HEALTHY INDIANA PLAN DEMONSTRATION

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SECTION 1115 ANNUAL REPORT

State of Indiana

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Executive Summary

On January 27, 2015, the Centers for Medicare & Medicaid Services (CMS) granted a waiver of requirements under Section 1902(a) of the Social Security Act (the Act) and approved the Healthy Indiana Plan (HIP) 2.0 1115(a) demonstration waiver. HIP 2.0 aims to cover non-disabled adults between the ages of 19 and 64 with income at or below 138 percent of the federal poverty level (FPL), as well as Section 1931 parents and caretaker relatives and low-income 19 and 20 year olds. The demonstration is statewide and is approved for a three-year period, beginning February 1, 2015 through January 31, 2018. This report outlines the activities and impact for Demonstration Year Three (February 1, 2017 – January 31, 2018).

The program's Demonstration Year Three built on its efforts from Demonstration Years One and Two. There was an increase in enrollment from approximately 370,000 fully and conditionally enrolled members at the end of Demonstration Year One, to approximately 416,000 fully and conditionally enrolled members at the end of Demonstration Year Two, to approximately 423,000 fully and conditionally enrolled members at the end of Demonstration Year Three. HIP 2.0 also continues to be cost effective, and has met budget neutrality requirements for the third year in a row.

The HIP 2.0 program builds on Indiana's history of consumer-driven health plans in both the private and Medicaid spaces. Indiana pioneered applying a consumer driven model to the Medicaid population with the original HIP program, which was passed in 2007 and began enrollment in 2008. Since then, HIP has been providing Hoosiers with opportunities to take charge of their own health care needs.

In 2015, Indiana was granted an 1115 demonstration waiver for HIP 2.0, which replaces the traditional Medicaid program for non-disabled adults and expands HIP to all individuals with incomes at or below 138 percent of the FPL. HIP 2.0 includes a number of program features that are designed to create a consumer driven health plan that influences member behavior to meet HIP 2.0's core objectives:

- Make Hoosiers healthier;
- Provide new coverage pathways for uninsured Hoosiers;
- Promote employer sponsored health insurance;
- Create incentives for Hoosiers to transition from public assistance to stable employment;
- Promote personal responsibility; and
- Engage participants in making health care decisions based on cost and quality.

Consumer driven behavior is incentivized by providing members with a Personal Wellness and Responsibility (POWER) Account, which functions similarly to a health savings account. POWER Accounts are funded in part by members' contributions and in balance by the State. Members are encouraged to make monthly contributions to their POWER Accounts.[1] These

[1] Members can also make an annual contribution to cover the PAC for the entire year. Native Americans and pregnant women are not eligible to pay PAC.

contributions — called POWER Account Contributions or "PAC" — are indexed to two percent of a member's household income, with a minimum contribution of $1 per month and a maximum contribution of $100 per month.[2] Members who make these monthly contributions are enrolled in HIP Plus, a plan with enhanced benefits, including dental and vision coverage, that does not require co-payments for services.[3] Members who do not make these contributions within 60 days are, depending on the member's income, either transitioned into a more limited benefit plan if the member's income is at or below 100 percent of FPL – HIP Basic – or not enrolled in or disenrolled from coverage if the member's income is above 100 percent of the FPL. HIP Basic maintains essential services but reduces access to expanded benefits and requires co-payments for most services.

HIP 2.0 also maintains a number of special program activities designed to encourage members to make responsible use of health care services and transition away from public assistance. HIP 2.0 introduces a graduated co-payment for non-emergent use of emergency room (ER) services. Members are required to make a co-payment of $8 for their first non-emergent ER visit and $25 for each subsequent non-emergent ER visit.[4] Finally, HIP 2.0 includes Gateway to Work (GTW), which refers HIP participants to the State's workforce training programs and connects members to potential employers.

Program Accomplishments

HIP 2.0 showed favorable results in program metrics during Demonstration Year Three. A summary of key program accomplishments is presented below.

Enrollment

- There were 422,723 conditionally and fully enrolled individuals in HIP 2.0 as of January 31, 2018, the end of Demonstration Year Three. This included 403,075 fully enrolled members, which is 1,277 more than were enrolled at the end of Demonstration Year Two. There were 556,325 unique individuals who were ever-enrolled in HIP 2.0 during Demonstration Year Three.
- There was a 3.3 percent decrease in fully enrolled Basic members and a 2.3 percent increase in fully enrolled Plus members from the end of Demonstration Year Two to the end of Demonstration Year Three.

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[2] Per federal regulation 42 CFR 447.78, HIP members are not allowed to pay more than five percent of their household income in a given benefit quarter towards HIP cost sharing requirements. This limit is often referred to as the "5 percent threshold" and includes all payments by the member or his/her family members for the following: Monthly contributions, Co-pays, and Children's Health Insurance Program (CHIP) premiums. HIP Plus members who meet the threshold on a quarterly basis have a PAC amount of $1 (the minimum) for the remainder of the quarter.

[3] Plus members are not required to make co-payments for services *except* for non-emergency use of the emergency room.

[4] Whether or not a visit is deemed non-emergent is initially determined by the provider at the place of service. Visits are evaluated according to the *prudent layperson standard*, which is defined as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part." From 42 U.S.C. § 1395dd (e) (1), see Indiana Health Coverage Programs Provider Reference Manual: Emergency Services (February 13, 2017).

Affordability

- 86.4 percent of the fully enrolled HIP 2.0 members had incomes at or below the FPL at the end of Demonstration Year Three.
- 54.5 percent of members with incomes at or below the FPL were enrolled in HIP Plus at the end of Demonstration Year Three.[5]
- Only 2.5 percent of fully-enrolled members received assistance making their PAC from an employer or non-profit organization.

Emergency Room Utilization

- Around 24 percent of ER visits were deemed non-emergent. There was little variation in non-emergent use of the ER between HIP Basic, Plus, and State programs.

HIP Employer Link

- With the submission of the HIP Waiver Extension Application and Amendment, the State discontinued HIP Employer Link and stopped adding new members in July 2017. Remaining HIP Link members were transferred to HIP Plus effective January 1, 2018.

Gateway to Work

- FSSA received 5,113 calls from members expressing interest in participating in GTW program in Demonstration Year Three.

[5] This includes some special eligibility groups who are not required to make PAC.

1. Goal of Report

The goal of this report - ***Indiana HIP 2.0: Annual Report for Demonstration Year Three*** - is to provide a progress report for the HIP 2.0 activities conducted from February 1, 2017 through January 31, 2018, as required by the Centers for Medicare & Medicaid Services (CMS). This report focuses on operational, enrollment, and fiscal accomplishments for Demonstration Year Three and summarizes the four Quarterly Reports provided to CMS in this year.[6,7,8,9] The Special Terms and Conditions (STCs) for Indiana's 1115 demonstration require that Indiana provide an Annual Report for each Demonstration Year.

Overview of Annual Report

This report summarizes the Quarterly Reports developed for Demonstration Year Three, which illustrate the program's focus in the demonstration year. This includes data on operational efforts, as well as statistics on enrollment, POWER Account contributions, closures, eligibility processing, presumptive eligibility, and expenditures. In addition, this report compares data and reviews trends between Demonstration Years One, Two, and Three, as applicable.

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6 Healthy Indiana Plan 2.0 (June 30, 2017) Section 1115 Quarterly Report: Demonstration Year 3; Demonstration Quarter 1. Retrieved April 4, 2018 from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-qtrly-rpt-feb-apr-06302017.pdf

7 Healthy Indiana Plan 2.0 (October 1, 2017) Section 1115 Quarterly Report: Demonstration Year 3; Demonstration Quarter 2. Retrieved April 4, 2018 from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-qtrly-rpt-aug-oct-10012017.pdf

8 Healthy Indiana Plan 2.0 (December 31, 2017) Section 1115 Quarterly Report: Demonstration Year 3; Demonstration Quarter 3. Retrieved April 4, 2018 from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-qtrly-rpt-aug-oct-12312017.pdf

9 The Healthy Indiana Plan 2.0, Section 1115 Quarterly Report: Demonstration Year 3; Demonstration Quarter 4 Report has not been publicly released.

2. Program History

On January 27, 2015, CMS granted a waiver of requirements under Section 1902(a) of the Social Security Act (the Act) and approved the Healthy Indiana Plan (HIP) 2.0 1115(a) demonstration waiver. HIP 2.0 aims to cover non-disabled adults between the ages of 19 and 64 with income at or below 138 percent of the federal poverty level (FPL), as well as Section 1931 parents and caretaker relatives and low-income 19 and 20 year olds. The demonstration is statewide and is approved for a three-year period, beginning February 1, 2015 through January 31, 2018.

The demonstration provides Indiana's residents with health care coverage through a consumer directed model, which utilizes a high-deductible health plan paired with a Personal Wellness and Responsibility (POWER) Account, operating similarly to a health savings account (HSA). Under HIP 2.0, Indiana created new choices for low-income adults by creating the new HIP Plus and HIP Basic benefit packages. In addition, the demonstration gives Indiana the authority to require POWER Account contributions (PAC) for individuals with income above the FPL.

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

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

Over the three-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.

3. Program Overview

HIP 2.0, administered by Indiana's Family and Social Services Administration (FSSA), began accepting applications on January 27, 2015 for coverage beginning February 1, 2015. HIP 2.0 offers coverage through two plans – HIP Plus and HIP Basic – with different benefit packages and cost sharing arrangements to encourage members to take an active role in their personal health management.

HIP 2.0 provides coverage through a high deductible health plan, administered by a Managed Care Entity (MCE), paired with a POWER Account, which operates similarly to an HSA. Under HIP 2.0, members who consistently make required PAC are enrolled in HIP Plus – a plan that includes enhanced benefits such as dental and vision coverage.[10] Members with income under 100 percent of the FPL who do not make PAC are enrolled in the HIP Basic plan, a more limited benefit plan that does not include coverage for dental services, vision services, bariatric surgery, or temporomandibular joint (TMJ) treatment.

HIP Basic, unlike HIP Plus, requires co-payments for most services and is available to individuals with incomes less than or equal to 100 percent of the FPL. If an individual with income above 100 percent of the FPL never makes PAC, he/she is not enrolled in HIP 2.0. Individuals with income above 100 percent of the FPL who make at least one PAC, but subsequently stop making required PAC, are disenrolled and cannot re-enroll for six months.[11]

Both HIP Plus and HIP Basic members use their POWER Accounts to pay for covered services. POWER Accounts are funded up to a ceiling of $2,500. For members who make PAC (i.e., Plus members), this amount is a combination of member and State contributions. Members contribute two percent of their household income, with a minimum contribution of $1 per month and a maximum contribution of $100 per month, while the State contributes the difference. For members who do not make PAC, the POWER Account is funded in full by the State.

POWER Accounts are used to pay for the first $2,500 of covered services. Services thereafter are covered by the member's MCE. Members may rollover a portion of unused funds from the account (depending on how much the member contributed to the account) to the next benefit year to reduce future contributions. Plus members with leftover funds can double their reduction to future contributions by receiving preventive services recommended by their health plan. HIP Basic members with leftover funds who receive preventive services can reduce future contributions if they enroll in Plus in their next benefit year.

HIP 2.0 also maintains a traditional Medicaid benefits package, referred to as the "State plan," for some of HIP's more vulnerable populations, including members who are medically frail, Transitional Medical Assistance (TMA) participants, Section 1931 low-income parents and caretakers, and low-income 19-20 year olds. Members in the State plan are subject to the same cost-sharing incentives as Regular plan members (e.g., PAC is required to maintain Plus enrollment and Basic members pay co-payments for most services).[12] However, all State plan

[10] Native American and pregnant women are exempt from POWER Account contributions.

[11] Certain populations are exempt from disenrollment even if their income is above 100 percent of the FPL: medically frail and Transitional Medical Assistance (TMA) participants, and individuals experiencing a qualifying event.

[12] Pregnant women and Native Americans are exempt from cost-sharing.

members, regardless of whether they are enrolled in Basic or Plus, are eligible for enhanced coverage, including dental and vision benefits.

HIP Employer Link and Gateway to Work

In addition to expanding coverage and implementing a new cost-sharing structure, HIP 2.0 also introduced two new programs: HIP Employer Benefit Link, known as HIP Employer Link (formerly HIP Link), and Gateway to Work (GTW).

HIP Employer Link was an optional program for employed low-income Indiana residents with ESI. Employers who wanted to offer this option to their employees were required register and be approved as a qualifying HIP Employer Link organization. Employees who were eligible for HIP 2.0 and working for a participating employer had the option to elect HIP Employer Link or HIP 2.0 coverage. Participating individuals received a POWER Account valued at $4,000, which they used to pay for ESI premiums, deductibles, and co-payments, for example. In addition, participating employees contributed two percent of their household income to the cost of their HIP coverage, as in HIP Plus. With the submission of the HIP Waiver Extension Application and Amendment, the State discontinued HIP Employer Link and stopped adding new members in July 2017.

GTW is a free and voluntary program for eligible HIP members, which connects members with job training and job search resources. Members are referred to a State contractor that provides education and training services and helps connect HIP members to potential employers. They are offered a variety of services including an initial assessment of their skills and abilities to achieve their employment goals. In addition, members receive help with their job search as the program provides assistance completing job applications, creating resumes, practicing job interview skills, and researching job openings. GTW features tools to match participants' experience and skills with employers who have job openings. Non-participation in GTW does not affect HIP 2.0 coverage or benefits.

4. Summary of Demonstration Year Three Activities

This section summarizes key operational activities, associated challenges, and efforts to overcome those challenges that took place throughout Demonstration Year Three. It also includes a summary of HIP 2.0 program evaluation activities conducted during the demonstration year.

New Managed Care Entity and Selection Period

The State welcomed a new MCE, CareSource, to the program, which began serving HIP 2.0 members on February 1, 2017. All three previously participating HIP 2.0 MCEs – Anthem, MDwise, and MHS – remained with the program.

The first annual HIP MCE selection period ran from November 1, 2017 through December 15, 2017, allowing HIP members to pick their MCE for the next calendar year. This practice aligns with commercial markets, where plan selection is done on an annual basis. Members could call the State's enrollment broker to change their MCE if desired. Any member who did not elect to change MCEs was re-enrolled with their current MCE for 2018. A new plan was selected by 3,769 members.

Transition to New MMIS

On February 13, 2017, the State's new Medicaid Management Information System (*Core*MMIS) went live replacing a legacy system that had been in operation for more than 20 years. This transition required substantial collaboration between the State, the eligibility system, MMIS vendor, and the contracted MCEs. Ensuring continuity of care to members with minimal disruption to providers was a top priority for all parties. The State simultaneously implemented a new provider health care portal, which provides greater online functionality for enrolled providers.

To help ensure a smooth transition to *Core*MMIS, the State established daily calls for different stakeholder groups to allow for open communication and real time problem solving. Call series were established with State staff, MCEs, providers, and other key stakeholders. These daily calls allowed for different stakeholder groups to report issues or concerns and allowed the MMIS vendor to address any questions that arose. The State monitored progress through dashboards and multiple reports to track the implementation.

HIP 2.0 Section 1115 Demonstration Waiver Application and Amendment

At the end of Demonstration Year Two, on January 31, 2017, the State submitted an application to renew the HIP 2.0 1115 demonstration waiver. On July 20, 2017, the State submitted an amendment to the application, which included a request to expand GTW participation as a requirement for members in the HIP program, end the HIP Employer Link program, change the POWER Account contribution amounts, and several technical revisions.

The amendment included an outline of the proposed GTW expansion, as well as a request to delay implementation until 2019 to allow for program development throughout 2018. The GTW proposal included several groups of individuals who would not be required to participate, such as those who are medically frail, pregnant, or the primary caretaker for a young child or elderly

non-dependent. The proposal outlined some of the activities that would be counted as participation, including work, school and volunteer activities.

In addition to the required public notice and hearing opportunities, executive staff from FSSA traveled across the state to meet with stakeholders, which allowed FSSA to share plans outlined in the amendment, hear stakeholder concerns and suggestions, and answer questions regarding the Waiver Extension Application and Amendment. This allowed the State to gain valuable insight and several ideas shared in these meetings were incorporated into the final amendment request.

Operational activities in Demonstration Year Three focused on developing business and system design changes to incorporate new HIP program design elements that were requested in the HIP waiver extension application and amendment. While awaiting CMS approval, the State moved forward with system design to be prepared for implementation of changes in early 2018.

In November 2017, on-site visits were conducted with each of the four MCEs to assess readiness for new operational policies, which became effective in January and February 2018. State staff attended meetings with each MCE to ensure that operational changes were in place and compliant with the updated policy.

On December 28, 2017, a public hearing was held regarding the proposed changes to the HIP Rule found in Indiana Administrative Code. The rule Amends 405 IAC 10 to align with the administrative simplifications and changes requested through the waiver extension.

The Section 1115 demonstration was approved on February 1, 2018, and is effective February 1, 2018 through December 31, 2020.

Employer Link

With the submission of the HIP Waiver Extension Application and Amendment, the State included the decision to discontinue the HIP Employer Link program. The State worked diligently to recruit employers into the program, but were not able to attain the level of enrollment that was anticipated.

The HIP Employer Link Team submitted phase-out plans to CMS and stopped adding new employers or members into the program in July 2017. All members in the program at the end of December 2017 were automatically transferred to HIP Plus. The HIP Employer Link team performed outreach to enrolled members and employers to assure them that there would be no gap in coverage. The program was phased-out on December 31, 2017 and all members were directly opened in HIP Plus as of January 1, 2018.

Annual Public Forum

On August 31, 2017, the State held the required annual public forum for the HIP 2.0 program. The Medicaid Advisory Committee was again used as the venue for this public forum. Medicaid Director Allison Taylor, then Interim Director, provided an update on the program, highlighting overall program enrollment, presumptive eligibility and some key utilization statistics for non-emergent ER use and rates of preventive treatment.

Attendees at the public forum represented a variety of organizations from professional associations, community health providers, advocacy organizations and HIP 2.0 MCEs. Organizations included the Indiana Primary Health Care Association, Indiana Hospital Association, Indiana Minority Health Coalition, Indiana University Health, St. Vincent Health, Covering Kids and Families and Anthem. After the State presentation, approximately 10 individuals provided public comment. Comments ranged from individual member anecdotes and testimonials to the impact of HIP 2.0 on a particular community or population.

The vast majority of comments and testimony were highly favorable to the HIP 2.0 program. Speakers expressed their continued support of HIP 2.0 and were positive about continuing their relationships with the program, the State, and stakeholder groups moving forward. Several speakers mentioned their organizational goals to continue to identify and enroll HIP eligible individuals moving toward full enrollment. To that end, several speakers encouraged the continuation and even expansion of data sharing to help meet this goal. One speaker specifically addressed the challenge of overcoming the stigma of Medicaid and convincing people that this program was something they deserved to participate in and benefit from. He praised the unique HIP marketing programs that help elevate the program as a "public commodity" and not a program to be stigmatized.

HIP 2.0 Program Evaluations

As required under the STCs, Indiana must conduct a number of program and policy evaluations throughout the course of the three-year demonstration. Brief status updates on evaluations conducted in Demonstration Year Three are included here and in *5. Program Metrics*.

Emergency Room Co-payment Evaluation

As required by the STCs, Indiana submitted an Emergency Room Co-payment Protocol on May 1, 2015, which CMS approved on February 4, 2016. On September 16, 2016, CMS extended the ER graduated co-payment pilot program to operate through the end of the HIP 2.0 demonstration, January 31, 2018. The final independent assessment was based on data from January 1, 2016 – December 31, 2016 and was submitted to CMS on October 4, 2017.

POWER Account Contributions and Co-payments Evaluation

The STCs require that Indiana conduct an independent evaluation of the PAC policy to assess 1) the affordability of PAC; and 2) the effect of the disenrollment-for-non-payment-of-PAC policy on enrollment. The assessment was based on data from the start of HIP 2.0 (February 2015) through November 30, 2016 and was submitted to CMS on March 31, 2017.

Provider Payment Rates

The STCs require the State to submit an annual Provider Payment Rates report by December 30 in Demonstration Year One and by September 30 of each subsequent Demonstration Year. The report 1) evaluates whether the differential in MCE provider payment rates between Hoosier Healthwise (HHW) and HIP 2.0 has resulted in unequal access to health care services; 2) describes corrective actions implemented if evaluation shows access between programs is not equal; and 3) describes any upcoming changes to the provider payment rates in either the HHW and/or HIP 2.0 programs. Indiana submitted the Demonstration Year Three report on September 25, 2017.

5. Program Metrics

HIP 2.0 Enrollment by Income Level and Benefit Plan

Table 1 details HIP 2.0 enrollment, by FPL, at the end of Demonstration Year Three. **Table 2** outlines enrollment at the end of Demonstration Year Two. **Table 3** details enrollment at the end of Demonstration Year One.

Table 1: Enrollment at the End of Demonstration Year Three

Percent FPL	Basic				Plus				Total HIP Enrollment
	State	Regular	Basic Total	Percentage of Total HIP Enrollment in Income Level	State	Regular	Plus Total	Percentage of Total HIP Enrollment in Income Level	
<23%	51,985	36,268	88,253	38.8%	73,548	65,781	139,329	61.2%	**227,582**
23-50%	3,250	8,585	11,835	36.3%	5,621	15,165	20,786	63.7%	**32,621**
51-75%	3,728	11,968	15,696	36.2%	6,711	20,994	27,705	63.8%	**43,401**
76-100%	2,955	9,797	12,752	28.7%	7,337	24,402	31,739	71.3%	**44,491**
Total <101%	**61,918**	**66,618**	**128,536**	**36.9%**	**93,217**	**126,342**	**219,559**	**63.1%**	**348,095**
101-138%	2,019	3,723	5,742	12.9%	9,034	29,764	38,798	87.1%	**44,540**
>138%	1,692	31	1,723	39.4%	2,429	218	2,647	60.6%	**4,370**
Unknown	472	1,292	1,764	29.1%	1,068	3,238	4,306	70.9%	**6,070**
Grand Total	**66,101**	**71,664**	**137,765**	**34.2%**	**105,748**	**159,562**	**265,310**	**65.8%**	**403,075**

Source: SSDW/EDW: February 1, 2017 – January 31, 2018. Data received on March 16, 2018.
Note: Individuals over 138 percent of the FPL may continue in the program due to TMA or appeal status.

Table 2: Enrollment at the End of Demonstration Year Two

Percent FPL	Basic				Plus				Total HIP Enrollment
	State	Regular	Basic Total	Percentage of Total HIP Enrollment in Income Level	State	Regular	Plus Total	Percentage of Total HIP Enrollment in Income Level	
<23%	52,547	36,257	88,804	39.5%	69,675	66,387	136,062	60.5%	**224,866**
23-50%	3,299	8,484	11,783	38.7%	4,963	13,678	18,641	61.3%	**30,424**
51-75%	3,736	12,534	16,270	38.5%	5,877	20,075	25,952	61.5%	**42,222**
76-100%	3,324	13,406	16,730	36.0%	5,925	23,800	29,725	64.0%	**46,455**
Total <101%	**62,906**	**70,681**	**133,587**	**38.8%**	**86,440**	**123,940**	**210,380**	**61.2%**	**343,967**
101-138%	3,142	4,174	7,316	13.5%	9,925	36,806	46,731	86.5%	**54,047**
>138%	32	38	70	25.6%	63	140	203	74.4%	**273**
>138% (TMA)	1,528	0	1,528	43.5%	1,983	0	1,983	56.5%	**3,511**
Grand Total	**67,608**	**74,893**	**142,501**	**35.5%**	**98,411**	**160,886**	**259,297**	**64.5%**	**401,798**

Source: SSDW/EDW: February 1, 2016 – January 31, 2017.
Note: Individuals over 138 percent of the FPL may continue in the program due to TMA or appeal status.

Table 3: Enrollment at the End of Demonstration Year One

Percent FPL	Basic				Plus				Total HIP Enrollment
	State	Regular	Basic Total	Percentage of Total HIP Enrollment in Income Level	State	Regular	Plus Total	Percentage of Total HIP Enrollment in Income Level	
<23%	53061	25,788	78,849	42.1%	58,057	50,584	108,641	57.9%	**187,490**
23%-50%	2,704	6,949	9,653	34.8%	4,128	13,920	18,048	65.2%	**27,701**
51%-75%	2,639	10,283	12,922	34.2%	4,540	20,330	24,870	65.8%	**37,792**
76%-100%	2,262	10,813	13,075	31.7%	4,490	23,627	28,117	68.3%	**41,192**
Total <101%	**60,666**	**53,833**	**114,499**	**38.9%**	**71,215**	**108,461**	**179,676**	**61.1%**	**294,175**
101%-138%	2,028	3,318	5,346	12.8%	6,265	30,318	36,583	87.2%	**41,929**
>138%	216	743	959	19.6%	583	3,362	3,945	80.4%	**4,904**
>138% (TMA)	1,047	0	1,047	39.7%	1,592	0	1,592	60.3%	**2,639**
Grand Total	**63,957**	**57,894**	**121,851**	**35.5%**	**79,655**	**142,141**	**221,796**	**64.5%**	**343,647**

Source: SSDW/EDW: February 1, 2015 – January 31, 2016.
Note: Individuals over 138 percent of the FPL may continue in the program due to TMA or appeal status.

There were 403,075 fully enrolled HIP members as of January 31, 2018. This data does not include conditionally eligible Hoosiers who have not made a PAC and who will move into HIP Plus if they do make PAC or move into HIP Basic if they do not and are eligible. The total of fully and conditionally enrolled Hoosiers at the end of the Demonstration Year Three was 422,723. There were 556,325 unique individuals who were ever-enrolled in HIP 2.0 throughout Demonstration Year Three.[13]

At the end of Demonstration Year Three, 265,310 members (65.8 percent) were enrolled in HIP Plus and 82.8 percent of these Plus recipients were members with incomes less than or equal to 100 percent of the FPL. As in Demonstration Years One and Two, the majority (61.2 percent) of the lowest income members under 23 percent of the FPL are enrolled in HIP Plus as opposed to Basic (38.8 percent). Of all HIP members with incomes equal to or less than 100 percent of the FPL, 219,559 members (63.1 percent) are enrolled in HIP Plus.

Of total HIP enrollment at the end of Demonstration Year Three:

- 86.4 percent are members with incomes less than or equal to 100 percent of the FPL (348,095 members)
- 56.5 percent are members with incomes less than 23 percent of the FPL (227,582 members)
- 54.5 percent are members with incomes less than or equal to 100 percent of the FPL who are enrolled in HIP Plus (219,559 members)

Total enrollment across the three demonstration years is shown in **Table 4**. Total enrollment increased by 16.9 percent from Demonstration Year One to Demonstration Year Two (58,151

[13] Source: SSDW/EDW: February 1, 2017 – January 31, 2018. Data received on March 8, 2018.

members) and by 0.3 percent from Demonstration Year Two to Demonstration Year Three (1,277 members).

Table 4: Grand Total HIP 2.0 Enrollment in Demonstration Years One, Two, and Three

	Basic				Plus				Total
	State	Regular	Basic Total	Percentage of Total HIP Enrollment	State	Regular	Plus Total	Percentage of Total HIP Enrollment	
Grand Total HIP 2.0 Enrollment - Demonstration Year One	63,957	57,894	121,851	35.5%	79,655	142,141	221,796	64.5%	343,647
Grand Total HIP 2.0 Enrollment - Demonstration Year Two	67,608	74,893	142,501	35.5%	98,411	160,886	259,297	64.5%	401,798
Grand Total HIP 2.0 Enrollment - Demonstration Year Three	66,101	71,664	137,765	34.2%	105,748	159,562	265,310	65.8%	403,075

Source: SSDW/EDW: February 1, 2015 – January 31, 2018.

Between Demonstration Years Two and Three, Basic enrollment decreased by 3.3 percent (4,736 members) and Plus enrollment increased by 2.3 percent (6,013 members). The proportion of members enrolled in Basic and Plus was the same in Demonstration Years One and Two, 35.5 percent and 64.5 percent, respectively. In Demonstration Year Three, the proportion was 34.2 percent enrolled in Basic and 65.8 percent enrolled in Plus.

Native American Enrollment

Native American members, who are exempt from cost-sharing and PAC, have the option to opt-out of a HIP 2.0 managed care plan and enroll in a fee-for-service program. Enrollment figures for Demonstration Year Three are included in **Table 5**, and are consistent across Demonstration Years. In Demonstration Year One, 88 Native Americans enrolled in HIP Plus, 61 in the State Plan, and 25 opted out. This was comparable to enrollment in Demonstration Year Two when 189 Native Americans enrolled in HIP Plus, 81 enrolled in the State Plan, and 38 opted out. In Demonstration Year Three, 119 Native Americans enrolled in HIP Plus, 94 enrolled in the State Plan, and 30 opted out.

Table 5: Native American Enrollment and Opt Out at the End of Demonstration Year Three

	Plus	State	Total who Opted Out
Total Enrolled	119	94	30

Source: SSDW/EDW: February 1, 2017 – January 31, 2018. Data received on March 16, 2018.

POWER Account Contributions from Third Parties

Tables 6 and **7** outline the total number of members who received help paying PAC from either an employer or a participating non-profit organization during Demonstration Year Three. In Demonstration Year Three, 603 employers made a contribution on behalf of 864 members, and 483 non-profit organizations assisted with POWER Account contributions for 9,381 members.

Table 6: Employer POWER Account Contributions during Demonstration Year Three

	Total
Number of Employers Participating	603
Number of Members on Whose Behalf an Employer Makes a Contribution	864
Total Amount of Employer Contributions	$36,913.53
Average Amount of Employer Contributions	$61.22

Source: Office of Medicaid Policy and Planning (OMPP) Quality and Reporting: February 1, 2017 – January 31, 2018. Data received on March 2, 2018.

Table 7: Non-Profit Organization POWER Account Contributions during Demonstration Year Three

	Total
Number of Non-Profit Organizations Participating	483
Number of Members on Whose Behalf a Non-Profit Makes a Contribution	9,381
Total Amount of Non-Profit Contributions	$131,914.98
Average Amount of Non-Profit Contributions	$14.06

Source: OMPP Quality and Reporting: February 1, 2017 – January 31, 2018. Data received on March 2, 2018.

Between Demonstration Year One and Demonstration Year Two, there were decreases in both the number of employers participating and number of members receiving financial support making their PAC from employers. Between Demonstration Year Two and Demonstration Year Three, there was an increase in POWER account contributions from third parties:

- 124 employers participated in Demonstration Year One, 45 in Demonstration Year Two, and 603 in Demonstration Year Three.
- 131 members received financial support from their employers in Demonstration Year One, 70 in Demonstration Year Two, and 864 in Demonstration Year Three. However, in all three years less than one percent of members making PAC received help from their employers.
- There was an increase in the number of non-profits participating from 75 in Demonstration Year One, to 180 in Demonstration Year Two, to 483 in Demonstration Year Three.
- This increased participation by non-profits amounted to 9,381 members in Demonstration Year Three, up from 7,953 members in Demonstration Year Two. In Demonstration Year Three, 3.5 percent of members making PAC received financial support from a non-profit organization compared to three percent in Demonstration Year Two and less than one percent (0.5 percent) in Demonstration Year One.

Disenrollment: Closures & Reasons

Table 8 identifies where those individuals transitioned after closure, either to another Medicaid category or out of the Medicaid program altogether.

Table 8: HIP 2.0 Closures in Demonstration Year Three

Closures By HIP Category	Moved to Another Medicaid Category (Non HIP)	Moved Out of the Medicaid Program
Regular Plus	6,465	50,014
Regular Basic	3,502	43,731
State Plus	7,768	22,256
State Basic	3,004	22,201
Other	175	844
Total	**20,914**	**139,046**
Grand Total	**210,316**	

Source: SSDW/EDW: February 1, 2017 – January 31, 2018. Data received on March 6, 2018.

In Demonstration Year Three, 11,793 HIP 2.0 members with incomes above 100 percent of the FPL were disenrolled from the program for failing to make PAC.[14] Only members with incomes above 100 percent of the FPL can be disenrolled for failure to make PAC. These closures represent 18.0 percent of all HIP members with income above 100 percent of the FPL who were ever-enrolled in Plus during Demonstration Year Three.[15] This is a decrease from 20.4 percent (12,156) in Demonstration Year Two[16] and an increase from 6.3 percent (4,486) in Demonstration Year One.[17] During Demonstration Year Three**,** 210,316 individuals left the HIP program.

The majority of individuals who left HIP 2.0 (139,046 individuals, 66.1 percent), left the Medicaid program altogether. The remaining 20,914 members moved into another Medicaid category, which means they were still receiving health care services provided by the State. These counts represent closures and do not account for members who may have come back to the State and been reopened. Upon termination, individuals can have their eligibility restored if they return their paperwork within 90 days of the termination date.

Table 9 shows the five most common reasons for all HIP 2.0 closures; other reasons that members' accounts may have been closed in Demonstration Year Three are not reported here.

[14] Source: SSDW/EDW: February 1, 2017 – January 31, 2018. Data received on March 6, 2018.
[15] Source: SSDW/EDW: February 1, 2017 – January 31, 2018. Data received on March 8, 2018.
[16] Healthy Indiana Plan Demonstration Section 1115 Annual Report Demonstration Year 2. (April 28, 2017).
[17] Healthy Indiana Plan Demonstration Annual Report Demonstration Year 1. (April 29, 2016). Retrieved April 5, 2018 from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-annl-rpt-feb-jan-2016-04292016.pdf

Table 9: All HIP 2.0 Closures – Top 5 Reasons in Demonstration Year Three

Number of Closures	Reason for Closure
50,515	Individual failed to comply with or complete redetermination
27,204	Income exceeds program eligibility standards
15,347	Failure to provide all required information
13,203	Receipt of or increase in earned or self-employment income
11,795	Failure to make payment to Power Account

Source: SSDW/EDW: February 1, 2017 – January 31, 2018. Data received on March 6, 2018.

The most common reason for HIP 2.0 closures in Demonstration Year Three was failure to comply with or complete a redetermination. The second most common reason was that the individual's income exceeded the program eligibility threshold. The same two reasons were the most common in Demonstration Year Two and in Demonstration Year One, as well; however, the frequency ranking of the two was reversed in Year One.

When the closure reasons are broken out for those above and below 100 percent of the FPL, there are some differences. **Table 10** shows that the most common closure reason for members at or below 100 percent of the FPL was failure to comply with or complete redetermination. As demonstrated in **Table 11,** the most common closure reason for members above 100 percent of the FPL was that their income exceeds program eligibility standards.

Table 10: HIP 2.0 Closures 100% FPL and Under – Top 5 Reasons in Demonstration Year Three

Number of Closures	Reason for Closure
45,409	Individual failed to comply with or complete redetermination
12,505	Failure to provide all required information
10,374	Not an Indiana resident
8,163	Income exceeds program eligibility standards
6,877	Closure of a system determined close (no notice)

Source: SSDW/EDW: February 1, 2017 – January 31, 2018. Data received on March 6, 2018.

Table 11: HIP 2.0 Closures 100% FPL and Above – Top 5 Reasons in Demonstration Year Three

Number of Closures	Reason for Closure
19,041	Income exceeds program eligibility standards
11,793	Failure to make payment to Power Account
10,717	Receipt of or increase in earned or self-employment income
5,106	Individual failed to comply with or complete redetermination
2,842	Failure to provide all required information

Source: SSDW/EDW: February 1, 2017 – January 31, 2018. Data received on March 6, 2018.

Emergency Room Utilization

Table 12 shows the number of emergency room visits in calendar year 2017. This data is collected from the MCEs on a paid date basis, not an incurred date basis, which means that this

data reflects claims paid during the experience period with a 90 day claims lag time. Therefore, the reporting period for this data is January 1 – December 31, 2017, but the experience period is from October 1, 2016 – September 30, 2017.

Table 12: Emergency Room Utilization, by Plan Type, in Calendar Year 2017

Category	Number of Annual ER Visits	Number of ER Visits Deemed Emergent	Number of ER 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	144,685	108,000	36,685	57	74.6%	25.4%
Basic	79,673	60,671	19,002	84	76.2%	23.8%
State Plan	248,563	191,339	57,214	106	77.0%	23.0%

Source: OMPP Quality and Reporting: January 1 – December 31, 2017. Data received on March 2, 2018.

The total number of ER visits during the reporting period was 472,921. Of these, 112,901 (23.9 percent) were deemed non-emergent, which is similar to 23.0 percent in Demonstration Year Two. There is little variation between HIP eligibility categories.

Eligibility Determinations and Processing

Table 13 shows the typical processing time for each aid category by number of days from application to authorization and then from authorization to full eligibility. It also presents the current number of pending applications at the end of Demonstration Year Three.

Table 13: Eligibility Processing in Demonstration Year Three

Case Type	Average Number of Days From Application to Authorization	Average Number of Days from HIP Authorization to Full Eligibility	Number of Pending HIP Applications
Regular Plus	24	14	23,924
Regular Basic	23	11	1,684
State Plan Plus	22	18	5,200
State Plan Basic	21	25	56
HIP Employer Link	23	1	0

Source: Indiana Client Eligibility System (ICES): February 1, 2017 – January 31, 2018. Data received on March 8, 2018.
Note: In addition, there are 1,035 Pending applications for HIP Maternity ('MAMA') category (with application date between January 16, 2018 and January 31, 2018).

The number of days from application to authorization remained relatively stable across all three Demonstration Years. In Demonstration Year Three, it ranged from 21 days for State Basic to 24 days Regular Plus. During Demonstration Year Two it ranged from 20 days for State Plus to 23 days for Regular Basic.[18] In Demonstration Year One, it ranged from 20 days for State Plan Plus

[18] Healthy Indiana Plan Demonstration Section 1115 Annual Report Demonstration Year 2. (April 28, 2017).

to 31 days for State Basic.[19] The largest drop was seen for State Basic from 31 days in Demonstration Year One to 21 days in Demonstration Year Three. These processing times are within the current regulations, which state that eligibility determinations may not exceed 45 days for non-disabled Medicaid applicants.

There were also decreases in the number of days from HIP authorization to full eligibility. During Demonstration Year Three, the average number of days from HIP authorization to full eligibility ranged from one day for HIP Employer Link to 25 days for the State Basic plan. This demonstrates an improvement over Demonstration Year One, during which the average number of days from HIP authorization to full eligibility ranged from 16 days for the State Basic plan to 34 days for the Regular Basic plan.[20] There was an increase between Demonstration Year Two and Demonstration Year Three for State Basic, from 17 to 25 days.[21]

Table 14 shows the total number of HIP 2.0 applications that the State received during each quarter of Demonstration Year Three. It also includes the number of applications received via referrals from the FFM. A total of 346,421 individuals applied for HIP 2.0 coverage in Demonstration Year Three; down from 610,562 in Demonstration Year Two.[22]

Table 14: HIP 2.0 Applications Received in Demonstration Year Three

Time Period	Number of Applications Received	Number of Applications Received from Federally Facilitated Marketplace
First Quarter: February 1, 2017 – April 30, 2017	81,407	5,284
Second Quarter: May 1, 2017 – July 31, 2017	81,616	4,000
Third Quarter: August 1, 2017 – October 31, 2017	81,376	3,858
Fourth Quarter: November 1, 2017 – January 31, 2018	102,022	21,806
Demonstration Year 3: February 1, 2017 – January 31, 2018	**346,421**	**34,948**

Source: Indiana Client Eligibility System (ICES): February 1, 2017 – January 31, 2018. Data received on March 6, 2018.

HIP Employer Link

In Demonstration Year Three, the State decided to end the HIP Employer Link program. Over the course of HIP 2.0, the State worked to recruit employers into the program but were not able to attain the level of enrollment that was anticipated. The program stopped adding new employer or employee members in July 2017 and was completed phased-out as of December 31, 2017, when all members were enrolled in HIP Plus beginning January 1, 2018. **Table 15** shows program details for Demonstration Year Three as well as for the full program timeframe, June 1, 2015 – December 31, 2017.

[19] Healthy Indiana Plan Demonstration Annual Report Demonstration Year 1. (April 29, 2016). Retrieved April 5, 2018 from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-annl-rpt-feb-jan-2016-04292016.pdf

[20] *Ibid.*

[21] Healthy Indiana Plan Demonstration Section 1115 Annual Report Demonstration Year 2. (April 28, 2017).

[22] *Ibid.*

Table 15: HIP Employer Link Enrollment

	Demonstration Year Three February 1, 2017 – December 31, 2017	Program to Date June 1, 2015 – December 31, 2017
Employer enrollment	17	87
Employee enrollment	78	92
Grievances	0	0
Participants moving from ESI to HIP Plus	54	67

Source: SSDW/EDW. Data received on March 8, 2018.

As shown in **Table 16**, 85 percent of HIP Employer Link-participating employees had POWER Account balances of $0 - $1,000 as the program ended.

Table 16: HIP Employer Link POWER Account Balances

POWER Account Balance	Number of Employees
$4,000 – $3,000	1
$3,000 – $2,000	1
$2,000 – $1,000	10
$1,000 – $0	66

Source: DXC HIP Employer Link: February 1, 2017 – January 31, 2018. Data received on March 6, 2018.
Note: All account balances start at $4,000.

Presumptive Eligibility

The Presumptive Eligibility (PE) program continues to be active in Indiana with a total of 103,561 applications submitted in Demonstration Year Three and 81.9 percent of those applications approved for PE coverage, as shown in **Table 17**. This is down slightly from the 133,295 applications submitted for PE coverage in Demonstration Year Two; however, the percent of applications approved is up from 73.1 percent in Demonstration Year Two.

Table 17: Presumptive Eligibility Applications and Performance

Provider Type	PE Applications Submitted	PE Applications Approved	% PE Applications Approved	IHCP Applications Submitted	IHCP Applications Approved*	% IHCP Applications Approved**
Acute Care Hospital	82,764	67,321	81.3%	52,096	22,855	43.9%
Community Mental Health Center	6,124	4,934	80.6%	3,323	1,420	42.7%
FQHC	11,631	10,108	86.9%	8,077	4,470	55.3%
Psychiatric Hospital	2,646	2,157	81.5%	1,596	655	41.0%
Rural Health Clinic	229	173	75.5%	138	75	54.3%
County Health Department	167	141	84.4%	126	97	77.0%
Grand Total	**103,561**	**84,834**	**81.9%**	**65,793**	**20,065**	**30.5%**

Source: EDW: February 1, 2017 – January 31, 2018. Data received on March 8, 2018.
Notes: * Applications submitted in the demonstration year 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.

Of the 84,834 PE approved applications, 65,793 (77.6 percent) resulted in an Indiana Health Coverage Programs (IHCP) application for full coverage. The percent of PE recipients that are being approved for full IHCP benefits remains low overall: 30.5 percent in Demonstration Year Three, compared to 35.6 percent in Demonstration Year Two,[23] and 31.5 percent in Demonstration Year One.[24] The top denial reasons include failure to cooperate in verifying income, income exceeding program eligibility standards, and failure to verify Indiana residency. Indiana will continue monitoring these reasons for any changes.

Table 18 provides detail about the number of Qualified Providers (QP) completing HPE/PE applications. Column (a) depicts the number of provider entities that are signed up to perform QP activities, broken out by provider type. Column (b) shows the number of physical locations where the entity operates and carries out QP activities. Column (c) shows the total number of provider entities that are eligible to sign up to be a QP. At the end of Demonstration Year Three, 216 providers (65.7 percent of eligible entities) were signed up as a QP. The majority of QPs are acute care hospitals (54.2 percent), accounting for almost all potential acute care hospital providers (117 out of 121).

[23] Healthy Indiana Plan Demonstration Section 1115 Annual Report Demonstration Year 2. (April 28, 2017).
[24] Healthy Indiana Plan Demonstration Annual Report Demonstration Year 1. (April 29, 2016). Retrieved April 5, 2018 from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-annl-rpt-feb-jan-2016-04292016.pdf

Table 18: Presumptive Eligibility Qualified Providers

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	119	121
Community Mental Health Center	21	55	25
FQHC	26	152	26
Psychiatric Hospital	20	20	41
Rural Health Clinic	22	22	67
County Health Department	10	10	49
Grand Total	**216**	**378**	**329**

Source: Indiana AIM: February 1, 2017 – January 31, 2018. Data received on March 8, 2018.

When individuals work with a QP and are determined eligible, they receive a determination letter that serves as their proof of their PE coverage. Once the member is assigned an MCE, they are sent an invoice and may submit a Fast Track payment,[25] which would be applied to their future coverage, if approved for full IHCP benefits.

Annual Presumptive Eligibility Effectiveness Survey

Indiana conducted a brief survey of Presumptive Eligibility providers in January and February of 2018 (survey can be found in **Appendix A**). Of the 96 providers surveyed, 91 reported being eligible to make PE determinations. Of the 96 providers surveyed, approximately 95 percent reported that the PE process is either very effective or somewhat effective at eliminating gaps in health care coverage. Eighty-four percent reported that they track whether members complete a full Medicaid application and approximately 74 percent report that they believed the success rate of their PE members getting full Medicaid coverage is over 50 percent.

Fast Track Payments

Table 19 shows the number of unique Fast Track payments, by month, for Demonstration Year Three. Fewer Fast Track payments were made each month in Demonstration Year Three than in Demonstration Year Two, and the total is down from 70,174 in Demonstration Year Two.[26]

[25] Fast Track allows individuals to make a $10 payment at the time of application, after applying, or while the application is being processed, as a mechanism to expedite the start of HIP Plus coverage. The $10 payment is applied towards the member's first PAC. If the individual is not found eligible for HIP, the State will refund the payment. If the member's PAC amount is less than $10 per month, the $10 payment is applied to their first coverage month, with the remaining amount applied to future months.

[26] Healthy Indiana Plan Demonstration Section 1115 Annual Report Demonstration Year 2. (April 28, 2017).

Table 19: Fast Track Payments

Month Payment was Made	Fast Track Payment Counts
February 2017	4,394
March 2017	4,450
April 2017	3,002
May 2017	2,783
June 2017	2,766
July 2017	4,411
August 2017	4,675
September 2017	4,878
October 2017	4,702
November 2017	5,093
December 2017	5,322
January 2018	5,913
Total	**52,389**

Source: MCE data: February 1, 2017 – January 31, 2018. Data received on March 14, 2018.

Gateway to Work (GTW)

Detailed in **Table 20,** as of January 31, 2018, a total of 573,768 letters have been mailed to inform HIP members of the GTW program. There have been over 5,000 calls received, of which 43 calls were interest calls from HIP 2.0 members. A total of 52 GTW orientations were scheduled, with a total of 14 orientations attended.

Table 20: Gateway to Work Metrics for Demonstration Year Three

Metric	Count
Number of Letters Sent to HIP 2.0 Members	573,768
Number of Calls Received	5,113
Number of Interest Calls Received	43
Number of Gateway to Work Orientations Scheduled	52
Number of Gateway to Work Orientations Attended	14

Source: OMPP Quality and Reporting: February 1, 2017 – January 31, 2018. Data received on March 14, 2018.

HIP 2.0 Program Evaluations

Federal Evaluation of Waiver

The CMS hired Social and Scientific Systems Inc. as an evaluation contractor for the ongoing Federal evaluation of HIP 2.0. The evaluation will include a qualitative analysis, beneficiary surveys with descriptive analyses, and an impact analysis to accomplish four goals: 1) understand operational costs associated with developing and executing HIP 2.0; 2) estimate HIP 2.0's impact on health insurance coverage, access to care, quality, affordability, and health behavior; 3) document beneficiary understanding of key HIP 2.0 program features; and 4)

provide information that can inform CMS, Indiana, and other interested parties on how to improve Medicaid programs. The evaluation began in December 2016 and is scheduled to end in December 2018.

HIP 2.0 Interim Evaluation Report

The HIP 2.0 Interim Evaluation Report was conducted by an independent evaluator, The Lewin Group, and submitted to CMS on July 6, 2016.

Non-emergency Medical Transportation (NEMT) Waiver Evaluation

In the HIP 2.0 waiver application, submitted July 2, 2014, Indiana requested a waiver of the requirement to provide non-emergency medical transportation (NEMT) for all populations except: pregnant women, medically frail individuals, Transitional Medical Assistance (TMA) participants, low-income parents and caretakers, and low-income 19 and 20 year olds. These members qualify for Indiana's traditional Medicaid benefit package, called the State Plan benefit package, which includes NEMT coverage.

The State submitted a waiver extension request on August 12, 2016, which CMS approved on November 25, 2016. This temporary extension of Indiana's NEMT waiver continued it through the end of the HIP 2.0 demonstration, January 31, 2018.

As outlined in the STCs, Indiana is required to conduct an independent evaluation of the NEMT waiver. The final evaluation plan was approved December 28, 2015. The initial *Indiana HIP 2.0: Evaluation of the NEMT Waiver*, conducted by The Lewin Group, an independent vendor, was submitted to CMS on March 11, 2016. The final NEMT waiver evaluation was submitted to CMS on November 2, 2016.

POWER Account Contributions and Co-payments Monitoring Status and Evaluation

Per HIP 2.0's STCs, the State is required to monitor POWER Account Contributions and conduct an independent evaluation of the PAC policy to assess 1) the affordability of PAC; and 2) the effect of the disenrollment-for-non-payment-of-PAC policy on enrollment. Indiana engaged an independent vendor, The Lewin Group, to complete this evaluation.

The *POWER Account Contribution Assessment* reflects available data from the beginning of the HIP 2.0 demonstration on February 1, 2015 through December 1, 2016, which included results of a survey of enrolled, disenrolled, and not enrolled individuals. The assessment addressed the following key points:

- How many individuals left HIP 2.0 due to non-payment of POWER Account?
- How do individuals perceive the affordability of PAC?
- How are disenrolled individuals accessing health care?
- Are individuals aware of the non-payment penalty?

Only 13,550 members (about 7 percent) who could lose coverage due to non-payment of PAC were disenrolled for non-payment. In addition, 58 percent of respondents who disenrolled reported being able to "always" or "usually" get routine appointments as soon as needed.

Members also viewed HIP 2.0 as an affordable program with 59 percent of HIP Plus survey respondents reporting that they "rarely" or "never" worried about having enough money to pay PAC.

The *Healthy Indiana Plan 2.0: POWER Account Contribution Assessment* was submitted to CMS on March 31, 2017.[27]

Emergency Room Co-payment Evaluation

To encourage appropriate use of the ER, HIP 2.0 established graduated co-payments for non-emergent use of the ER: $8 for the first non-emergent visit and $25 for each subsequent non-emergent visit within the same 12 month benefit period.[28] As outlined in the STCs, Indiana is required to conduct an independent evaluation of the emergency room co-pay structure. The Emergency Room Co-payment Protocol was approved by CMS on February 4, 2016, at which time the MCEs began implementing the study design.

The CMS-approved ED Co-Pay Protocol specified the creation of a control and test group were created to test whether applying a $25 co-payment for subsequent non-emergent ER visits affects subsequent ER utilization. The control group was a randomly-selected group of members who were not subject to the $25 ER graduated co-payment; control group members pay $8 per non-emergent ER visit, regardless of their number of non-emergent visits. The test group included all other HIP members (excluding the members of the control group)[29]; test group members' first non-emergent ER visit is subject to the $8 co-payment and all subsequent non-emergent ER visits within the membership year are subject to the $25 co-pay.

Using data provided by the FSSA for the period of January 1, 2016 – December 31, 2016, the *Healthy Indiana Plan 2.0: 2016 Emergency Room Co-Payment Assessment* examined demographic characteristics of the control and test group member samples, ER utilization, member payment of the ER co-payments, nurse hotline use, and urgent and primary care utilization.

The majority of members (80 to 86 percent across the MCEs) did not visit the ER in calendar year 2016. The number of non-emergent ER visits between the test and control groups varied by MCE and quarter, with no discernable patterns. Few members incurred the ER co-pay for non-emergent visits between August and December 2016. For example, in December 2016, 7,287 members incurred either an $8 or $25 co-pay, while 18,413 had their co-pay waived. Few members called the nurse hotline prior to a non-emergent ER visit; in total, 933 test group

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[27] The Lewin Group. (2017). *Healthy Indiana Plan 2.0: POWER Account Contribution Assessment.* Retrieved March 26, 2018 from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf

[28] The policy is authorized under Section 1916(f) of the Social Security Act. Section 1916(f) of the Social Security Act stipulates that "No deduction, cost sharing, or similar charge may be imposed under any waiver authority of the Secretary, except as provided in subsections (a)(3) and (b)(3) and section 1916A, unless such waiver is for a demonstration project which the Secretary finds after public notice and opportunity for comment" and outlines the conditions for imposing cost sharing, most notably that the policy should "test a unique and previously untested use of co-payments" and "is based on a reasonable hypothesis which the demonstration is designed to test in a methodologically sound manner, including the use of control groups of similar recipients of medical assistance in the area."

[29] The test group also excluded members who are exempt from cost-sharing (*i.e.*, pregnant women, Native Americans, and individuals subject to the five-percent cost sharing threshold).

members and five control group members called in 2016 prior to a non-emergent ER visit. There was no consistent pattern in the differences in primary care and urgent care visits between the test and control groups.

The *Healthy Indiana Plan 2.0: 2016 Emergency Room Co-Payment Assessment*, was conducted by The Lewin Group, an independent vendor, and was submitted to CMS on October 4, 2017.[30]

[30] The Lewin Group. (2017). *Healthy Indiana Plan 2.0: 2016 Emergency Room Co-Payment Assessment.* Retrieved March 26, 2018 from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-2016-emrgncy-room-copymt-assessment-rpt-10042017.pdf

6. Total Annual Expenditures

HIP 2.0 is cost-effective and continues to meet budget neutrality requirements. All Section 1115 Medicaid research and demonstration waivers are required to be budget neutral, meaning that the demonstration may not cost more to the federal government than it would have cost had it not been implemented. HIP 2.0 has met its federal budget neutrality targets for Demonstration Years One, Two, and Three. The estimated total cumulative cost for Demonstration Year One (February 1, 2015 – January 31, 2016) was $1.83 billion, including administrative costs. The estimated total cumulative cost for Demonstration Year Two (February 1, 2016 – January 31, 2017) was $2.37 billion, including administrative costs. The estimated total cumulative cost for Demonstration Year Three (February 1, 2017 – January 31, 2018) is $2.45 billion, including administrative costs. Each of these figures are below the originally projected costs for this program.

7. Detailed Annual Enrollment

The following tables provide additional detail on total HIP 2.0 enrollment at the end of Demonstration Year Three. Enrollment by age, race, and aid category at the end of Demonstration Year Three are shown in **Table 21**; the same metrics for Demonstration Year Two are provided in **Table 22** and for Demonstration Year One in **Table 23.**

Table 21: HIP 2.0 Enrollment by Member Characteristics at the End of Demonstration Year Three

Member Cohort	Basic				Plus				Total HIP Enrollment
	State	Regular	Basic Total	Percentage of Total HIP Enrollment in Cohort	State	Regular	Plus Total	Percentage of Total HIP Enrollment in Cohort	
Age Group									
<20	3,015	3,457	6,472	60.0%	1,727	2,594	4,321	40.0%	10,793
20-29	26,426	26,221	52,647	44.2%	27,408	39,141	66,549	55.8%	119,196
30-39	23,250	20,464	43,714	39.3%	31,846	35,787	67,633	60.7%	111,347
40-49	9,612	12,241	21,853	28.4%	22,499	32,504	55,003	71.6%	76,856
50-59	3,234	7,661	10,895	17.3%	16,592	35,404	51,996	82.7%	62,891
60+	564	1,620	2,184	9.9%	5,676	14,132	19,808	90.1%	21,992
Race									
Asian	560	977	1,537	16.5%	1,911	5,893	7,804	83.5%	9,341
Black	17,363	19,321	36,684	48.2%	16,213	23,204	39,417	51.8%	76,101
Hispanic	3,486	3,819	7,305	35.5%	5,125	8,154	13,279	64.5%	20,584
Native American (opt-in)	0	0	0	0.0%	94	119	213	100.0%	213
Indian	67	69	136	31.1%	108	193	301	68.9%	437
White	44,069	46,299	90,368	31.2%	80,903	117,979	198,882	68.8%	289,250
Other	556	1,179	1,735	24.3%	1,394	4,020	5,414	75.7%	7,149
Grand Total	**66,101**	**71,664**	**137,765**	**34.2%**	**105,748**	**159,562**	**265,310**	**65.8%**	**403,075**

Source: SSDW/EDW: February 1, 2017 – January 31, 2018. Data received on March 16, 2018.

The age and race distribution in Demonstration Year Three is almost identical to the distribution in Demonstration Year Two. Of all HIP 2.0 enrollees, almost 60 percent are in their twenties and thirties, 29.6 percent and 27.6 percent, respectively, and over one-third are 40-59 years old. The majority of HIP members are White (71.8 percent), with Black members representing the second largest cohort (18.9 percent). All other races account for 9.4 percent of total enrollment when combined.

Of total HIP enrollment (403,075 members), 34.2 percent are enrolled in Basic and 65.8 percent are enrolled in Plus. There is a similar breakdown for members in their thirties and forties,

though, generally, the proportion enrolled in Plus increases with age. Looking at the Basic/Plus breakdown by race, White, Indian, and Hispanic enrollment in Basic and Plus mimics the distribution of the total HIP population. Black enrollment is almost evenly split with 48.2 percent enrolled in Basic and 51.8 enrolled in Plus.

Table 22: HIP 2.0 Enrollment by Member Characteristics at the End of Demonstration Year Two

Member Cohort	Basic				Plus				Total HIP Enrollment
	State	Regular	Basic Total	Percentage of Total HIP Enrollment in Cohort	State	Regular	Plus Total	Percentage of Total HIP Enrollment in Cohort	
Age Group									
<20	3,463	4,126	7,589	61.2%	1,892	2,917	4,809	38.8%	12,398
20-29	29,706	28,228	57,934	47.3%	25,950	38,585	64,535	52.7%	122,469
30-39	22,843	20,966	43,809	39.5%	30,908	36,140	67,048	60.5%	110,857
40-49	8,428	12,237	20,665	27.5%	21,021	33,524	54,545	72.5%	75,210
50-59	2,687	7,744	10,431	17.1%	14,236	36,231	50,467	82.9%	60,898
60+	481	1,592	2,073	10.4%	4,404	13,489	17,893	89.6%	19,966
Race									
Asian	584	1,051	1,635	19.0%	1,663	5,287	6,950	81.0%	8,585
Black	18,146	20,492	38,638	50.4%	14,717	23,294	38,011	49.6%	76,649
Hispanic	3,607	4,015	7,622	38.4%	4,614	7,635	12,249	61.6%	19,871
Native American (opt-in)	2	2	4	2.1%	81	108	189	97.9%	193
Indian	71	82	153	34.0%	107	190	297	66.0%	450
White	44,636	48,165	92,801	32.1%	76,034	120,489	196,523	67.9%	289,324
Other	562	1,086	1,648	24.5%	1,195	3,883	5,078	75.5%	6,726
Grand Total	**67,608**	**74,893**	**142,501**	**35.5%**	**98,411**	**160,886**	**259,297**	**64.5%**	**401,798**

Source: SSDW/EDW: February 1, 2016 – January 31, 2017.
Note: Native Americans were temporarily enrolled in Basic due to pending verifications.

Table 23: HIP 2.0 Enrollment by Member Characteristics at the End of Demonstration Year One

Member Cohort	Basic				Plus				Total HIP Enrollment
	State	Regular	Basic Total	Percentage of Total HIP Enrollment in Cohort	State	Regular	Plus Total	Percentage of Total HIP Enrollment in Cohort	
Age Group									
<20	2,680	2,526	5,206	49.6%	2,230	3,054	5,284	50.4%	10,490
20-29	28,375	22,325	50,700	47.8%	22,893	32,454	55,347	52.2%	106,047
30-39	22,076	16,078	38,154	39.6%	26,274	31,844	58,118	60.4%	96,272
40-49	8,168	9,580	17,748	27.4%	16,267	30,794	47,061	72.6%	64,809
50-59	2,404	6,147	8,551	16.8%	9,473	32,808	42,281	83.2%	50,832
60+	254	1,238	1492	9.8%	2,518	11,187	13,705	90.2%	15,197
Race									
Asian	576	820	1396	20.7%	1,351	4,011	5,362	79.3%	6,758
Black	17,638	16,233	33,871	50.5%	12,653	20,492	33,145	49.5%	67,016
Hispanic	3,408	2,815	6,223	37.8%	3,840	6,396	10,236	62.2%	16,459
Native American (opt-in)	0	0	0	0.0%	55	69	124	100.0%	124
Indian	71	75	146	37.4%	79	165	244	62.6%	390
White	41,703	37,084	78,787	31.8%	60,776	107,886	168,662	68.2%	247,449
Other	561	867	1428	26.2%	901	3,122	4023	73.8%	5,451
Grand Total	**63,957**	**57,894**	**121,851**	**35.5%**	**79,655**	**142,141**	**221,796**	**64.5%**	**343,647**

Source: SSDW/EDW: February 1, 2015 – January 31, 2016.

Enrollment by County

Total HIP 2.0 enrollment at the county level is detailed in **Table 24**. Enrollment for all 92 counties is included. Members listed as "Other" live in state border zip codes. Ohio County has the fewest (270) HIP members and Marion County has the most (77,409) HIP members. Further detail is provided in **Appendix B**, which includes county level enrollment by aid category, age group, and race.

Table 24: Enrollment by County at the End of Demonstration Year Three

County Name	Total HIP Enrollment	County Name	Total HIP Enrollment	County Name	Total HIP Enrollment
Adams	1,299	Henry	3,775	Posey	1,209
Allen	22,459	Howard	6,076	Pulaski	888
Bartholomew	3,744	Huntington	1,995	Putnam	1,932
Benton	581	Jackson	2,299	Randolph	1,826
Blackford	989	Jasper	1,942	Ripley	1,514
Boone	2,004	Jay	1,316	Rush	1,141
Brown	962	Jefferson	2,128	St. Joseph	16,287
Carroll	970	Jennings	1,882	Scott	2,153
Cass	2,343	Johnson	7,258	Shelby	2,971
Clark	6,074	Knox	2,667	Spencer	976
Clay	2,037	Kosciusko	3,387	Starke	2,090
Clinton	1,916	Lagrange	1,023	Steuben	1,671
Crawford	851	Lake	38,257	Sullivan	1,557
Daviess	1,711	LaPorte	8,618	Switzerland	659
Dearborn	2,471	Lawrence	3,245	Tippecanoe	7,659
Decatur	1,369	Madison	10,521	Tipton	725
DeKalb	2,104	Marion	77,409	Union	441
Delaware	8,725	Marshall	2,247	Vanderburgh	11,707
Dubois	1,191	Martin	608	Vermillion	1,299
Elkhart	9,025	Miami	2,495	Vigo	8,871
Fayette	2,379	Monroe	7,499	Wabash	1,742
Floyd	3,932	Montgomery	2,021	Warren	434
Fountain	1,036	Morgan	4,142	Warrick	2,251
Franklin	1,208	Newton	950	Washington	2,025
Fulton	1,285	Noble	2,123	Wayne	4,968
Gibson	1,711	Ohio	270	Wells	1,175
Grant	5,377	Orange	1,574	White	1,242
Greene	2,377	Owen	1,675	Whitley	1,197
Hamilton	7,374	Parke	1,126	Other	21
Hancock	2,946	Perry	1,034	**Total**	**403,075**
Harrison	2,063	Pike	762		
Hendricks	4,876	Porter	8,731		

Source: SSDW/EDW: February 1, 2017 – January 31, 2018. Data received on March 16, 2018.

8. 2017 HIP Initiatives from the OMPP Quality Strategy Plan

The Indiana Office of Medicaid Policy and Planning (OMPP) monitors quality initiatives annually in several ways:

- **Quality and Operational Reports:** The MCEs are required to provide monthly, quarterly, and annual reports related to HIP quality and operational requirements. These reports are analyzed for accuracy and progress. The State creates dashboards that show the current status of each quality measure as well as historical trends of each MCE's key performance indicators. The MCEs' reporting metrics are also placed on dashboards to allow for comparative analysis for all risk-based managed care Medicaid members.
- **Monthly Onsite Meetings:** OMPP conducts monthly onsite meetings where the MCEs are asked to report on a variety of topics including, but not limited to, specific conditions of interest, preventive care efforts, HEDIS outcomes, member outreach, quality management and improvement work plans, and continuing efforts to coordinate physical and behavioral health care.
- **Quality Plans:** OMPP also ensures the plans understand and are following all reporting requirements as documented to assure consistency and accuracy in the data submitted.

The following objectives are specific to HIP. Some of these objectives have been monitored and maintained from previous years while other measures are new for the calendar year 2017 Quality Strategy Plan.

1. Access to Care

Objective	Methodology	Goal
HIP members shall have access to primary care within a maximum of 30 miles of the member's residence and at least two providers of each specialty type within 60 miles of member's residence.	The MCE must ensure that each member has an ongoing source of primary care appropriate to the member's needs.	90 percent of all HIP members shall have access to primary care within a minimum of 30 miles of member's residence and at least two providers of each specialty type within 60 miles of member's residence.
2017 Results		
For 2017, 100 percent of Indiana's HIP members had access to primary care within a maximum of 30 miles of the member's residence, per quarterly geographical access reporting provided by all four MCEs to OMPP. One of the focus studies completed in the 2016 External Quality Review, for the calendar year 2015, involved an in-depth review of geographical access to primary care for all Indiana Medicaid members by MCE and region.		

2. Access to Care

Objective	Methodology	Goal
HIP members shall have access to dental and vision care within a maximum of 60 miles of the member's residence and at least two providers of each specialty type within 60 miles of the member's residence.	The MCE must ensure that each member has an ongoing source of dental and vision care appropriate to the member's needs.	90 percent of all HIP members shall have access to dental and visual care within a minimum of 60 miles of member's residence and at least two providers of each specialty type within 60 miles of the member's residence.
2017 Results		
For 2017, 100 percent of Indiana's HIP members had access to dental care within a maximum of 30 miles of the member's residence and vision care within a maximum of 60 miles of the member's residence, per quarterly geographical access reporting provided by all four MCEs to OMPP. One of the focus studies completed in the 2016 External Quality Review, for the calendar year 2015, involved an in-depth review of geographical access to dental and vision care for all Indiana Medicaid members by MCE and region.		

3. POWER Account Roll-Over

Objective	Methodology	Goal
HIP members who obtain a preventive exam during the measurement year receive POWER Account roll-over. Only codes and code combinations listed in the categories 'Preventive Care Counseling Office Visit' and 'Alternative Preventive Care Counseling Visit' apply to this measure.	OMPP will track the number of HIP members who receive a qualifying preventive exam.	Achieve at or above 85 percent of the number of members who receive a preventive exam during the year.
2017 Results		
For 2017, all of the plans reported a rate of preventive examinations for HIP members between 34-49.8 percent, which was an increase from 2016. HIP Plus members had a higher rate of receipt of preventive care as opposed to HIP Basic members. Indiana's HIP program experienced an increase in member enrollment beginning in February of 2015 and the enrollment numbers have continued to increase monthly. The influx of membership into the HIP program has caused preventive care outcomes to decrease. For 2017, two of the four MCEs achieved increased HEDIS preventive care rates with one achieving the HEDIS 50th percentile and a second achieving the HEDIS 25th percentile.		

4. ER Admissions per 1,000 member months

Objective	Methodology	Goal
ER admissions per 1,000 member months.	OMPP is using HEDIS measures for tracking ER admissions per 1,000 member months.	Achieve at or below 75 visits per 1,000 member months.
2017 Results		
None of the MCEs achieved the goal of 75 or fewer ER visits per 1,000 member months in 2017. Utilizing HEDIS 2017 scores, for measurement year 2016, OMPP spent considerable time in 2017 evaluating the MCEs' ER practices and development of strategies to decrease the rates. OMPP analyzed quarterly HIP reporting submitted by the MCEs, including the ER admission rates, and feedback was provided verbally and via dashboard reviews. OMPP analysis revealed that the large increase in HIP membership for each of the MCEs during 2016 was a primary factor in the increase in ER visits. OMPP will continue these monitoring efforts in 2018.		

5. Improvement in Behavioral Health

Objective	Methodology	Goal
Percentage of members who received follow-up within 7 days of discharge from hospitalization for mental health disorders.	OMPP is using HEDIS measures for tracking the percentages of members receiving follow-up.	Achieve at or below 90th percentile for members who receive follow-up within 7 days of discharge from hospitalization for mental health disorders (HEDIS).
2017 Results		
One of the four MCEs achieved the 2017 OMPP pay-for-outcome metrics set for the HEDIS 7-day follow-up after hospitalization measure by increasing the percentage of their members who received these visits. Two of the MCEs experienced increased rates over the year during 2017. OMPP analyzed quarterly HIP reporting submitted by the MCEs that documented each plan's rate of follow-up within 7 days of discharge from hospitalization for members with mental health disorders, and feedback was provided verbally and via dashboard reviews. OMPP will continue these monitoring efforts in 2018.		

6. Ambulatory Care

Objective	Methodology	Goal
Number of outpatient and emergency department visits per member months.	OMPP is using HEDIS AMB as a data based evidence to promote best practices in Utilization Management.	Achieve at or above 90th percentile of Outpatient Visits (HEDIS). Achieve at or below 10th percentile of Emergency Department Visits (HEDIS).
2017 Results		
The four MCEs continue to attempt to increase the percentage of outpatient visits per member months for their HIP members. The rates are much higher for the 45-64 year age group versus the 20-44 year age group. Reporting submitted by the MCEs to OMPP during 2017 showed that all the MCEs reported much higher rates of outpatient visits per member months for those members enrolled in HIP Plus versus those enrolled in either the HIP State Plan or HIP Basic. The rates for those enrolled in HIP Plus and HIP State Plan were similar and higher than those in HIP Basic. HIP Basic members received one-half to one-third fewer outpatient visits per member months. OMPP provides feedback to the MCEs regarding their ambulatory care rates via verbal feedback, as well as dashboard reviews. OMPP will continue to monitor the MCE results for this metric in 2018.		

7. Pregnant Women Smoking Cessation

Objective	Methodology	Goal
Increase the referral of pregnant women who smoke to the Indiana Tobacco Quitline for smoking cessation services.	Monthly Indiana Tobacco Quitline reports.	Achieve an increase in the percentage who are referred to and have one contact with the Indiana Tobacco Quitline.
2017 Results		
One of the four MCEs increased their referrals of pregnant members to the Quitline for 2017 and received their pay-for-outcome incentives from OMPP.		

8. Right Choices Program (RCP)

Objective	Methodology	Goal
Provide quality health care through health care management. RCP administrators conduct utilization reviews, create a care coordination team and collaborate with the member to ensure that the member receives appropriate, medically necessary care.	OMPP monitors monthly data to assess the MCEs' utilization management efforts to reduce inappropriate hospital, pharmacy, and physician utilization while making efforts to improve the member's health status and increase provider participation in the RCP program.	A minimum of 90 percent of the findings of appeals filed by members to be removed from RCP will be upheld because the member was correctly assessed as requiring RCP services.
2017 Results		
Data is not available at the time of report submission.		

9. Medically Frail

Objective	Methodology	Goal
Provide quality health care to members identified as medically frail.	Administrative reporting.	Identify individuals who meet the medically frail criteria and offer access to enhanced services.
2017 Results		
Data is not available at the time of report submission.		

9. Conclusion

At the end of Demonstration Year Three, HIP 2.0 continued to improve upon the successes of the first two years of the demonstration. Enrollment increased to 403,075 fully enrolled members. The program met budget neutrality requirements for the third year in a row. The majority of members continue to make POWER Account contributions to stay enrolled in HIP Plus. This includes members with incomes below 100 percent of the FPL who are eligible to enroll in HIP Basic, which does not require POWER Account contributions. Operational focus continues to be on developing and implementing business and system design changes to incorporate new HIP program design elements requested in the HIP waiver extension application, which was approved by CMS on February 1, 2018.

Appendix A. Annual Presumptive Eligibility Effectiveness Survey

Q1. Are you a qualified Presumptive Eligibility provider?

Answer Choices	Responses	Percentage
YES	91	94.79%
NO	0	0.00%
DON'T KNOW	3	3.13%
REFUSED	2	2.08%
Total	**96**	-

Q2. What type of Presumptive Eligibility process do you offer? Which of the following do you conduct? (Select all that apply)

Answer Choices	Responses	Percentage
PE FOR PREGNANT WOMEN (PEPW) ONLY	38	39.58%
HOSPITAL PE (HPE)	25	26.04%
REGULAR PE (PE)	22	22.92%
PRISONERS PE	8	8.34%
DON'T KNOW	1	1.04%
REFUSED	2	2.08%
Total	**96**	-

Q3. Thinking about the Presumptive Eligibility (PE) process, how would you rate the overall effectiveness of the PE process at eliminating gaps in health care coverage?

Answer Choices	Responses	Percentage
VERY EFFECTIVE	44	45.83%
SOMEWHAT EFFECTIVE	47	48.96%
NOT THAT EFFECTIVE	0	0.00%
NOT EFFECTIVE AT ALL	0	0.00%
DON'T KNOW	2	2.08%
REFUSED	3	3.13%
Total	**96**	-

Q4. Do you track how many people who signed up for Presumptive Eligibility coverage went on to complete an application?

Answer Choices	Responses	Percentage
YES	81	84.37%
NO	9	9.37%
DON'T KNOW	3	3.13%
REFUSED	3	3.13%
Total	**96**	-

Q5. What would you say is the success rate of your PE members getting full HIP coverage? Would you say it is:

Answer Choices	Responses	Percentage
LESS THAN 25%	5	5.21%
25-49%	2	2.08%
50-74%	22	22.92%
75-99%	46	47.91%
100%	3	3.13%
DON'T KNOW	18	18.75%
Total	**96**	-

Appendix B. Enrollment by County

Enrollment by County and Aid Category

This appendix includes three sets of enrollment figures for all 92 counties in Indiana. Members listed as “Other” live in state border zip codes. **Tables B1a** and **B1b** detail enrollment in each county by aid category: State Basic, Regular Basic, State Plus, and Regular Plus. **Tables B2a** and **B2b** include enrollment by county by age group: <20, 20-29, 30-39, 40-49, 50-59, 60+. The last set of tables, **Tables B3a** and **B3b**, show county enrollment by race: White, Black, Asian, Indian, Hispanic, and Other.

Table B1a: Enrollment by Aid Category, Counties A – L

County Name	Basic		Plus		Total	County Name	Basic		Plus		Total
	State	Regular	State	Regular			State	Regular	State	Regular	
Adams	189	228	320	562	1,299	**Fulton**	219	224	352	490	1,285
Allen	3,581	4,241	5,588	9,049	22,459	**Gibson**	254	278	490	689	1,711
Bartholomew	658	549	1,122	1,415	3,744	**Grant**	904	1,015	1,339	2,119	5,377
Benton	94	91	184	212	581	**Greene**	388	360	628	1,001	2,377
Blackford	153	168	269	399	989	**Hamilton**	749	920	1,993	3,712	7,374
Boone	276	307	581	840	2,004	**Hancock**	438	457	829	1,222	2,946
Brown	79	122	264	497	962	**Harrison**	269	345	527	922	2,063
Carroll	150	141	274	405	970	**Hendricks**	567	677	1,307	2,325	4,876
Cass	388	400	669	886	2,343	**Henry**	607	597	1,107	1,464	3,775
Clark	924	966	1,714	2,470	6,074	**Howard**	1,067	1,150	1,635	2,224	6,076
Clay	316	331	552	838	2,037	**Huntington**	288	296	575	836	1,995
Clinton	321	311	524	760	1,916	**Jackson**	366	426	610	897	2,299
Crawford	100	129	227	395	851	**Jasper**	265	295	573	809	1,942
Daviess	281	255	470	705	1,711	**Jay**	187	200	372	557	1,316
Dearborn	295	371	761	1,044	2,471	**Jefferson**	359	421	580	768	2,128
Decatur	243	230	352	544	1,369	**Jennings**	307	273	578	724	1,882
DeKalb	327	339	603	835	2,104	**Johnson**	1,034	1,031	2,095	3,098	7,258
Delaware	1,400	1,440	2,349	3,536	8,725	**Knox**	426	523	695	1,023	2,667
Dubois	136	171	316	568	1,191	**Kosciusko**	599	481	949	1,358	3,387
Elkhart	1,750	1,603	2,477	3,195	9,025	**Lagrange**	162	137	286	438	1,023
Fayette	378	386	662	953	2,379	**Lake**	6,576	7,499	9,083	15,099	38,257
Floyd	725	697	1,095	1,415	3,932	**LaPorte**	1,471	1,535	2,292	3,320	8,618
Fountain	180	154	281	421	1,036	**Lawrence**	422	460	909	1,454	3,245
Franklin	152	177	329	550	1,208						

Source: SSDW/EDW: February 1, 2017 – January 31, 2018. Data received on March 16, 2018.

Table B1b: Enrollment by Aid Category, Counties M – Z

County Name	Basic		Plus		Total	County Name	Basic		Plus		Total
	State	Regular	State	Regular			State	Regular	State	Regular	
Madison	1,824	1,969	2,791	3,937	10,521	**Scott**	381	352	621	799	2,153
Marion	14,109	16,057	18,839	28,404	77,409	**Shelby**	466	488	855	1,162	2,971
Marshall	348	331	633	935	2,247	**Spencer**	139	149	263	425	976
Martin	77	84	177	270	608	**Starke**	302	240	661	887	2,090
Miami	401	406	742	946	2,495	**Steuben**	250	229	445	747	1,671
Monroe	908	1,204	1,866	3,521	7,499	**Sullivan**	223	248	428	658	1,557
Montgomery	338	339	534	810	2,021	**Switzerland**	115	98	166	280	659
Morgan	594	568	1,230	1,750	4,142	**Tippecanoe**	1,302	1,415	1,966	2,976	7,659
Newton	154	135	279	382	950	**Tipton**	99	108	181	337	725
Noble	357	321	577	868	2,123	**Union**	61	59	124	197	441
Ohio	40	38	72	120	270	**Vanderburgh**	2,165	2,681	2,861	4,000	11,707
Orange	202	233	414	725	1,574	**Vermillion**	221	204	405	469	1,299
Owen	241	245	453	736	1,675	**Vigo**	1,518	1,598	2,471	3,284	8,871
Parke	171	156	339	460	1,126	**Wabash**	245	265	505	727	1,742
Perry	157	179	299	399	1,034	**Warren**	75	57	111	191	434
Pike	108	119	215	320	762	**Warrick**	335	305	623	988	2,251
Porter	1,186	1,329	2,358	3,858	8,731	**Washington**	318	309	561	837	2,025
Posey	199	213	332	465	1,209	**Wayne**	795	845	1,426	1,902	4,968
Pulaski	125	109	271	383	888	**Wells**	139	170	328	538	1,175
Putnam	324	320	514	774	1,932	**White**	170	159	309	604	1,242
Randolph	306	295	474	751	1,826	**Whitley**	165	159	345	528	1,197
Ripley	228	219	415	652	1,514	**Other**	3	1	11	6	21
Rush	175	193	314	459	1,141	**TOTAL**	**66,101**	**71,664**	**105,748**	**159,562**	**403,075**
St. Joseph	3,022	3,056	4,157	6,052	16,287						

Source: SSDW/EDW: February 1, 2017 – January 31, 2018. Data received on March 16, 2018.

Enrollment by County and Age

Table B2a: Enrollment by Age, Counties A – L

County Name	<20	20-29	30-39	40-49	50-59	60+	Total	County Name	<20	20-29	30-39	40-49	50-59	60+	Total
Adams	48	413	344	225	194	75	1,299	**Fulton**	34	381	361	224	201	84	1,285
Allen	618	7,029	6,310	4,186	3,143	1,173	22,459	**Gibson**	37	490	490	328	285	81	1,711
Bartholomew	74	1,126	1,066	714	549	215	3,744	**Grant**	134	1,624	1,457	1,039	853	270	5,377
Benton	10	169	165	112	94	31	581	**Greene**	61	650	607	495	426	138	2,377
Blackford	34	267	295	193	151	49	989	**Hamilton**	212	1,858	2,042	1,579	1,186	497	7,374
Boone	50	565	524	411	339	115	2,004	**Hancock**	78	796	815	598	484	175	2,946
Brown	20	199	232	211	215	85	962	**Harrison**	59	539	607	374	350	134	2,063
Carroll	29	233	263	192	178	75	970	**Hendricks**	125	1,392	1,376	969	713	301	4,876
Cass	75	671	647	456	361	133	2,343	**Henry**	101	1,058	961	774	673	208	3,775
Clark	130	1,825	1,837	1,131	863	288	6,074	**Howard**	142	1,817	1,746	1,211	902	258	6,076
Clay	50	565	525	415	344	138	2,037	**Huntington**	48	583	573	375	323	93	1,995
Clinton	67	555	561	356	279	98	1,916	**Jackson**	47	700	611	449	353	139	2,299
Crawford	23	218	197	170	168	75	851	**Jasper**	72	612	471	380	307	100	1,942
Daviess	44	475	499	331	277	85	1,711	**Jay**	43	371	342	271	196	93	1,316
Dearborn	67	657	696	520	403	128	2,471	**Jefferson**	52	629	611	410	321	105	2,128
Decatur	43	391	373	269	216	77	1,369	**Jennings**	32	521	493	408	319	109	1,882
DeKalb	76	613	544	428	322	121	2,104	**Johnson**	175	2,158	2,055	1,442	1,061	367	7,258
Delaware	239	2,647	2,289	1,656	1,454	440	8,725	**Knox**	62	819	764	451	408	163	2,667
Dubois	31	350	298	246	187	79	1,191	**Kosciusko**	85	977	948	631	550	196	3,387
Elkhart	261	2,846	2,406	1,556	1,386	570	9,025	**Lagrange**	35	274	245	211	184	74	1,023
Fayette	65	653	606	572	372	111	2,379	**Lake**	1,153	11,232	10,321	7,285	6,148	2,118	38,257
Floyd	104	1,263	1,159	714	524	168	3,932	**LaPorte**	250	2,631	2,347	1,583	1,368	439	8,618
Fountain	35	297	244	203	195	62	1,036	**Lawrence**	82	903	880	648	520	212	3,245
Franklin	15	326	313	264	210	80	1,208								

Source: SSDW/EDW: February 1, 2017 – January 31, 2018. Data received on March 16, 2018.

Table B2b: Enrollment by Age, Counties M – Z

County Name	<20	20-29	30-39	40-49	50-59	60+	Total	County Name	<20	20-29	30-39	40-49	50-59	60+	Total
Madison	246	2,994	2,805	2,077	1,837	562	10,521	**Scott**	36	624	569	462	349	113	2,153
Marion	2,160	23,423	22,169	14,308	11,480	3,869	77,409	**Shelby**	72	850	809	545	530	165	2,971
Marshall	71	667	568	404	383	154	2,247	**Spencer**	25	261	249	194	176	71	976
Martin	15	150	184	118	119	22	608	**Starke**	58	547	572	403	396	114	2,090
Miami	63	718	678	517	391	128	2,495	**Steuben**	38	486	441	303	290	113	1,671
Monroe	175	2,480	2,117	1,364	982	381	7,499	**Sullivan**	31	467	418	294	270	77	1,557
Montgomery	45	612	552	361	330	121	2,021	**Switzerland**	13	165	189	127	118	47	659
Morgan	81	1,151	1,128	881	674	227	4,142	**Tippecanoe**	194	2,661	2,165	1,321	1,019	299	7,659
Newton	36	255	241	208	151	59	950	**Tipton**	20	191	206	147	119	42	725
Noble	63	636	497	419	365	143	2,123	**Union**	18	124	108	87	77	27	441
Ohio	1	71	75	49	47	27	270	**Vanderburgh**	250	3,459	3,457	2,188	1,807	546	11,707
Orange	42	411	402	299	292	128	1,574	**Vermillion**	29	371	338	280	205	76	1,299
Owen	34	424	408	366	332	111	1,675	**Vigo**	235	2,842	2,388	1,636	1,339	431	8,871
Parke	36	317	266	230	205	72	1,126	**Wabash**	47	524	480	325	269	97	1,742
Perry	13	280	292	197	186	66	1,034	**Warren**	11	114	121	82	79	27	434
Pike	20	182	202	149	162	47	762	**Warrick**	63	605	640	429	381	133	2,251
Porter	239	2,561	2,457	1,647	1,378	449	8,731	**Washington**	59	545	542	405	339	135	2,025
Posey	33	330	328	232	211	75	1,209	**Wayne**	104	1,416	1,361	964	804	319	4,968
Pulaski	13	235	235	186	166	53	888	**Wells**	24	352	311	217	208	63	1,175
Putnam	56	534	567	337	302	136	1,932	**White**	41	337	304	255	220	85	1,242
Randolph	64	480	464	421	276	121	1,826	**Whitley**	28	361	328	221	176	83	1,197
Ripley	51	445	420	297	209	92	1,514	**Other**	0	3	3	4	8	3	21
Rush	29	324	295	230	194	69	1,141	**TOTAL**	**10,793**	**119,196**	**111,347**	**76,856**	**62,891**	**21,992**	**403,075**
St. Joseph	484	4,843	4,482	3,004	2,485	989	16,287								

Source: SSDW/EDW: February 1, 2017 – January 31, 2018. Data received on March 16, 2018.

Enrollment by County and Race

Table B3a: Enrollment by Race, Counties A – L

County Name	White	Black	Asian	Indian	His-panic	Native Ameri-can	Other	Total	County Name	White	Black	Asian	Indian	His-panic	Native Ameri-can	Other	Total
Adams	1,189	35	10	0	51	0	14	1,299	**Fulton**	1,211	19	10	0	35	0	10	1,285
Allen	12,945	5,550	2,117	25	1,407	4	411	22,459	**Gibson**	1,604	71	9	1	7	1	18	1,711
Bartholomew	3,396	110	36	3	126	2	71	3,744	**Grant**	4,537	600	23	5	170	2	40	5,377
Benton	536	3	0	1	33	0	8	581	**Greene**	2,340	3	7	1	11	1	14	2,377
Blackford	970	0	2	3	10	0	4	989	**Hamilton**	5,507	663	575	10	263	3	353	7,374
Boone	1,831	40	43	1	45	3	41	2,004	**Hancock**	2,752	87	23	0	39	2	43	2,946
Brown	924	5	4	1	8	2	18	962	**Harrison**	1,997	20	10	1	16	0	19	2,063
Carroll	922	10	3	0	25	1	9	970	**Hendricks**	3,728	512	255	6	156	3	216	4,876
Cass	1,987	61	41	2	229	3	20	2,343	**Henry**	3,614	72	7	2	39	1	40	3,775
Clark	4,979	664	63	13	222	2	131	6,074	**Howard**	4,978	851	42	6	114	0	85	6,076
Clay	1,987	15	6	0	8	0	21	2,037	**Huntington**	1,915	12	11	3	23	5	26	1,995
Clinton	1,716	23	5	1	156	1	14	1,916	**Jackson**	2,161	34	10	0	66	4	24	2,299
Crawford	832	1	0	1	3	0	14	851	**Jasper**	1,828	16	8	2	61	2	25	1,942
Daviess	1,593	33	8	1	60	1	15	1,711	**Jay**	1,273	5	2	1	21	1	13	1,316
Dearborn	2,379	33	7	2	12	0	38	2,471	**Jefferson**	2,032	36	9	5	20	1	25	2,128
Decatur	1,337	3	5	0	12	3	9	1,369	**Jennings**	1,821	16	6	1	26	0	12	1,882
DeKalb	2,019	7	7	3	29	0	39	2,104	**Johnson**	6,230	246	427	8	163	5	179	7,258
Delaware	7,284	1,148	60	9	118	6	100	8,725	**Knox**	2,515	76	9	2	41	0	24	2,667
Dubois	1,068	12	9	1	67	1	33	1,191	**Kosciusko**	3,018	52	25	6	232	5	49	3,387
Elkhart	6,239	1,508	104	8	968	8	190	9,025	**Lagrange**	918	7	11	2	56	0	29	1,023
Fayette	2,304	45	5	3	11	1	10	2,379	**Lake**	14,831	15,568	352	39	6,612	11	844	38,257
Floyd	3,285	469	38	6	65	6	63	3,932	**LaPorte**	6,569	1,532	34	10	341	6	126	8,618
Fountain	1,001	3	3	1	17	1	10	1,036	**Lawrence**	3,141	11	22	7	18	2	44	3,245
Franklin	1,195	2	1	0	2	1	7	1,208									

Source: SSDW/EDW: February 1, 2017 – January 31, 2018. Data received on March 16, 2018.

Table B3b: Enrollment by Race, Counties M – Z

County Name	White	Black	Asian	Indian	His-panic	Native Ameri-can	Other	Total	County Name	White	Black	Asian	Indian	His-panic	Native Ameri-can	Other	Total
Madison	8,794	1,296	54	10	237	2	128	10,521	**Scott**	2,109	13	4	4	12	0	11	2,153
Marion	34,704	33,089	3,720	80	4,244	29	1,543	77,409	**Shelby**	2,798	73	10	1	58	0	31	2,971
Marshall	2,018	28	8	2	167	1	23	2,247	**Spencer**	935	16	2	1	9	1	12	976
Martin	595	2	0	0	6	0	5	608	**Starke**	2,024	7	2	3	29	3	22	2,090
Miami	2,361	62	5	9	33	2	23	2,495	**Steuben**	1,586	10	5	2	36	3	29	1,671
Monroe	6,379	573	157	11	130	6	243	7,499	**Sullivan**	1,520	9	4	1	11	0	12	1,557
Montgomery	1,909	43	8	1	45	0	15	2,021	**Switzerland**	648	1	2	1	2	0	5	659
Morgan	4,020	29	20	2	32	2	37	4,142	**Tippecanoe**	5,504	1,283	160	10	529	10	163	7,659
Newton	911	8	1	1	17	1	11	950	**Tipton**	672	2	3	0	32	0	16	725
Noble	1,882	16	43	2	138	1	41	2,123	**Union**	430	3	2	1	1	0	4	441
Ohio	259	1	1	0	3	1	5	270	**Vanderburgh**	8,896	2,337	113	12	146	3	200	11,707
Orange	1,505	20	5	3	13	1	27	1,574	**Vermillion**	1,268	5	5	3	11	0	7	1,299
Owen	1,642	10	1	3	5	0	14	1,675	**Vigo**	7,607	884	82	13	128	6	151	8,871
Parke	1,103	8	1	2	8	1	3	1,126	**Wabash**	1,690	11	3	0	20	2	16	1,742
Perry	1,005	8	3	1	6	0	11	1,034	**Warren**	415	1	5	0	6	0	7	434
Pike	748	2	2	0	3	0	7	762	**Warrick**	2,083	52	36	3	19	4	54	2,251
Porter	7,032	639	95	10	777	7	171	8,731	**Washington**	1,991	14	4	1	7	0	8	2,025
Posey	1,137	34	5	1	12	0	20	1,209	**Wayne**	4,382	421	27	9	58	3	68	4,968
Pulaski	861	6	3	0	7	0	11	888	**Wells**	1,103	14	7	0	30	1	20	1,175
Putnam	1,851	29	10	1	24	0	17	1,932	**White**	1,132	15	8	1	67	1	18	1,242
Randolph	1,734	22	7	5	42	0	16	1,826	**Whitley**	1,156	6	7	0	10	1	17	1,197
Ripley	1,471	6	8	3	13	0	13	1,514	**Other**	14	4	0	0	1	0	2	21
Rush	1,110	6	5	0	11	0	9	1,141	**TOTAL**	**289,250**	**76,101**	**9,341**	**437**	**20,584**	**213**	**7,149**	**403,075**
St. Joseph	9,818	4,694	224	21	1,175	20	335	16,287									

Source: SSDW/EDW: February 1, 2017 – January 31, 2018. Data received on March 16, 2018.