HEALTHY INDIANA PLAN 2.0

PROJECT NUMBER: 11-W-00296/5

SECTION 1115 QUARTERLY REPORT

STATE OF INDIANA

REPORTING PERIOD:

Demonstration Year: 3 (02/01/17 – 1/31/18)

Demonstration Quarter: 2/2017 (05/2017-07/2017)

Date submitted to CMS: October 1, 2017

INTRODUCTION

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

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

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

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

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

The State of Indiana respectfully submits year three, quarter two Healthy Indiana Plan 1115(a) demonstration report.

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KEY EVENTS

In July, the State submitted an amendment to the HIP Waiver extension application submitted in January. This amendment added the request to expand Gateway to Work 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. An outline of the proposed Gateway to Work expansion was included in the amendment, as well as the delayed implementation to allow for program development throughout 2018 with implementation set for 2019. The proposal included several groups of individuals who would not be required to participate, such as those who are medically frail, pregnant, or are 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 the State to meet with stakeholders. These meetings allowed FSSA to share plans outlined in the amendment, hear stakeholder concerns and suggestions, and to answer questions. This allowed the State to gain valuable insight and several ideas shared in these meetings were incorporated into the final amendment request.

During this quarter, the HIP Employer Link program stopped enrolling new employers and members into the program. Members may remain enrolled until December 2017 and will then be transitioned to HIP Plus. Please see the Employer Link section of this report for more information.

OPERATIONAL CHALLENGS & ACHIEVEMENTS

Operational focus in this quarter was on developing business and system design changes to incorporate new HIP program design elements that are requested in the HIP waiver extension application. While awaiting CMS approval, the State moved forward with system design in order to be prepared for implementation of changes in 2018.

ENROLLMENT BY INCOME LEVEL AND BENEFIT PLAN

Table 1 details HIP 2.0 enrollment by FPL and benefit plan. There were 403,006 fully enrolled members as of July 31, 2017, these numbers do not include those who are conditionally eligible and will move into Plus if they make a POWER Account contribution or Basic if they do not. There were 264,274 individuals (66%) making their POWER Account contributions and receiving HIP Plus benefits. We continue to see most of the lowest income members (60.5%), under 23% FPL making POWER Account contributions. At the end of the quarter, 54,985 individuals (20.8% of total enrollees) had income over 100% FPL.

Table 1: Enrollment at the End of Quarter 2 (July 31, 2017)

	Basic				Plus				
	State	Regular	Basic Total	Percentage of Basic Enrollment	State	Regular	Plus Total	Percentage of Plus Enrollment	Total HIP Enrollment
<23%	45,666	34,166	79,832	39.5%	65,111	57,135	122,246	60.5%	202,078
23-50%	4,869	8,335	13,204	37.7%	7,086	14,780	21,866	62.3%	35,070
51-75%	5,146	12,188	17,334	36.7%	8,106	21,801	29,907	63.3%	47,241
76-100%	4,682	12,979	17,661	33.4%	8,632	26,638	35,270	66.6%	52,931
Total <101%	**60,363**	**67,668**	**128,031**	**38.0%**	**88,935**	**120,354**	**209,289**	**62.0%**	**337,320**
101 - 138%	3,810	5,118	8,928	15%	12,829	39,442	52,271	85%	61,199
>138 %	1,721	52	1,773	40%	2,443	271	2,714	60%	4,487
Grand Total	**65,894**	**72,838**	**138,732**	**34%**	**104,207**	**160,067**	**264,274**	**66%**	**403,006**

*Source: SSDW/EDW

POWER ACCOUNT CONTRIBUTION FROM THIRD PARTIES

Tables 2 and **3** outline the total number of members who received help paying PAC from either an employer or a participating non-profit organization during Q1 2017. The number of employers electing to make POWER Account contributions in the quarter was 37, these employers made contributions on behalf of 41 members. Also, there were 60 non-profit organizations that made contributions on behalf of 2,157 members.

Third party contributions continue to represent a very small portion of the overall program. These numbers represent those groups that have made a formal arrangement with a MCE to pay on behalf of another individual. The State may not be aware of informal arrangements or payments on behalf of members, including those from friends or relatives.

Table 2: Employer Power Account Contributions during Quarter 2 (May – July 2017)

	Total
Number of Employers Participating	37
Number of Members on Whose Behalf an Employer Makes a Contribution	41
Total Amount of Employer Contributions	$1,076.42
Average Amount of Employer Contributions	$26.25

*Source: OMPP Quality and Reporting

Table 3: Non-Profit Organization Power Account Contributions during Quarter 2 (May – July 2017)

	Total
Number of Non Profit Organizations Participating	60
Number of Members on Whose Behalf a Non Profit Makes a Contribution	2,157
Total Amount of Non Profit Contributions	$24,869.52
Average Amount of Non Profit Contributions	$11.53

*Source: OMPP Quality and Reporting

DISENROLLMENT

Table 4 represents the number of individuals that were dis-enrolled from the program for failure to pay their required POWER Account Contribution. In this quarter, out of the 54,985 members with incomes over 100% of the FPL, 1,708 members were disenrolled. This is a continued decrease in the number of disenrollments for failure to make Power Account contributions.

Table 4: Closure for Failure to Pay Power Account during Quarter 2 (May - July 2017)

FPL	Count	Description
FPL >100%	1,708	Failure to make payment to power account

*Source: SSDW/EDW

CLOSURES & REASONS

Table 5 documents that 29,192 individuals left the HIP 2.0 program in Q2 2017. 3,646 of those were individuals who moved to a different Medicaid program outside of HIP. 25,546 individuals were closed out of the program all together, down from 32,516 last quarter (Q1). The closure reasons listed in the tables below continue to reflect non-compliance with redetermination and an increase in income as the main reasons for leaving the program. The numbers below show closures and do not account for the members who may have come back to the State and been reopened. Upon termination, individuals can have their eligibility restored if they return their paperwork within 90 days.

Table 5: Closures during Quarter 2 (May – July 2017)

HIP category	Moved to Another Medicaid Category (Non HIP)	Moved Out of the Medicaid Program
Regular Plus	1,050	9,262
Regular Basic	634	7,958
State Basic	584	4,004
State Plus	1,361	4,195
Other	17	127
Totals	**3,646**	**25,546**
Total	**29,192**	

*Source: SSDW/EDW

Table 6 lists the five most common reasons for all HIP 2.0 closure (above and below 100% FPL). The most common reason for closure in this quarter continues to be that the individual failed to comply with or complete redetermination. The second most common closure reason was that the individual's income exceeded program eligibility standards. The same two reasons were the most common last quarter. There are many other closures for a variety of other reasons and the below counts do not include all closures.

Table 6: All Closures -Top 5 reasons during Quarter 1 (May – July 2017)

Number of Closures	Reason
8,305	Individual fails to comply with or complete redetermination
5,556	Individual income exceeds program eligibility standards
2,172	Individual is not an Indiana resident
1,708	Individual failed to make POWER Account contribution
727	Individual is eligible for SSI Related Medicaid

*Source: SSDW/EDW

When the closure reasons are broken out for those above and below 100% FPL there are some differences. **Table 7** shows the most common closure reason for members under 100% FPL was failure to comply with or complete redetermination, and these closures have decreased by 25% this quarter. **Table 8** shows the most common closure reason for members above 100% FPL, is an increase in income that exceeds program eligibility standards. These individuals are referred to the Marketplace for coverage.

Table 7: Closures 100% FPL and Under – Top 5 Reasons in Quarter 2 (May – July 2017)

Number of Closures	Reason
7,557	Individual fails to comply with or complete redetermination
1,974	Individual is not an Indiana resident
1,651	Individual income exceeds program eligibility standards
704	Individual eligible for SSI related income
453	Written voluntary withdrawal from assistance

*Source: SSDW/EDW

Table 8: Closures 100% FPL and Above – Top 5 Reasons in Quarter 2 (May – July 2017)

Number of Closures	Reason
3,905	Individual income exceeds program eligibility standards
1,708	Individual failed to make POWER Account contribution
748	Individual fails to comply with or complete redetermination
198	Individual is not an Indiana resident
198	Written voluntary withdrawal from assistance

*Source: SSDW/EDW

EMERGENCY ROOM UTILIZATION

Table 9 below documents the number of emergency room visits by HIP 2.0 members for calendar quarter 2. The data is collected on a paid basis not an incurred basis, meaning that this data reflects the claims paid during the experience period with a 90 day claims lag time. In this instance, April-June 2017 reporting period, shows the claims payment activity for the January – March 2017(Q1) experience period.

Table 9: Emergency Room Utilization Calendar Quarter 2

Category	Number of ER visits in the period	Number of ER visits deemed emergent	Number of visits deemed non-emergent	Number of Adjudicated ER claims per 1,000 members	Percent of claims deemed emergent	Percent of claims deemed non-emergent
Plus	37,071	27,724	9,347	84	74.8%	25.2 %
Basic	18,833	13,926	4,907	102	74%	26%
State Plan	59,025	44,400	14,625	132	75.2%	24.8%

*Source: OMPP Quality and Reporting

ELIGIBILITY DETERMINATION and PROCESSING

Table 10 shows the typical processing time for each aid category by number of days from application to authorization and then from authorization to full eligibility. The State continues to report excellent application processing times. On average, individual applications are approved in less than 20 days.

Table 10: Eligibility Processing in Quarter 2 (May – July 2017)

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	18.73	5.46	10,344
Regular Basic	18.9	5.64	2,234
State Plan Plus	17.75	6.06	3,296
State Plan Basic	17.98	14.77	386
HIP Link	13.33	NA	3

*Source: OMPP Quality and Reporting

HIP EMPLOYER LINK

In July, the State of Indiana submitted the HIP 2.0 Waiver Extension Amendment with the decision to end 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. Due to this, the state decided to phase out the program.

The HIP Employer Link Team submitted phase out plans to CMS and stopped adding new employers or members into the program in July. The phase out plan includes assurances that all members in the program at the end of December 2017 will be automatically transferred to HIP Plus without a gap in coverage. In coming months, the HIP Employer Link team will be performing outreach and communication to enrolled members and employers to assure them that there will be no gap in coverage. The program will complete phase-out on December 31, 2017 with all members directly opened in HIP Plus on January 1, 2018.

Table 11: HIP Employer Link Enrollment in Quarter 2 (May – July 2017)

	Quarter	Program to Date
Employer enrollment	4	100
Employee enrollment	6	69
Grievances	0	0
Participants moving from ESI to HIP Plus	3	10

*Source: OMPP HIP Employer Link

Table 12: HIP Employer Link POWER Account Balances in Quarter 2 (May – July 2017)

POWER Account Balance	Number of Employees
$4,000-$3,000	26
$3,000-$2,000	30
$2,000-$1,000	11
$1,000-$0	2

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

*Source: OMPP HIP Employer Link

PRESUMPTIVE ELIGIBILITY

The Presumptive Eligibility (PE) program continues to be very active in Indiana. **Table 13** details the activity for all Qualified Providers (QPs) in the program. The State is seeing some improvement in the number of PE recipients that are being approved for full IHCP benefits at application but the overall number remains low at approximately 55%. The top denial reasons have been identified, and continued monitoring will be conducted for any changes. These denials include: failure to cooperate in verifying income, income exceeding program eligibility standards, and failure to verify Indiana residency.

Table 13: PRESUMPTIVE ELIGIBILITY APPLICATIONS and PERFORMANCE in Quarter 2 (May – July 2017)

Provider Type	PE Applications Submitted	PE Applications Approved	% PE Applications Approved	IHCP Applications Submitted	IHCP Applications Approved*	% IHCP Applications Approved**
Acute Care Hospital	22,025	17,386	78.9%	7,692	4,088	53.1%
Community Mental Health Center	1,484	1,121	75.5%	435	270	62.1%
Federally Qualified Health Center	2,916	2,438	83.6%	1,205	771	64.0%
Psychiatric Hospital	588	454	77.2%	205	135	65.9%
Rural Health Clinic	47	37	78.7%	16	6	37.5%
County Health Department	42	34	80.9%	28	19	67.9%
Grand Total	**27,102**	**21,470**	**79.2%**	**9,581**	**5,289**	**55.2%**

*****Source: EDW
*Applications submitted in the performance quarter may have still been pending when data was run.
**This number only reflects those that have had a determination made at that time. It may change over time.

Table 14 provides information on the number of Qualified Providers (QPs) that are completing HPE/PE applications for individuals. The number in column (a) is the number of provider entities that are signed up to perform QP activities, broken out by provider type. The number in column (b) shows the number of physical locations where the entity operates and carries out QP activities. The number in column (c) shows the total number of provider entities that are eligible to sign up to be a QP.

Table 14: PRESUMPTIVE ELIGIBILITY QUALIFIED PROVIDERS in Quarter 2 (May – July 2017)

Provider Type	No. of Qualified Provider Entities (a)	No. of Qualified Provider Locations (b)	Total Potential Provider Entities by Type (c)
Acute Care Hospital	113	117	125
Community Mental Health Center	21	55	25
Federally Qualified Health Center	26	152	26
Psychiatric Hospital	20	20	41
Rural Health Clinic	22	22	67
County Health Department	10	10	49
Total	**212**	**376**	**333**

*Source: Indiana CoreMMIS