HEALTHY INDIANA PLAN DEMONSTRATION

PROJECT NUMBER: 11-W-00296/5

SECTION 1115 QUARTERLY REPORT

State of Indiana

REPORTING PERIOD:

Demonstration Year: 2 (02/01/16 – 1/31/17)

Demonstration Quarter: 3/2016 (8/2016-10/2016)

Date submitted to CMS: December 30, 2016

HiP 2.0

HEALTHY INDIANA PLAN℠

Health Coverage = Peace of Mind

Introduction:

This Section 1115(a) demonstration provides authority for the state to offer the Healthy Indiana Plan (HIP) 2.0, which provides health care coverage for adults through a consumer directed model which provides accounts similar to a health savings account called a Personal Wellness and Responsibility (POWER) Account coupled with a high-deductible health plan. 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, and a defined contribution 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 year two, quarter three 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.

Contracts starting January 1, 2017 will add one new managed care entity (MCE) to the three existing MCEs currently serving Medicaid members in the State. In this quarter, extensive efforts have focused on reviewing all MCEs for their readiness to administer both the Hoosier HealthWise and HIP programs under these new contracts. This included on-site readiness reviews at all locations during the first week of October and reviews of all policy and program documentation.

The state is preparing to go into the HIP redetermination window that applies to all of the first HIP 2.0 cohort. This group will begin to receive redetermination materials in November 2016 for their benefit period beginning Feb 1, 2017.

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.

During this quarter, enhancements were made to the cost sharing tracking process. Enhancements allowed the MCE, who tracks cost sharing and maximums, to share that information with Hewlett Packard Enterprises, the state's Medicaid Management Information System (MMIS) vendor. This allows all parties to know when the member has hit their cost share maximum for the quarter.

The state's new MMIS system is in final stages of development before go-live. Most of the system discussions during this quarter focused on the transition from the current MMIS system to the new MMIS system. This included testing with the various vendor systems to assure a smooth transition.

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

Table 1 below shows enrollment in HIP 2.0 at the end of Oct 2016. These numbers do not include those who are conditionally eligible and will move into Plus if they make a POWER Account contribution or Basic if they do not. The total number of enrollees into the program have increased by 18,018 since last quarter. Table 1 shows that in this quarter, 258,450 individuals (66.4%) were making their POWER Account contributions and receiving HIP Plus benefits. We continue to see a majority of the lowest income members (61.82%), under 23% FPL making POWER Account contributions.

At the end of the quarter, 54,055 individuals (13.9% of enrollees) had income over 100% FPL. This is slightly down as the past three quarters have shown around 14.5% of enrollees over 100% FPL.

Table 1 **HIP 2.0 Enrollment** Oct 31, 2016									
% FPL	Basic				Plus				Total
	State	Regular	Total	Percentage	State	Regular	Total	Percentage	
<23%	49,759	34,103	83,862	38.18%	69,187	66,592	135,779	61.82%	219,641
23%-50%	2,564	8,024	10,588	36.00%	4,247	14,602	18,849	64.0%	29,437
51%-75%	2,693	11,715	14,408	35.30%	4,901	21,486	26,387	64.70%	40,795
76%-100%	2,360	12,416	14,776	32.60%	5,079	25,442	30,501	67.4%	45,277
Total <101%	57,376	66,258	123,634	36.89%	83,414	128,102	211,516	63.11%	335,150
101%-138%	2,523	3,433	5,956	11.7%	8,234	36,847	45,081	88.30%	51,037
>138%**	1,138	27	1,165	38.60%	1,730	123	1,853	61.40%	3,018
Grand Total	61,037	69,718	130,755	33.60%	93,378	165,072	258,450	66.4%	389,205

**Individuals over 138% may continue on the program due to TMA or appeal status. *Source: SSDW/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. Third party contributions continue to represent a very small portion of the overall program. The number of employers electing to make POWER Account contributions in the quarter was 17. These employers made contributions on behalf of 17 members. There were 70 non-profit organizations that made contributions on behalf of 2,049 members. This is slightly down from 76 non-profits making contributions for 2,270 members in the last quarter. These numbers represent those groups that have made a formal arrangement with a Managed Care Entity (MCE) to pay on behalf of another individual. 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, including those from friends or relatives.

Table 2 **Employer Power Account Contributions** July 1, 2016 – Sept 30, 2016	
	Total
Number of Employers Participating	17
Number of Members on Whose Behalf an Employer Makes a Contribution	17
Total Amount of Employer Contributions	$448.74
Average Amount of Employer Contributions	$26.40

*Source: OMPP Quality and Reporting

Table 3 **Non-Profit Organization Power Account Contributions** July 1, 2016 – Sept 30, 2016	
	Total
Number of Non Profit Organizations Participating	70
Number of Members on Whose Behalf a Non Profit Makes a Contribution	2,049
Total Amount of Non Profit Contributions	$24,663
Average Amount of Non Profit Contributions	$12.04

*Source: OMPP Quality and Reporting

Since the last quarterly report (Q2), there has been a correction in the number of closures due to failure to pay POWER Account contribution. An error was identified in how the number of closures were calculated. Due to this error, previous reporting overstated the numbers who were closed. Corresponding updates have been made for Q1 and Q2 numbers. The updated numbers are reported in Table 4 to reflect the accurate numbers.

Table 4 **HIP 2.0 Closure for Failure to Pay POWER Account**			
Q1 Count Feb 1, 2016 – Apr 30, 2016		**Q2 Count May 1, 2016 – July 31, 2016**	
Reported	Corrected	Reported	Corrected
3,375	2,321	3,069	2,442

*Source: OMPP Quality and Reporting

In this quarter, 4,621 individuals were dis-enrolled from the program for failure to pay their required POWER Account contribution. This is up from last quarter, analysis is ongoing to identify the reason for the increase in the number of disenrolled members and will be reported in Q4. Out of the 4,621 closures, 2,699 (58%) were subject to 6-month mandatory disenrollment

Table 5 HIP 2.0 Closure for Failure to Pay POWER Account Aug 1, 2016 – Oct 31, 2016		
FPL	**Count**	**Description**
FPL > 100%	4,621*	Failure to make payment to power account

*Source: SSDW/EDW

Table 6 documents that 36,747 individuals left the HIP 2.0 program during the quarter. 4,841 of those were individuals who moved to a different Medicaid program. 31,906 individuals were closed out of the program. The closure reasons listed in the tables below continue to reflect increase in income and non-compliance with redetermination as the main reasons for leaving the program. The numbers below show closures and do not account for the members who may have come back to the state and been reopened. Upon termination, individuals can have their eligibility restored should they return their paperwork within 90 days.

Table 6 HIP Closures Aug 1, 2016 – Oct 31, 2016		
Closures by HIP Category	**Moved to Another Medicaid Category** (Non HIP)	**Moved Out of the Medicaid Program**
Regular Plus	1,713	13,308
Regular Basic	832	9,581
State Basic	629	4,226
State Plus	1,640	4,633
Other	27	158
Totals	**4,841**	**31,906**
Total		**36,747**

*Source: SSDW/EDW

The most frequent closure reasons for all HIP (above and below 100% FPL) are below. Table 7 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 reason for closure in this quarter was an income change that left the member ineligible. The second most common closure reason is that the individual failed to comply with or complete redetermination, this number has decreased from last quarter (Q2).

Table 7
All HIP Closures – Top 5 Reasons
Aug 1, 2016 – Oct 31, 2016

Number of Closures	Reason for Closure
10,973	Individual income exceeds program eligibility standards
7,260	Individual fails to comply with or complete redetermination
4,621	Failure to make payment to POWER account
3,498	Individual is not an Indiana resident
2,749	Individual is eligible for another Medicaid category

*Source: SSDW/EDW

When the closure reasons are broken out for those above and below 100% FPL there are some differences. As documented in table 8, the most common closure reason for members under 100% is failing to comply with or complete redetermination. Table 9 shows that for those over 100% FPL a majority of closures are due to the member's income exceeding program eligibility standards. These individuals are referred to the Marketplace for coverage.

Table 8
HIP Closures 100% FPL and Under – Top 5 Reasons
Aug 1, 2016- Oct 31, 2016

Number of Closures	Reason for Closure
6,611	Individual fails to comply with or complete redetermination
3,193	Individual is not an Indiana resident
3,163	Individual is eligible for another Medicaid category
2,349	Individual income exceeds program eligibility standards
1,975	Individual failed to provide all required information

*Source: SSDW/EDW

Table 9
HIP Closures over 100% FPL – Top 5 Reasons
Aug 1, 2016 – Oct 31, 2016

Number of Closures	Reason for Closure
8,320	Individual income exceeds program eligibility standards
4,621	Individual failed to make POWER Account contribution
668	Individual failed to provide all required information
649	Individual fails to comply with or complete redetermination
509	Individual is eligible for another Medicaid category

*Source: SSDW/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 10 below documents the number of emergency room visits by HIP 2.0 members for calendar quarter 3. The data is collected on a paid basis not an incurred basis, meaning that this data reflects the claims paid during the experience period with a 90 day claims lag time. In this instance the July-September 2016 reporting period shows the claims payment activity for the April-June 2016 (Q2) experience period. The data shows a decrease in the percentage of non-emergent visits to the ER in the most recent reporting period.

Table 10
Emergency Room Utilization
July 1, 2016– Sept 30, 2016 (report period)
Calendar Quarter 3

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	46,733	36,856	9,877	110	78.9%	21.1%
Basic	32,063	25,364	6,699	202	79%	21%
State Plan	62,245	46,219	16,026	173	74.3%	25.7%

*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, individual applications are approved in 11-13 days. Applications for HIP Link do take a bit more time, but are complete in 23 days on average.

Table 11 **Eligibility Processing** Aug 1, 2016- Oct 31, 2016			
	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	11.32	5.46	13,333
State Plan Basic	10.86	14.86	92
State Plan Plus	10.27	6.14	3,131
Regular Basic	12.82	13.03	1,450
HIP Link	23	1	10

*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 is continuing to make a significant impact for Hoosier employers and their employees. In this past quarter, the State has seen an increase in employee participation. With the help of our new marketing/public relations vendor, HIP Employer Benefit Link (generally called "HIP Link") has been rebranded and is now called "HIP Employer Link." Along with the name change, HIP Employer Link has a new website, logo, and color scheme. This is an effort to distinguish the program from HIP 2.0 and create a new brand identity for the program. A statewide advertising campaign began the second week of November with print, radio, and social media advertising. In addition, two new staff have joined the state team, increasing capacity for outreach and recruiting efforts.

Table 12 **HIP Link Enrollment** Aug 1, 2016- Oct 31, 2016		
	Quarter 8/1/16-10/31/16	Program to Date 8/1/16-10/31/16
Employer enrollment	12	62
Employee enrollment	20	55
Grievances	0	0
Participants moving from ESI to HIP Plus	3	3

*Source: OMPP HIP Link

Table 13 **HIP Link POWER Account Balances** Aug 1, 2016- Oct 31, 2016	
POWER Account Balance	Number of Employees
$4,000-$3,000	28
$3,000-$2,000	13
$2,000-$1,000	9
$1,000-$0	2

**Note: all account balances will start at $4,000*

*Source: OMPP HIP Link

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

The NEMT waiver evaluation is on-going and is due for submission to CMS in November (Q4).

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

The ER co-payment study is on-going. Future reports will document progress on the project and outcomes.

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 14 details the activity for all qualified providers (QPs) in the program. The State has seen improvement in the number of PE recipients that are being approved for full IHCP benefits at application but the overall rate is still low at

just under 42%. Research into this data is on-going to monitor the denial reasons for these applicants to understand if applicants are denied for procedural reasons, such as not providing documentation, or if they do not meet eligibility requirements.

Table 14
Presumptive Eligibility Applications and Performance
Aug 1, 2016 – Oct 31, 2016

Provider Type	HPE Applications Submitted	HPE Applications Approved	% PE Applications Approved	IHCP Applications Submitted	IHCP Applications Approved*	% IHCP Applications Approved**
Acute Care Hospital	29,275	20,656	70.6%	18,326	6,800	39.9%
Community Mental Health Center	1,473	1,108	75.2%	982	321	35.3%
Federally Qualified Health Center	3,171	2,658	83.8%	2,304	1,208	56.2%
Medical Clinic	1	1	100%	1	1	100%
Psychiatric Hospital	590	461	78.1%	417	162	42.3%
Rural Health Clinic	2	2	100%	1	1	50%
County Health Department	13	11	84.6%	9	5	55.6%
Grand Total	**34,525**	**24,897**	**72.1%**	**22,041**	**8,497**	**41.5%**

*Source: EDW

*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. It may change over time.

Table 15 provides information on the number of Qualified Providers (QPs) that are completing HPE/PE applications for individuals. The number in column (a) is the number of provider entities that are signed up to perform QP activities, broken out by provider type. The number in column (b) shows the number of physical locations where the entity operates and carries out QP activities. The number in column (c) shows the total number of provider entities that are eligible to sign up to be a QP. To date, 216 out of 333 (64.9%) eligible entities are signed up to be a QP. We have updated our methodology in counting both QPs and the number of potential QPs by type. This update is a more accurate reflection of the number of providers who could participate in the program. The previous methodology vastly over reported the number of potential providers. For example, using the previous methodology, one acute care hospital could be enrolled as a hospital, a rehabilitation unit, and a psych unit all under the acute care label. This would show up as three potential provider entities. In reality, all three are one provider entity in the same location and should be counted as one. We also updated the methodology to count potential provider entities in only one area. For example, one provider entity may be enrolled as both an acute care hospital and a psychiatric hospital, the new method will count the provider one time in their primary enrollment category. This updated methodology more accurately reflects the participation rate among providers and allows us to correctly identify entities who are not participating and target outreach efforts to those providers.

Table 15 **Presumptive Eligibility Qualified Providers** Aug 1, 2016 – Oct 31, 2016			
Provider Type	**Number of Qualified Provider Entities (a)**	**Number of Qualified Provider Locations (b)**	**Total Potential Provider Entities by Type (c)**
Acute Care Hospital	117	117	125
Community Mental Health Center	21	55	25
Federally Qualified Health Center	26	152	26
Psychiatric Hospital	20	20	41
Rural Health Clinic	22	22	67
County Health Department	10	10	49
Total	**216**	**376**	**333**

*Source: Indiana AIM