STATE OF INDIANA
OFFICE OF THE GOVERNOR
State House, Second Floor
Indianapolis, Indiana 46204

Michael R. Pence
Governor

June 3, 2016

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulations Development
Attention: CMS-10615/OMB Control Number 0938-1300, Room C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: Indiana public comment on CMS information collection concerning CMS's Healthy Indiana Program (HIP) 2.0 Beneficiaries Survey

To whom it may concern:

Thank you for the opportunity to provide comment on the draft Beneficiaries Survey. On behalf of the Administration, I would like to make it clear that we fully support efforts to evaluate the Healthy Indiana Plan (HIP) in order to improve the quality of coverage and access to it for Hoosiers.

Since the program's inception, Indiana has consistently used independent vendors to evaluate HIP, and we are continuing that effort under HIP 2.0, with the Lewin Group using an evaluation plan that CMS has approved. Results from an evaluation can only be productive when there is no question of bias from the entities performing the evaluation. Consequently, Indiana has strong concerns with CMS's selection of the Urban Institute (Urban) to perform an evaluation of our waiver, when Urban has already written a report on our program that called it "dubious." Hence, we would like to take this opportunity to formally detail our concerns with the three surveys.

The State and its vendors have spent numerous hours reviewing different versions of the survey. This feedback has been shared all along during discussions with CMS. However, we have yet to receive any answers or responses to many of the issues raised by the State and/or our independent evaluator, Lewin Group.

Our concerns revolve around several areas. First, there are many examples of where the survey questions are biased, and response options are leading. Secondly, the questions show a lack of understanding of how the HIP program operates today and could produce misleading results. Third, there are flaws within the survey structure and a number of questions phrased in a way that may be confusing to members – both of which could lead to distorted results. Finally, several questions that were already asked in state's survey were duplicated in the CMS survey while others were omitted. We would like to understand why and the decision-making process that led to it. We would also like to

request a copy of the analytical plan, including an overview of the proposed research questions, measures, comparison populations, and statistical methods.

For your reference, we have provided specific examples in the pages that follow. Please note, many of the questions are repeated in several of the surveys and our comments to those questions should be applied to all three surveys.

BIASED QUESTIONS & RESPONSES:

It is critical to allow a "don't know" or "not sure," or "prefer not to answer" option for all of the questions in the surveys. Yet a large number lack these options. Forcing an answer, as these surveys do, can lead to mistaken reporting and biased, inaccurate results. For example, one question asks,[1]

> What does HIP 2.0 say you should do if you think you need to go to the emergency room? Mark one or more:
>
> ☐ Go directly to the emergency room
> ☐ Call the phone number or hotline provided by HIP 2.0
> ☐ Call my doctor
> ☐ Ask my family or friends

By not allowing an option of "don't know", "not sure," or "prefer not to answer", this question forces members into providing responses (three of which within this example are inconsistent with HIP 2.0 policy) which encourage biased and inaccurate survey results.

In addition, the CMS surveys do not include questions about how members travel to their healthcare appointments. This omission is curious since CMS insisted that Indiana include a question on mode of transportation within its member survey.

Other examples of bias are listed below.

Enrollee Survey

Q7. Stating "Sometimes people need" for the transportation questions is biased and should be worded in a more neutral manner, such as:

Think about the most recent healthcare visit you had **scheduled** in the last 6 months. Which of these phrases best describes your transportation for that visit?

☐ I had transportation and went for that visit.
☐ I did not go for that visit for some other reason.
☐ I did not go for that visit mainly because I didn't have transportation.

[1] CMS HIP 2.0 Enrollee Survey. Question 14, page 4.

□ Don't know/not sure

Q27 and Q30. Members are asked whether their contributions or copays are affordable. Responses to this question as stated are leading and biased, and should be revised so that they do not include the word "afford" in the actual response.

Q46 - Q47. Members are asked to think about their overall experience and are then asked about the specific reasons for being dissatisfied. However, there is no question asking about being satisfied or correlating reasons. The lack of balance points to dissatisfaction and is leading. The dissatisfaction question is found in all of three of the surveys, and there are no questions regarding reasons for satisfaction in any of the surveys.

In addition, only the survey of individuals that have left the program or were disenrolled asks whether the person would enroll in the program again. We recommend that the question be asked in all of the surveys.

Disenrollee/Lockout Survey

Q21. Response options are limited, unbalanced, and could create biased responses. Response options should include a five-point Likert scale.

INACCURATE QUESTIONS

Many of the questions are inaccurate, because they do not reflect the current policy and/or operations of the HIP program.

For example, many of the questions throughout the surveys address enrollees' "choices". These questions may confuse members since they imply that members make an active choice on their enrollment form to enroll in HIP Plus versus HIP Basic. HIP Plus is the initial plan designation for all members. If they make their initial POWER account contribution (PAC), they remain in HIP Plus. If they fail to contribute and are below 100 percent of the federal poverty level (FPL), they are automatically transitioned to HIP Basic. The surveys do not contemplate this, and many of the questions in all the surveys are flawed to this end.

In addition, the relationship between the nurse hotline and the emergency room (ER) copay fee are not addressed correctly in the questions. We recommend reviewing our CMS-approved ER protocols to better understand how the program works. Other examples of inaccuracies are outlined below.

Enrollee Survey

Q7. In addition to the bias noted earlier, this question does not accurately reflect the types of transportation services offered by providers in Indiana. None offer mileage or taxi reimbursement.

Q12. HIP covers transportation to the emergency room when there is a danger to life, so the option for the "emergency room care" should be omitted.

Q25. This question is inaccurate because no one is required to make an annual contribution.

Q50 - Q51. The explanation of benefits is inaccurate. HIP does employ an ER copay, and coverage does not terminate for a member below 100 percent of the FPL if they fail to make their contribution. In addition, the three-month timeframe is not germane to the HIP program and could be confusing to HIP members. It appears that this is a reference to another program. This question is also listed in the other surveys.

New Enrollee Survey

Q5. This question is evaluating written materials and internet resources but does not specify the source of the materials. An individual may receive materials from the State, managed care organizations (MCOs), providers, or other sources.

Q7. This question evaluates if an individual received information from a customer service representative without identifying the source. There are six separate call centers within the State's purview (e.g., MCOs, enrollment brokers, eligibility, member services) that could potentially be providing information. In addition, other call centers outside of the State's purview, such as hospital systems, other provider call centers, or the federal Exchange could also be providing information about HIP.

Q9 - Q10. It is unclear what the purpose of these questions is and what is being evaluated. HIP members likely fill out a variety of forms before, during, and after enrollment, including applications for enrollment, requests for additional information, health assessments, etc. If a provider assisted a new enrollee, the provider might have also had the individual fill out provider specific forms. Further, forms are completed electronically and by paper and the survey does not consider this.

Q11. This question is misleading as application processing is dependent on many factors, including when the individual submitted all related verifications. In addition, the question could be interpreted in different ways – 1) as time elapsed from application submitted date to enrollment start date or 2) as the amount of time it took the member to get coverage after, for example, losing other coverage, which could include the time it took the member to learn about HIP and to complete an application. Finally, the responses should be quantifiable.

Q12 - Q16. As noted above, these questions may confuse members, because they imply that members can choose to enroll in Plus vs. Basic.

Q18. The responses to this question are limited and inaccurate, as they do not reflect all the possible choices, such as returning requests for verifications or information.

Q28 - Q29. The explanation of benefits is inaccurate—HIP does employ an ER copay. Coverage does not terminate for members below 100 percent of the FPL if they fail to make their contribution. Also, the three-month timeframe is not germane to the HIP program and could be confusing to HIP members. It appears that this is a reference to another program. These questions are also in other surveys.

Enrollee Survey

Q24. The question, as written, does not fully assess knowledge of the account. Asking whether they check the balance in their account is more appropriate than knowing the actual balance.

Q34. The question is inaccurate. The account balance is debited whether the person uses their debit card or not as the money still comes out of their account.

Disenrollee/Lockout Survey

Q4. As noted previously, this question may confuse members because it implies that members can choose to enroll in Plus vs. Basic.

Q13. There are other reasons why a person may no longer be enrolled in HIP, such as qualifying for another Medicaid program or failure to comply with documentation requests. Response choices need to be expanded to reflect the range of disenrollment reasons. In addition, there is no requirement for annual contributions, so the question is inaccurate as stated.

UNCLEAR QUESTIONS/SURVEY ISSUES

There are many examples of where the question, as drafted, is unclear, which could lead to biased results. For example, throughout all of the surveys, there are problems with verb tenses in many of the questions and responses. We recommend that all of the questions and responses be reviewed for this issue. In addition, disenrolled members should be asked if they voluntarily left or were disenrolled involuntarily (for non-payment or non-compliance related to eligibility). Also, understanding what plan the member thought they were in is also important, as the survey asks questions about the Basic plan separate from the Plus plan. The questionnaires should ask which plan the member had and whether they switched from one to the other.

Enrollee Survey

Q3 - Q4. The survey states that HIP offers different benefit packages and asks members if they are aware of Plus and Basic, but fails to describe the two packages, which may lead to confusion.

Q9. This question should distinguish between "scheduled" appointments and "non-scheduled" appointments.

Q10. This question is confusing because it is mixing two concepts – 1) ability to pay for and 2) ability to get transportation within the same question.

Q17. This question is confusing as written and could be misinterpreted.

Q18. This question is unclear. The member could have thought about visiting the ER and decided he/she did not have an emergency. The purpose of the question is unclear.

Q19. The purpose of the question is unclear and should evaluate the factors that led to the decision to go to the emergency room.

Q20. The wording in this question is unclear, as a person might have been charged a copay but failed to make the payment.

Q25 and Q26. Individuals are not required to make annual contributions, making the question inaccurate. In addition, response options for Q25 and Q26 overlap.

Q32 and Q33. The flow of Q32 and Q33 is confusing, and the responses will vary depending on the person's income level, which the survey doesn't account for.

Q54. The list of demographics avoid the "four-year" designation for undergraduate college degrees.

Q55. Additional response options are likely needed, such as "self-employment," "unable to work," and an open response.

New Enrollee Survey

Q15. The list of sources is not complete as an individual could have contacted one of the plans (i.e., MDwise, Anthem, or MHS), discussed this at an intake center, or consulted another unknown source.

Q17. This question is very vague. It is unclear what is meant by "something." We do not believe this question provides useful information.

Q19. This question is more closely related to Q11. The survey should clarify exactly what timeframe is being referenced. In terms of survey "flow," it would be reasonable to ask these two questions together.

Q20. Responses will vary depending on what plan the member has and the survey should ask members which plan they think they have (i.e., Basic, Plus, or "don't know").

Disenrollee/Lockout Survey

Q14. It would appear that the respondents who choose "other reason" at Q13 are the only ones who answer this question, and it is not clear whether the skip pattern will distinguish those who left voluntarily from those who were disenrolled involuntarily. In addition, the inclusion of the transportation option within this question is unclear and confusing.

Q31. This question assumes the member received preventive services and is misleading.

Q40. This question assumes that respondents knew that they were previously enrolled in HIP Plus; however, it is likely that some did not know the difference. Also, if the person does not know whether they are in HIP Basic, they should also skip to the end of the survey, since they would be unable to answer the next set of questions (Q41 through Q53).

Q41. Terminology ("better, same, worse") may be unclear. We suggest that the question be reworded to tie to coverage.

Q50 - Q53. These questions assume that respondents knew they were in Plus or Basic; however, it is likely that some did not know the difference. It is likely that some respondents will not know they were moved from Plus to Basic.

We provide this detailed letter to underscore the unambiguous concerns we have with the survey's flawed and biased questions and the misleading response options. We appreciate your consideration of our concerns. Should you have any questions or need clarification, please feel free to contact us as we are glad to assist.

Sincerely,

Tyler Ann McGuffee
Insurance and Health Policy Director
Office of Governor Mike Pence