access by way of HIP 2.0 and the POWER accounts?
10. How does HIP 2.0 intend to focus on preventative care and shift towards the use of health screenings, immunizations, and annual visits to PCPs?
11. Is there evidence to suggest that how the program is now designed will improve the care of Hoosiers?

Appendix C: Process Evaluation Questions

I. SERVICE PROVISION:

1. How does the program support patients in receiving quality care?
2. How does the program inform eligible targets about enrolment in POWER accounts?
3. How does the program get enrollees actively involved and engaged with the POWER accounts?
4. How does the program keep track of individuals' POWER accounts?
5. Which types of healthcare services does the program cover? Do they vary based on HIP coverage levels?
6. How does the program inform enrollees about non-emergent ER usage and their responsibility for payment? How does the program inform enrollees of what is considered appropriate use of the ER?
7. How does the program increase access to healthcare for the individual and increase access to services for the family?

II. SERVICE UTILIZATION:

1. How do targets enroll in HIP 2.0? Is it automatic?
2. How do targets obtain information regarding which providers see patients covered under HIP 2.0?
3. How do patients who don't have access to internet to see the HIP 2.0 website receive information on HIP 2.0?
4. What are the various stages of interaction/engagement? How are targets interacting/engaging with program?
5. How do beneficiaries use POWER accounts?
6. How do patients with a low income and limited assets use Power accounts? To what extent?
7. How many people in the target population did not enroll in HIP 2.0? Why? What are their barriers/problematic circumstances?

Appendix D: Member Survey for Process Evaluation

CURRENT MEMBER SURVEY

Who:

Collect data from individuals currently enrolled in HIP 2.0, Basic or Plus, that were also previously enrolled in HIP 1.0, Basic or Plus.

Purpose:

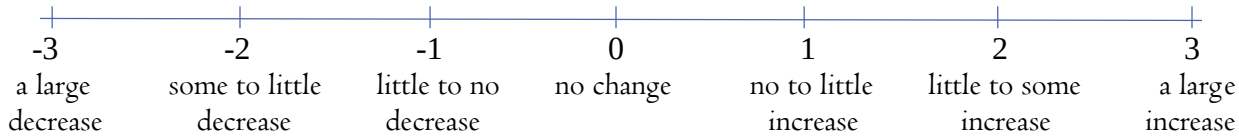
Collect qualitative data detailing the experience current members have within HIP 2.0. Questions include information about the type of services and support being received, as well as self-reported definitions and measurements of engagement.

Sample Question:

Does your household include minors? Check the box that corresponds to your answer.

- ☐ Yes
- ☐ No

How has your household's access to healthcare services been impacted by your transition from HIP 1.0 to HIP 2.0? Use the rating system below, and circle the response that corresponds most closely to your answer.



The above responses will be used to analyze service provision evaluation question #7.

PREVIOUS MEMBER SURVEY

Who:

Individuals not-currently enrolled in HIP 2.0, Basic or Plus, but were previously enrolled in HIP 1.0, Basic or Plus. This population includes individuals who left Hip 2.0 voluntarily, as well as those who became locked out due to non-payment of their POWER account contribution (PAC).

Purpose:

Collect qualitative data explaining the reasons, any barriers and/or any problematic circumstances keeping them from being a current member.

Sample Question:

Our information indicates that you are not currently an active participant in HIP 2.0. Please check the box that most closely corresponds with your reason of non-engagement.

- ☐ I am an active participant
- ☐ I never enrolled in HIP 2.0
- ☐ I was locked out of HIP 2.0 for 6 months due to non-payment

What barriers/circumstances exist that prohibit you from being an active participant in HIP 2.0? Please check all the boxes that apply. (Response options will be taken from the barriers/circumstances indicated on the Needs Assessment. An additional write-in option will also be given.)

The above responses will be used to analyze service utilization evaluation question #7.

Appendix E: Process Evaluation Methods

I. SERVICE PROVISION: *How is the program actually provided to target population?*

Internal Documentation

1. How does the program keep track of individuals' POWER accounts?

Inform Targets

1. How does the program inform eligible targets about enrollment in POWER accounts?
2. How does the program inform enrollees about non-emergent ER usage and their responsibility for payment? How does the program inform enrollees of what is considered appropriate use of the ER?

Support Targets

1. How are patients supported in receiving quality care?
    a) Method & Justification
        - Survey clients with answers aligning with theory
        - None of the above option and write in option
    b) Synthesize
        - Binary code for all that apply
        - Written option coded against the closest theory value or to "other"
2. How are enrollees actively involved and engaged with the POWER accounts?
    a) Method & Justification
        - Administrative data for # and % that get locked out for 6 months
        - Administrative data for clients who engage in methods highlighted by theory
    b) Synthesize
        - Binary code for all that apply as defined engagement
        - Binary code for locked out or not
3. Which types of healthcare services does the program cover? Do they vary based on HIP coverage levels?
    a) Method & Justification
        - Administrative Data
        - Systematic Random Sample across levels and income

b) Synthesize
    - Qualitative Descriptions and Data (# and %) for each type

4. How does the program increase access to healthcare for the individual and increase access to services for the family?
    a) Method & Justification
        - Survey Questions for Quantitative Data
    b) Synthesize
        - Code is binary for individual or family household
        - -3 to 3 Rate System for degree of increased care

II. SERVICE UTILIZATION: *How do clients actually interact with program?*

Get Informed

1. How do targets obtain information regarding which providers see patients covered under HIP 2.0?
2. How do patients who don't have access to internet to see the HIP 2.0 website receive information on HIP 2.0?

Use Program

1. How do targets enroll in HIP 2.0? Is it automatic?
    a) Method & Justification
        - Administrative Data
    b) Synthesize
        - Does it match theory?
2. How many people in the target population did not enroll in HIP 2.0? Why? What are their barriers/problematic circumstances?
    a) Method & Justification
        - Administrative Data for previous members
        - Survey Question for Qualitative Data
            - 3-4 main ideas and "other" option (see Needs Assessment)
            - Reasoning
            - Barriers/Problematic Circumstances
    b) Synthesize
        - Code is binary for enrollment

- Analyze written answers and code those similar in theme together
  - Evaluate coverage bias
- Evaluate coverage level (# or %)
  - Under-coverage – help too little
  - Over-coverage – help too many

3. What are the various stages of interaction/engagement? How are targets interacting/engaging with program?
   a) Method & Justification
      - Administrative Data
      - Survey Question for Quantitative Data (self-reported engagement)
   b) Synthesize
      - Code is binary for engagement
      - Binary code for each defined point of engagement in theory
      - Data divided into self-reported and program confirmed
4. How do beneficiaries use POWER accounts? - Payments (# and %) with balance at end of period
   a) Method & Justification
      - Administrative Data
   b) Synthesize
      - Code is binary for engagement
      - Stratified sample evaluation
5. To what extent do patients with a low income and limited assets use their Power accounts? - See question above for a specific population. defined by those qualified under basic
   a) Method & Justification
      - Administrative Data (Evaluate coverage level)
      - Survey Question for Qualitative Data (Evaluate coverage bias)
   b) Synthesize
      - Systematic Random Sample across levels and income
      - Code similar systematic differences together, describe each group among the various strata (highlighting differences)

Appendix F: Outcome Evaluation Questions & Survey Questions

I. OUTCOME EVALUATION QUESTIONS

1. How many patients enrolled are actually utilizing health services?
2. How many providers (and type/specialty) are now providing services to HIP enrollees?
3. To what extent are patients able to pay their copays and monthly payments to their POWER accounts?
4. To what extent are patients satisfied with the health services provided to them under HIP 2.0?
5. How are HIP enrollees using their accounts? How much are they using their accounts?
6. What evidence is being collected to show patients are assuming greater responsibility and to what extent are patients assuming greater responsibility of their personal health? If the program has worked as planned, and people have gained greatly responsibility over their health by taking preventive measures, has there been a reduction in healthcare spending?
7. To what extent are the assumptions behind using the POWER accounts hold true? Do they cause unintended barriers/issues?
8. Does having higher POWER account levels increase access and utilization of care services for enrollees?
9. What is the incidence of patients seeing their primary care physicians?
10. A big focus of HIP 2.0 is on preventive care and shifting the use from ER use and reactive medicine to preventive medicine. Has there been a shift in the use of health screenings, immunizations, and annual visits to PCPs since HIP 2.0 was implemented?

II. SAMPLE OUTCOME SURVEY QUESTIONS

These questions will be asked in the same Process Evaluation survey mentioned in Appendix D. The sample outcome questions are as follows:

1. What is the balance in your POWER Account at this time? Please write in your best estimate or select one of the options below:

☐ _____

☐ I do not know

☐ I choose not to answer

2. Why did you leave HIP? Select all that apply:

☐ Could not afford it anymore
☐ Did not need it anymore
☐ Forgot to re-enroll
☐ Got insurance through my employer
☐ Got insurance through my spouse
☐ Got Medicare
☐ Got Medicaid
☐ Not able to see doctor of my choice
☐ Not satisfied with plan
☐ Tried to re-enroll: staff could not help me/system failed/did not work
☐ Tried to re-enroll but staff did not get my paperwork completed in time
☐ Too complicated
☐ Too much paperwork
☐ No longer living in Indiana
☐ Became pregnant
☐ No longer income eligible
☐ Incarcerated
☐ I choose not to answer
☐ I do not know
☐ Other reason; Please specify _____

Appendix G: Outcome Evaluation Approach Summary

Hypothesis	Evaluation Question	Analytical Approach	Data Source	Metric
HIP Polices such as rollovers and healthy behaviors will encourage beneficiaries' compliance with required contributions and provide to actively manage POWER account funds	1. How are HIP enrollees using their accounts? How much are they using their accounts? 2. How many patients enrolled are actually utilizing health services?	Track the average balance and account balance of POWER accounts Utilizing bivariate analysis to explain and describe the number of members who make POWER account payments	Administrative Data	*Percent of POWER Accounts that have a balance at the end of the period*
				Average POWER account balance at the end of period
				Percentage of HIP Plus members who have an POWER account balance
			Enrollment Data	*Total Enrollment by HIP Plus vs. HIP Basic Plan*
				# Of enrolled in HIP Basic
				# enrolled in HIP Plus
			MCE Data	*# and amount of Individuals receiving incentives for healthy behaviors*
				# and amount of services individuals are receiving by MCE
Promote personal health responsibility	3. What evidence is being collected to show patients are assuming greater responsibility and to what extent are patients assuming greater responsibility of their personal health? If the program has worked as planned, and people have gained greatly responsibility over their health by taking preventive measures, has there been a reduction in healthcare spending? 4. To what extent are the assumptions behind using the POWER	Track the average balance and account balance of POWER accounts Track and compare trends in encounters	Administrative Data	*Percent of POWER Accounts that have a balance at the end of the period*
				Average POWER account balance at the end of period
				Percentage of HIP Plus members who have an POWER account balance
			Encounter Data	*Encounters with Primary*
				Encounters with Specialty
				Preventive Care Code

	accounts hold true? Do they cause unintended barriers/issues?			
POWER Account contributions for individuals are affordable and do not create barriers to health care services	5. Does having higher POWER account levels increase access and utilization of care services for enrollees? 6. To what extent are patients able to pay their copays and monthly payments to their POWER accounts	Track and compare HIP Plus vs HIP Basic Enrollment Track the average balance and account balance of POWER accounts	*Power Account Data*	Total enrollment by HIP Plus vs. HIP Basic Plan
			MCE Incentive Data	# and amount of individuals receiving incentives for healthy behavior and by income and by HIP Plus vs. HIP Basic Plan
			Encounter	Rate of primary care use, by income and HIP Plus vs. HIP Basic Plan
				Rate of specialty care use
				Rate of Medicine use
			Administrative Data	*Percent of POWER Accounts that have a balance at the end of the period*
				Average POWER account balance at the end of period
				Percentage of HIP Plus members who have an POWER account balance
HIP 2.0 will effectively promote beneficiary use of Preventive, primary, and chronic disease management care to achieve improved health outcomes	7. What is the incidence of patients seeing their primary care physicians? 8. A big focus of HIP 2.0 is on preventive care and shifting the use from ER use and reactive medicine to preventive medicine. Has there been an shift in the use of health screenings, immunizations, and annual visits to PCPs since HIP 2.0 was implemented	Track and compare utilization rates Track preventive care utilization rates and trends among different age and gender groups	*Encounter Data*	*Primary care encounters*
				Specialty Encounters
				Preventive Care Code
				Primary care and preventive care utilization
				Primary care encounters
				Specialty encounters
				Preventive care codes
			Administrative data	*POWER account preventive care rollover rates*
	9. How many providers (and type/specialty) are	Average the Number of encounters	*Encounters Data*	*Primary care encounters*

	now providing services to HIP enrollees?			*Specialty Encounters*
	10. Are patients satisfied with the health services provided to them under HIP 2.0?	Track member feedback for satisfaction of health services via access to different type of health care support before and after enrollment Using univariate and bivariate analysis to describe feedback from members for satisfaction of health services	*Survey of Current Members*	*Measure of ability to obtain primary care visit*
				Measure of ability to obtain prescription
			CAHPS Survey & Non Member Surveys	*Getting Care Quickly*
				Getting Needed Care
				How Well Doctors Communicate
				Health Information & Customer Service
				Overall Ratings