HEALTHY INDIANA PLAN DEMONSTRATION

PROJECT NUMBER: 11-W-00296/5

SECTION 1115 QUARTERLY REPORT

State of Indiana

REPORTING PERIOD:

Demonstration Year: 1 (02/01/15 – 1/31/16)

Demonstration Quarter: 3/2015 (8/15-10/31/15)

Date submitted to CMS: 12/29/15

HIP 2.0

HEALTHY INDIANA PLAN SM

Health Coverage = Peace of Mind

Introduction:

This section 1115(a) demonstration provides authority for the state to offer the Health Indiana Plan (HIP) 2.0, which provides health care coverage for adults through a managed care health plan and a consumer directed model which provides accounts similar to a health savings account called a Personal Wellness and Responsibility (POWER) account. Under HIP 2.0, Indiana creates new choices for low-income adults, such as the creation of the new Basic, Plus and HIP Link benefit packages, which are being implemented through the state plan. Other changes are effective through this demonstration, which provides authority for the charging of POWER account contributions, the implementation of healthy behavior incentives, and a premium assistance program for individuals with employer sponsored insurance (ESI). The Centers for Medicare & Medicaid Services (CMS) has granted a waiver of requirements under section 1902(a) of the Social Security Act (the Act). The demonstration will be statewide and is approved for a 3-year period, from February 1, 2015 through January 31, 2018.

With this demonstration, Indiana expects to achieve the following to promote the objectives of title XIX:

- Promoting increased access to health care services;
- Encouraging healthy behaviors and appropriate care, including early intervention, prevention, and wellness;
- Increasing quality of care and efficiency of the health care delivery system; and
- Promoting private market coverage and family coverage options through HIP Link to reduce network and provider fragmentation within families.

Over the 3-year period, Indiana seeks to demonstrate the following:

- Whether a monthly payment obligation linked to a POWER account will result in more efficient use of health care services;
- Whether the incentives established in this demonstration for beneficiaries to obtain preventive services and engage in healthy behaviors will result in better health outcomes and lower overall health care costs; and
- Whether POWER account contributions in lieu of cost sharing for individuals participating in the HIP Plus Plan will affect enrollment, utilization, and the use of preventive and other services by beneficiaries.

Overview

The State of Indiana respectfully submits the 3rd quarter Healthy Indiana Plan 1115(a) demonstration report.

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1. **A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, enrollment, quality of care, access, health plan financial performance that is relevant to the demonstration, the benefit package, and other operational issues.**

The third quarter of performance for HIP 2.0 continued to show the high level of preparation and coordination that allowed the state to implement this innovative program with success. Total enrollment at the end of the quarter stands at 301,972 fully eligible and enrolled individuals, with nearly 68% actively making contributions to their POWER Account in the first 9 months of the program which is consistent with a three-month average for the August to October quarter at 68%. Further breakdown of this eligibility by plan and federal poverty levels is provided below.

Accomplishments during the quarter include the receipt of final approval on the HIP Link Program Protocol and completion of an on-site visit from CMS regional and central office staff in September. The HIP Link program began operations in this quarter and enrolled the first employers into the program. Details on HIP Link program implementation can be found below in item #7. In September, the state hosted several CMS staff in an on-site visit that focused on the HIP program. CMS staff were able to meet with top state officials. State staff provided an in-depth presentation on all aspects of the HIP program to date, including reporting on enrollment, application processing, and a live demonstration of the Hospital Presumptive Eligibility application tool. CMS staff also visited two Division of Family Resources (DFR) local offices, IU hospital and one of the HIP MCOs to observe their day to day operations first hand.

During the quarter, the State made operational changes to how information is shared between programs. The State changed system processing so that changes to a member's SNAP or TANF case information would not automatically impact their HIP Case information. We were experiencing a high volume of non-material changes to SNAP or TANF information that would lead to a member being requested to submit information. If they did not respond to a SNAP or TANF request, their HIP coverage was also at risk of closure. With the changes, if a member fails to respond to questions regarding their SNAP or TANF case, it does not impact their HIP eligibility.

Beginning in October, HIP members were able to use POWER Account debit cards at the point of service to pay toward their deductibles for certain services received. This feature allows providers to be paid in real time and allows members to understand their healthcare expenses and manage their accounts. The act of paying for medical care directly at the point of service and obtaining a receipt educates the member about healthcare costs and highlights the value of having insurance. This program is currently optional for providers but the State is encouraging widespread adoption and use of the POWER Account debit card by eligible providers.

As directed by CMS, Indiana removed the Medically Frail Questionnaire from the Health Coverage application. This removal prompted some operational changes to the identification of Medically Frail individuals. The HIP MCEs will be responsible for identifying individuals that are medically frail and will also respond to requests for medically frail determination. The state also enhanced our eligibility system to proactively identify individuals who have an SSA disability determination and identify them as Medically Frail in our system. This allows them to retain their Medically Frail designation and not have to go through a redetermination each year, as long as they retain their SSA disability status. The State also identifies individuals that have HIV, as reported by the Indiana State Department of Health.

On October 30th the state submitted the Prior Claims Payment Program report which detailed the number of individuals with costs paid under the program and indicated that this program will be discontinued in January 2016, due to low utilization.

In this quarter, the State also prepared for the annual redetermination cycle for the first HIP 2.0 cohort who will have their benefit period end on January 31, 2016. This preparation included updates to redetermination language and the first major auto-redetermination of significant numbers of individuals.

2. A discussion of key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed.

The State continues to hold regular meetings with all involved stakeholders including the managed care entities, fiscal agent, systems and eligibility teams to monitor operational status and identify and implement solutions to operational challenges as they arise. These meetings include a daily meeting on all HIP operations and calls specifically focused on addressing individual client issues.

The State identified an issue regarding individuals that had been on the HIP program in the first six months and had experienced a change in category or eligibility that led to multiple benefit periods being generated in the system. This could lead to multiple shortened benefit periods. The State identified impacted individuals and merged the benefit periods so that individuals had one uninterrupted 12-month period. This allows for the POWER Account, cost sharing and rollover to be applied correctly for the individual. We also updated all systems (ICES, AIM, and MCE systems) to assure that all reflected the correct benefit period.

The State is still waiting for approval on the Non-Emergency use of the ER Co-Payment Protocol that was submitted to CMS in the previous quarter.

3. Enrollment figures for the quarter including enrollment figures for individuals by income level and benefit plan.

Table 1 below shows HIP 2.0 enrollment at the end of October. The table shows that 34,894 individuals (11.6% of enrollees) had income over 100% FPL, this is a slight increase over second quarter enrollment for this group (10.5% of enrollees). This lower than anticipated enrollment for this FPL level is likely due to the fact that federal policy does not require individuals who were receiving coverage prior to the HIP expansion through the Marketplace to move to HIP. If these individuals actively report an income change they are directed to HIP, but if no change is reported, they are allowed to maintain their Marketplace coverage, even though they qualify for HIP. Furthermore, recent enrollment data from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) shows that 64,216 Indiana residents between 100 and 150% FPL applied for Marketplace coverage and selected a plan. Many of these individuals are likely eligible for the HIP program, but the Marketplace has not informed them of their HIP eligibility.

For individuals enrolled in HIP during the third quarter of demonstration year 2015, about 68% or 204,174 are making their POWER Account contributions and receiving HIP Plus benefits. For individuals below 100% FPL, nearly 65% are electing to make a POWER Account contribution. The likelihood of making a POWER Account contribution increases as individual income increases from 60% of individuals under 23% of the federal poverty level to 74% of individuals between 76% and 100% of the federal poverty level, even though the amount of the POWER Account contribution has a corresponding increase with increased income.

Table 1 HIP 2.0 Quarterly Enrollment 2/1/2015-10/31-2015									
% FPL	Basic				Plus				Total
	State	Regular	Total	Percentage	State	Regular	Total	Percentage	
<23%	49,338	19,323	68,661	39.57%	58,103	46,738	104,841	60.42%	**173,502**
23%-50%	2,100	4,822	6,922	28.08%	3,651	14,073	17,724	71.91%	**24,646**
51%-75%	2,034	7,287	9,321	27.62%	4,113	20,306	24,419	72.37%	**33,740**
76%-100%	1,714	7,275	8,989	25.67%	3,828	22,195	26,023	74.32%	**35,012**
Total <101%	55,186	38,707	93,893	35.17%	69,695	103,312	173,007	64.82%	**266,900**
101%-138%	1,117	1,908	3,025	9.33%	4,952	24,423	29,375	90.66%	**32,400**
>138%*	659	43	702	28.14%	1,341	451	1,792	71.85%	**2,494**
Grand Total	**56,962**	**40,658**	**97,620**	**32.34%**	**75,988**	**128,186**	**204,174**	**67.65%**	**301,794**

*Individuals over 138% may continue on the program due to TMA or appeal status.

*Source: EDW

4. **Data related to POWER account including the number and average amount of contributions to POWER accounts from third parties, by type of entity, and by beneficiary income level, the HIP Plus and HIP Basic rollover numbers and amounts, and the rate of disenrollment for failure to pay POWER Account contributions.**

Tables 2 and 3 below outline POWER Account contributions that were made by either an employer or a non-profit organization. Though there has been some growth in third party contributions, it remains a small portion of the overall program. The number of employers electing to make POWER Account contributions has remained steady with 102 employers making a contribution on behalf of 108 employees. However, there has been an increase in the number of non-profit organizations making POWER Account contributions. This number has grown from 40 non-profits making contributions for 97 individuals in the second quarter to 52 non-profits making contributions for 193 individuals in the third quarter. These numbers represent those groups that have made a formal arrangement with a Managed Care Entity to pay on behalf of another individual. We understand that some informal arrangements or payments on behalf of members may not be included in these numbers and the MCEs may not be aware of other payments made on behalf of members.

Table 2 Employer Power Account Contributions February 1, 2015-October 31, 2015	
	YTD Total
Number of Employers Participating	102
Number of Members on Whose Behalf an Employer Makes a Contribution	108
Total Amount of Employer Contributions	$4,332.46
Average Amount of Employer Contributions	$60.46

*Source: OMPP Quality and Reporting

Table 3 Non-Profit Organization Contributions February 1, 2015-October 31, 2015	
	YTD Total
Number of Non-Profit Organizations Participating	52
Number of Members on Whose Behalf a Non-Profit Makes a Contribution	193
Total Amount of Non-Profit Contributions	$5,049.28
Average Amount of Non-Profit Contributions	$52.18

*Source: OMPP Quality and Reporting

Through eight months of HIP 2.0 program performance, 2,204 individuals were closed for failure to pay their POWER Account contribution. This represents about 6% of individuals over 100% FPL in the HIP Plus program.

Table 4 HIP 2.0 Closure for Failure to Pay POWER Account February 1, 2015-October 31, 2015	
FPL	Count
100% FPL or less	N/A
100% FPL or more	2,204

*Source: EDW

Table 5 documents that there have been a total of 43,628 individuals who have left the HIP program since February 2015. More than 7,149 of these closures represent a change in Medicaid aid category, meaning they are being served in another Medicaid program and continue to receive health care benefits. Some of these 7,149 are represented in the top five reasons listed below, others are not included here but fall into other "Reason for Closure" categories.

Table 5 HIP Closures February 1, 2015 – October 31, 2015	
HIP Category	**Closures For All Reasons**
Regular Plus	17,596
Regular Basic	7,925
State Basic	11,119
State Plus	6,988
TOTAL Closures	**43,628**

*Source: EDW

The most frequent closure reasons for all HIP (above and below 100% FPL) are below. This table lists the Top 5 most cited reasons for a closure. There are many other closures for a variety of reasons and the below counts do not include all closures. The top reasons for closure remain consistent with "failure to provide information" remaining as the number one reason.

Table 6 All HIP Closures – Top 5 Reasons February 1, 2015 - October 31, 2015	
Number of Closures	**Reason for Closure**
9,840	Failure to provide all required information
5,775	Receipt of or increase in earned or self-employment income
6,834	Income exceeds program eligibility standards
2,889	Moved to another Medicaid category
3,734	Not an Indiana resident
29,072	**Top 5 Total**

*Source: EDW

When the closure reasons are broken out for those above and below 100% FPL there are some differences. The vast majority of members under 100% are closed for failing to provide information. For those over 100% FPL a majority are due to the member's income exceeding program eligibility standards. These individuals are referred to the Marketplace for coverage.

Table 7 HIP Closures 100% FPL and Under – Top 5 Reasons February 1, 2015-October 31, 2015	
Number of Closures	**Reason for Closure**
8,719	Failure to provide all required information
2,647	Receipt of or increase in earned or self-employment income
2,542	Moved to another Medicaid category
3,530	Not an Indiana resident
2,386	Income exceeds program eligibility standards

*Source: EDW

Table 8 HIP Closures over 100% FPL – Top 5 Reasons February 1, 2015-October 31, 2015	
Number of Closures	**Reason for Closure**
4,448	Income exceeds program eligibility standards
3,128	Receipt of or increase in earned or self-employed income
1,121	Failure to provide all required information
2,197	Failure to make payment to POWER Account
684	End of TMA Eligibility

*Source: EDW

5. **Data related to emergency department use including the number of individuals by income level and a breakdown of the number of visits classified as an emergency vs. non-emergency by income level and benefit plan; the number of people who incurred the $8 and $25 copayments**.

Table 9 below documents the number of emergency room visits by HIP 2.0 members in the second calendar quarter of 2015. Reporting on ER utilization comes from actual claims experience, so data may vary over time as claims are submitted and adjudicated before reporting. The use of the ER for non-emergent situations remained steady from the first to second quarter on 2015. Future reports will break

out ER use by income level. The state is waiting for approval of our ER Co-Payment Protocol before we begin reporting on co-payment experience.

Table 9
Emergency Room Utilization
April – June 2015
Calendar Quarter 2

Category	Number of ER visits in the period	Number of ER visits deemed emergent	Number of visits deemed non-emergent	Number of Adjudicated ER claims per 1,000 members	Percent of claims deemed emergent	Percent of claims deemed non-emergent
Plus	9,722	8,364	1,358	178	86%	14%
Basic	2,041	1,439	602	280	71%	29%
State Plan	15,179	11,383	3,796	343	75%	25%

*Source: OMPP Quality and Reporting

6. Reports on speed of eligibility determinations for HIP 2.0 eligible individuals, including the average number of days between the submission of an application and an eligibility determination, and the average number of days between an eligibility determination and HIP 2.0 plan enrollment.

The State continues to report excellent application processing times. On average, most individual applications are approved in less than 21 days. Eligibility begins the first day of the month in which payment is made.

Table 10
Eligibility Processing
Aug. 1, 2015 - Oct. 31, 2015

	Number of days from application to authorization	Number of days from HIP Authorization for full eligibility	Number of pending HIP applications
Case Type	**Average Days**	**Average Days**	**Count**
Regular Plus	18.34	2.78	13,369
State Plan Basic	11.87	13	10
State Plan Plus	17.94	3.36	3,088
Native American HIP Plus	26.4	NA	NA
Regular Basic	21.75	2.68	1,248
HIP Link	21	NA	NA

*Source: ICES

7. A discussion of the HIP Link program, including but not limited to enrollment, HIP Account balance amounts, grievances, changes in employer contribution levels, participants moving from ESI coverage to HIP Plus or HIP Basic, other operational issues; and evaluation activities.

The HIP Link Alternative Benefit Plan was approved October 6, 2015 and the HIP Link Operational Protocol was approved by CMS on October 22, 2015. Prior to approval of the HIP Link Operational Protocol, the program infrastructure was established and review of potential employer participants had

begun. Preparation for individual enrollment was also underway to allow for a quick start to the program once approved. During the third quarter:

- 26 employer inquiries or applications received through the online HIP Link employer portal;
- 8 employer applications approved in the third quarter; 1 employer denied; and 17 pending/incomplete applications;
- Employer approval process extended to include onsite visits at the employer which gives the option to discuss the program with eligible employees and facilitate enrollment.
- Employer plans already approved by the Indiana Department of Insurance as meeting the essential health benefits were posted online as having preapproved benefits for HIP Link;
- System enhancements were complete to verify HIP Link enrollees that apply for the program; and Table 11 highlights the data elements we can report to date and indicates those data elements we will report in the future as the program is fully implemented.

Table 11

HIP Link Data Elements

Aug 1, 2015- October 31, 2015

Employer enrollment	8
Employee enrollment	0
HIP Link account balances	N/A *Note: all account balances will start at $4,000
Changes in employer contribution levels	N/A *Note: employer contribution levels are only projected to change once per year during annual renewal periods.
Grievances	N/A
Participants moving from ESI to HIP Plus	N/A

Along with the above activities, stakeholder outreach was also a focus. The HIP Link program is a key initiative of Governor Mike Pence, and he has continued to meet with business leaders throughout the state to champion the program. Additionally, HIP Link staff have continued to present the program to agent groups, chambers of commerce and state navigators to increase awareness and understanding of the program.

The HIP Link launch included plans for "beta" employers to gain employer and stakeholder feedback before the program was formally launched. . In the next quarter, a state strategy will be developed to increase awareness of the program. For future quarters, additional system enhancements, developments and outreach are planned to ensure all employed, eligible participants have access to HIP Link as a coverage option.

8. **The Status of the NEMT Evaluation and POWER Account Contributions and Copayments Monitoring.**

The State completed several key objectives of the HIP 2.0 evaluation during this quarter. First, the State attended weekly meetings with CMS to develop and finalize the questions within each of the six survey instruments for the HIP evaluation. The State submitted final drafts of the surveys to CMS on October 20, and the State is currently administering the surveys through its third-party contractor, The Lewin Group.

The State also attended weekly meetings with CMS to develop and finalize the metrics for the evaluation plan, and the State plans to submit a Final Evaluation Plan to CMS by December 27, in accordance with the HIP 2.0 Special Terms and Conditions.

The POWER Account Contributions and Copayments Monitoring Protocol ("Monitoring Protocol") was submitted to CMS on July 31, 2015 and it was accepted by CMS with no revisions on August 12, 2015.

9. **Reports on data required as part of the Health Incentives Protocol described in Section VIII and POWER Account Contributions and Copayments Monitoring Protocols.**

During the previous quarter, protocol documents for special monitoring requirements were submitted to CMS and the state was given approval in August on that protocol document.

10. **The number of hospitals and other entities participating in Presumptive Eligibility, by type and the number of applications filed by each entity. The number of full applications filed and the number determined eligible, by entity.**

The Presumptive Eligibility program continues to be very active in Indiana. Table 12 details the activity for all qualified providers in the program. In the performance quarter, more than 30,000 individuals had a PE segment. The rate of presumptively eligible members who complete the full IHCP application and gained full eligibility continues to be a relatively low number. In this quarter, only 28% of individuals who had a PE segment went through the entire application process and were approved for full Medicaid coverage. This number may increase as additional applications are approved. The State developed an administrative rule that establishes performance standards that are required for hospitals performing qualified provider activities. That rule was effective November 1, 2015 and will be discussed in the next quarterly report.

Table 12

Presumptive Eligibility Applications and Performance

August 1, 2015 - October 31, 2015

Provider Type	HPE Applications Submitted	HPE Applications Approved	Percent PE Applications Approved	IHCP Applications Submitted	IHCP Applications Approved*	Percent IHCP Applications Approved*
010 Acute Care Hospital	34,205	26,360	77%	15,658	4,210	27%
111 Community Mental Health Center	1,702	1,339	79%	881	197	22%
080 Federally Qualified Health Center	3,354	2,820	84%	2,018	716	35%
011 Psychiatric Hospital	544	423	78%	252	73	29%

081 Rural Health Clinic	33	26	79%	21	3	14%
130 County Health Department	4	2	50%	2	2	100%
Grand Total	**39,842**	**30,970**	**78%**	**18,832**	**5,201**	**28%**

*****Source: AIM

*Applications submitted in the performance quarter may have still been pending when data was run. This number only reflects those that have had a determination made at that time. This data will be updated next quarter and may be adjusted.

Table 13 provides information on the number of qualified providers that are completing HPE/PE applications for individuals. This number has grown from 157 qualified providers in the second quarter to 177 in the third quarter. This represents 250 locations where an individual can have a HPE/PE application completed. The third column, "Total Potential Providers by Type" column indicates the total number of specialty providers enrolled, for each type, in the Indiana Health Coverage Program. In the previous quarterly report, it was reported that local county health departments or rural health clinics had not enrolled however, special efforts have been made to reach Rural Health Clinics and County Health Departments. This led to an additional Rural Health Clinic enrolling and a County Health Department enrolling.

Table 13

Presumptive Eligibility Qualified Providers

February 1, 2015 – October 31, 2015

Provider Type	Number of Qualified Providers	Number of Qualified Provider Locations	Total Potential Provider by Type*
Acute Care Hospital	114	114	168
Community Mental Health Center	20	50	25
Federally Qualified Health Center	22	65	68
Psychiatric Hospital	15	15	32
Rural Health Clinic	5	5	66
County Health Department	1	1	57
Total	**177**	**250**	**416**

*Source: Indiana AIM

*This Column reflects the total number of providers of that type enrolled in the IHCP.