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: 1/2015 (2/15-4/15)

Date submitted to CMS: 8/5/15

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 1st quarter Healthy Indiana Plan 1115(a) demonstration report.

State Contact
Natalie Angel HIP Director Family and Social Services Administration W374 IGC-S, MS 07 402 W Washington St. Indianapolis, IN 46204-2739 Telephone: 317- 234-4457 Facsimile: 317-232-7382 natalie.angel@fssa.in.gov

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.**

While negotiating the waiver, the state made simultaneous and significant parallel efforts to implement the updated design of HIP 2.0 and prepare for enrollment. This included coordinating a multi-department, multi-vendor team including the HIP managed care plans. The team worked together to prepare the eligibility, MMIS and the three managed care plan systems to expand eligibility and operate the new design. In addition, the managed care contracts were amended to reflect the new HIP 2.0 program requirements, an emergency rule was created, new staff was hired and trained, and member notices, communications and materials were prepared.

To this end, the State of Indiana was ready to take applications for the new Healthy Indiana Plan (HIP 2.0) program on January 27, 2015, the day CMS provided approval. The launch has been largely successful with enrollment exceeding 230,000 in the first quarter.

The HIP 2.0 waiver provided approval for the state to end traditional Medicaid for all non-disabled adults in the State and expand coverage to adults ages 19-64 with household income at or below 138% FPL, estimated at approximately 350,000 Hoosiers. Therefore, in addition to the existing HIP members transitioning from the previous HIP waiver (HIP 1.0), the first individuals on the program were those transitioning from Medicaid, which included Section 1931 parents and caretaker relatives, 19 and 20 year old low-income dependents, and individuals receiving Transitional Medicaid assistance (TMA). In addition, the state coordinated with the federal marketplace to target and notify individuals with income between 100% and 138% FPL on the federal marketplace that were receiving tax credits to help facilitate the Marketplace enrollee's transition to HIP.

A key priority of the state on HIP 2.0 is encouraging members to make HIP Plus contributions, as data indicates that individuals making contributions to their POWER account utilize the health system in more appropriate ways and are more engaged in their health. Overall, first quarter HIP Plus enrollment was strong and the program experienced a HIP Plus enrollment rate of approximately 72%. This includes members that were not previously making any contributions towards their healthcare in traditional Medicaid and also members far below the poverty line. The high number of individuals choosing to make HIP Plus contributions during the first quarter demonstrates the success of the HIP 2.0 design. Also, data shows that very few contributions are coming from third-parties and most members are making these contributions themselves. Significant efforts were made by the managed care plans to educate members and providers about the advantages of HIP Plus. In addition, the managed care plans engaged in active outreach to new members to explain and set-up an appropriate payment mechanism.

The HIP program maintained consistency by contracting with the existing three HIP managed care entities (MCEs), as their contracts were still in effect. From the beginning, the MCEs were included in the state's HIP 2.0 design sessions, which helped facilitate the rapid implementation and allowed the state to begin offering coverage immediately following the waiver approval. This also assured that the MCEs would be proactive in their network development to assure that there were adequate provider networks in place for all services, including the new dental and vision benefit and pharmacy carve-in, immediately upon program implementation.

In anticipation of CMS approval, extensive readiness reviews were conducted with each of the three MCEs to assure that they were prepared to accept a growing population of HIP members and administer the program according to the new HIP 2.0 framework. Throughout this process, the state continuously monitored and evaluated the plans and their ability to continue to assure adequate access to care and quality health care delivery. The State conducted both desk reviews and several on-site reviews for each plan. A team of experts from the state provided standard language on an extensive array of HIP 2.0 written materials including, but not limited to: (i) member information, (ii) provider credentialing information, (iii) public promotional material, and (iv) internal MCE policy and procedure documentation. During readiness review, the state ensured that all such provided material was incorporated appropriately. The state also conducted on-site reviews to see MCE operations and to view demonstrations of MCE systems to verify readiness prior to program implementation.

A new aspect of the HIP 2.0 program was the carve-in of pharmacy services. To simplify this process for providers, links were established on the HIP.IN.GOV website for providers to access formulary information for all HIP based plans. The State also ensured that the existing fee-for-service pharmacy vendor would process prescriptions for transitioning members for the first 30 days to ensure no interruptions in coverage.

All three health plans opted to work with a dental benefit manager to implement the new HIP Plus dental benefit. The dental benefit manager established two new provider relations positions. Those positions are staffed with two qualified individuals who have worked throughout the dental community and have established strong connections throughout Indiana. The State also developed several dental-specific provider bulletins to help providers understand how the HIP 2.0 dental benefit is designed.

During the rollout of the HIP program, there was an acute HIV epidemic that came to light in Scott County, Indiana. The State rapidly mobilized a multi-agency prevention and treatment outreach campaign. The Family and Social Services Administration (FSSA) that operates the HIP program placed staff on the ground in Scott County to facilitate presumptive eligibility (PE) into Medicaid and HIP as appropriate and to train qualified providers to conduct PE determinations. FSSA also coordinated meetings between the Indiana State Department of Health (ISDH) and the HIP managed care plans to ensure that HIV positive individuals were automatically considered medically frail upon enrollment in HIP, as well as to coordinate on-going case management and treatment.

In addition to the underlying efforts required for the rollout of a significant program, the state also successfully completed all of the 1st quarter requirements of the Special Terms and Conditions (STCs). In addition, the state initiated extensive program design and implementation efforts related to several areas of the program that were negotiated late in the waiver process, including, but not limited to the managed care opt-out solution for Native Americans/Alaskan Natives, fast-track payment system, credit card fast-track payment, lock-out exceptions, and prior claims payment. The state also developed and submitted the detailed operational protocols for the POWER account, copayments, and emergency room co-payments to CMS. In addition, the state developed a Request for Proposal (RFP) for an evaluation vendor which was awarded to the Lewin Group. The HIP 2.0 final administrative rule was finalized and effective June 15, 2015. The state also initiated efforts for a media campaign and continued its on-going stakeholder communications. In addition throughout this process, the state has also continued efforts to further develop the HIP Link program, including submitting required ABP documents.

During the first quarter of the implementation, the state dedicated a number of resources to ensure smooth operations which will also continue in the second quarter. The Deputy Secretary of FSSA convenes daily meetings with the eligibility team and IT vendors to monitor system operations. Several weekly meetings occur with all HIP vendors including the managed care plans and enrollment broker to rapidly identify and address member, system and operational issues. In addition, a specialized unit, deemed the Customer Service Team was appointed to rapidly handle unique member issues and help identify any possible systemic issues as quickly as possible. Customer service was a key focus of the first quarter and will remain so as the program continues to rollout.

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.**

Dental benefits: Early in the program dental providers reported confusion applying the copayments. The State worked with the managed care entities, the dental subcontractor and the state's Dental Association to produce a series of provider bulletins to answer questions and to quickly clarify provider confusion.

Expansion of Presumptive Eligibility (PE): With the expansion of presumptive eligibility to Community Mental Health Centers, Federally Qualified Health Centers, Rural Health Clinics, and County Health Departments; the State had to train providers and quickly established webinars to train providers and establish the necessary qualified provider status for these new provider classifications. There were reports that pharmacies were not accepting PE, nor processing prescriptions as required. The State produced provider bulletins to explain how the PE program worked. In addition, the State worked with the managed care plans to address member concerns, which has significantly reduced the number of reported issues. The state continues to actively monitor PE determinations by provider and the number of individuals submitting full applications. Efforts have been made to update the administrative rule around PE determinations, and the state will seek to put new quality standards into place.

Auto-assignment: In addition, there were reports regarding member issues with plan selection and assignment to health plans. There were a number of underlying issues related to the auto-assignment logic that contributed to this problem and have been corrected. Due to this issue, the state did not process terminations for non-payment during the first quarter and provided additional time for the transitioning members to make POWER account contributions to their health plans.

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

Members in HIP 1.0 began coverage in HIP Plus because they were already making contributions to their POWER account. The HHW individuals that were transitioning into HIP started in HIP Basic and were given the opportunity to make a contribution into their POWER account to access the HP Plus. Over 70% of the HIP participants chose to make POWER account contribution and participate in HIP Plus.

Table 1
HIP 2.0 Quarterly Enrollment
2/1/2015-4/30-2015

% FPL	Basic				Plus				Total
	State	Regular	Total	Percentage	State	Regular	Total	Percentage	
<23%	49,809	9,630	59,439	87.8%	48,388	34,633	83,021	51.0%	142,460
23%-50%	1,374	887	2,261	3.3%	2,209	14,180	16,389	10.1%	18,650
51%-75%	1,244	1,174	2,418	3.6%	2,442	19,998	22,440	13.8%	24,858
76%-100%	918	1,199	2,117	3.1%	2,207	20,897	23,104	14.2%	25,221
Total <101%	53,345	12,890	66,235	97.8%	55,246	89,708	144,954	89.0%	211,189
101%-138%	812	151	963	1.4%	1,777	15,668	17,445	10.7%	18,408
>138%	532	3	535	0.8%	346	163	509	0.3%	1,044
Grand Total	54,689	13,044	67,733	100%	57,369	105,539	162,908	100%	230,641

*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**.

Rollover doesn't occur until the 16 months into the program and therefore will not be reported until 2016.

Tables 2 and 3 below outline POWER account contributions that were made by either an employer or a non-profit organization. In the first quarter of performance, 54 employers and 24 non-profit organizations made contributions on behalf of a HIP Member. In total, 106 out of 162,908 HIP Plus members had a POWER account contribution made on their behalf. Non-payment information will be reported in the next quarterly report as no individuals were terminated for non-payment during the first quarter due to the grace period and the extension due to issues with plan choice.

Table 3 Employer Power Account Contributions February 1, 2015-April 30, 2015	
	YTD Total
Number of Employers Participating	54
Number of Members on Whose Behalf an Employer Makes a Contribution	60
Total Amount of Employer Contributions	$1,999.04
Average Amount of Employer Contributions	$33.82

*Source: OMPP Quality and Reporting

Table 4 Non-Profit Organization Contributions February 1, 2015-April 30, 2015	
	YTD Total
Number of Non-Profit Organizations Participating	24
Number of Members on Whose Behalf a Non-Profit Makes a Contribution	46
Total Amount of Non-Profit Contributions	$1,358.87
Average Amount of Non-Profit Contributions	$65.4

*Source: OMPP Quality and Reporting

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**.

The ER room data will be reported in the next quarterly report in anticipation of the approval of the ER protocol by CMS.

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.**

Table 8 Eligibility Processing Feb 1, 2015-April 30,2015			
	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	18.89	35.21	12,633
State Plan Basic	16.02	45	2
State Plan Plus	17.74	32.88	6150
Native	23	NA	NA

American HIP Plus			
Regular Basic	20.39	33.78	1217

*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 Program was in operational policy design phase during the quarter. The HIP Link operational protocol was submitted to CMS on May 26, 2015, and has not yet been finalized and approved. Therefore, there is no data to report at this time.

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

During the quarter, protocol documents for special monitoring requirements have been submitted to CMS and the state is awaiting final approval before this data can be reported.

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 quarter, protocol documents for special monitoring requirements have been submitted to CMS and the state is awaiting final approval before this data can reported.

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.

Table 9

Presumptive Eligibility Applications and Performance

Feb 1, 2015-April 30, 2015

Provider Type	PE Applications Submitted	PE applications Approved	IHCP Applications Submitted	IHCP Applications Approved*
Acute Care Hospital	26,788	20,455	18,492	11,413
Community Mental Health Center	299	231	221	124
Federally Qualified	1,100	899	854	430

Health Center				
Psychiatric Hospital	176	136	132	90
Rural Health Clinic	6	3	3	2
County Health Department	0	0	0	0
Grand Total	**28,369**	**21,724**	**19,702**	**12,059***

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. This data will be updated next quarter and may be adjusted.

Table 10

Presumptive Eligibility Qualified Providers

Feb 1, 2015-April 30, 2015

Provider Type	Number of Qualified Provider	Total Potential Provider by Type*
Acute Care Hospital	114	168
Community Mental Health Center	23	25
Federally Qualified Health Center	27	68
Psychiatric Hospital	17	32
Rural Health Clinic	19	66
County Health Department	8	57
Total	**208**	**416**

*Source: Indiana AIM