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: 3/2017 (08/2017-10/2017)

Date submitted to CMS: Dec 31, 2017

INTRODUCTION

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

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

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

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

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

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

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KEY EVENTS

On August 31, 2017, the State held the required annual public forum on the HIP 2.0 program. The Medicaid Advisory Committee was again used as the venue for this public forum. Interim Medicaid Director Allison Taylor 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 Managed Care Entities. 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 speaker comments and testimony was 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.

OPERATIONAL CHALLENGS & ACHIEVEMENTS

Operational focus in this quarter remained on developing business and system design changes to incorporate new HIP program design elements 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. The state is awaiting approval of our 1115 waiver extension request.

ENROLLMENT BY INCOME LEVEL AND BENEFIT PLAN

Table 1 details HIP 2.0 enrollment by FPL and benefit plan. There were 403,855 fully enrolled members as of October 31, 2017, these numbers do not include those who are conditionally eligible and will move into HIP Plus if they make a POWER Account contribution or Basic if they do not. The total number of enrollees into the program have increased by 849 since last quarter. There were 263,838 individuals (65.3%) making their POWER Account contributions and receiving HIP Plus benefits. We continue to see most of the lowest income members (60.2%), under 23% FPL making POWER Account contributions. At the end of the quarter, 68,377 individuals (16.9% of total enrollees) had income over 100% FPL.

Table 1: Enrollment at the End of Quarter 3 (October 31, 2017)

	Basic				Plus				
	State	Regular	Basic Total	Percentage of Basic Enrollment	State	Regular	Plus Total	Percentage of Plus Enrollment	Total HIP Enrollment
<23%	43,510	34,345	77,855	39.8%	61,261	56,689	117,950	60.2%	195,805
23-50%	5,346	8,214	13,560	37.8%	7,470	14,878	22,348	62.2%	35,908
51-75%	5,859	12,207	18,066	37.1%	8,727	21,935	30,662	62.9%	48,728
76-100%	5,485	13,272	18,757	34.1%	9,280	27,000	36,280	65.9%	55,037
Total <101%	60,200	68,038	128,238	38.2%	86,738	120,502	207,240	61.8%	335,478
101 - 138%	4,281	5,579	9,860	15.5%	13,484	40,162	53,646	84.5%	63,506
>138 %	1,867	52	1,919	39.4%	2,628	324	2,952	60.6%	4,871
Grand Total	**66,348**	**73,669**	**140,017**	**34.7%**	**102,850**	**160,988**	**263,838**	**65.3%**	**403,855**

*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 Q3 2017. The number of employers electing to make POWER Account contributions in the quarter was 201, these employers made contributions on behalf of 218 members. In this quarter, there was a significant increase in the number of employers participating, growing from 37 employers to 201 and from 41 members to 218. Also, there were 65 non-profit organizations that made contributions on behalf of 1,891 members, we see that this number has increased from 60 to 65 since last quarter (Q2).

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 3 (Aug – October 2017)

	Total
Number of Employers Participating	267
Number of Members on Whose Behalf an Employer Makes a Contribution	371
Total Amount of Employer Contributions	$14,197.97
Average Amount of Employer Contributions	$38.27

*Source: OMPP Quality and Reporting

Table 3: Non-Profit Organization Power Account Contributions during Quarter 3 (Aug – October 2017)

	Total
Number of Non Profit Organizations Participating	176
Number of Members on Whose Behalf a Non Profit Makes a Contribution	2,337
Total Amount of Non Profit Contributions	$39,140
Average Amount of Non Profit Contributions	$16.75

*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 68,377 members with incomes over 100% of the FPL, 3,221 members were disenrolled, which is about 4.7 % of the population.

Table 4: Closure for Failure to Pay Power Account during Quarter 3 (Aug – October 2017)

FPL	Count	Description
FPL >100%	3,221	Failure to make payment to power account

*Source: SSDW/EDW

CLOSURES & REASONS

Table 5 documents that 45,104 individuals left the HIP 2.0 program in Q3 2017. 5,925 of those were individuals who moved to a different Medicaid program outside of HIP. 39,179 individuals were closed out of the program all together. 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 3 (Aug – October 2017)

HIP category	Moved to Another Medicaid Category (Non HIP)	Moved Out of the Medicaid Program
Regular Plus	1,775	14,221
Regular Basic	893	11,906
State Basic	909	6,455
State Plus	2,305	6,361
Other	43	236
Totals	5,925	39,179
Total	**45,104**	

*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 was 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 3 (Aug – October 2017)

Number of Closures	Reason
12,470	Individual failed to comply with or complete redetermination
8,247	Individual income exceeds program eligibility standards
3,839	Individual is not an Indiana resident
3,221	Individual failed to make POWER Account contribution
1,125	Individual eligible for SSI related income

*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. **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 3 (Aug – October 2017)

Number of Closures	Reason
11,210	Individual fails to comply with or complete redetermination
3,460	Individual is not an Indiana resident
2,477	Individual income exceeds program eligibility standards
1,090	Individual eligible for SSI related income
628	Written voluntary withdrawal from assistance

*Source: SSDW/EDW

Table 8: Closures 100% FPL and Above – Top 5 Reasons in Quarter 3 (Aug – October 2017)

Number of Closures	Reason
5,770	Individual income exceeds program eligibility standards
3,221	Individual failed to make POWER Account contribution
1,175	Individual fails to comply with or complete redetermination
379	Individual is not an Indiana resident
362	Individual currently has Medicare Part A or Part B

*Source: SSDW/EDW

EMERGENCY ROOM UTILIZATION

Table 9 below documents the number of emergency room visits by HIP 2.0 members for calendar quarter 3. The data is collected on a paid basis not an incurred basis, meaning that this data reflects the claims paid during the experience period with a 90 day claims lag time. In this instance, Aug - October 2017 reporting period, shows the claims payment activity for the May - July 2017(Q2) experience period. In this quarter, we see that the number of ER non-emergent visits have decreased slightly since last quarter (1,867 less non-emergent visits).

Table 9: Emergency Room Utilization Calendar Quarter 3 (Aug – October 2017 reporting period)

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	34,279	26,436	7,843	379	77.1%	22.9%
Basic	19,679	15,199	4,480	396	82.5%	17.5%
State Plan	67,642	52,943	14,689	597	78.3%	21.7%

**Note: This table does not include CareSource data.*
*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.

Table 10: Eligibility Processing in Quarter 3 (Aug – October 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	20.5	5.45	12,216
Regular Basic	19.64	3.17	1,384
State Plan Plus	19.36	6.46	3,620
State Plan Basic	16.14	11.56	155
HIP Link	NA	NA	0

*Source: OMPP Quality and Reporting

HIP EMPLOYER LINK

In this quarter, new employer and employee participation in HIP Employer Link did not increase. Due to the decision to end the program, new enrollment for employers was stopped in July 2017.

Many members have been pleased with their HIP Link coverage and plan to transition to HIP Plus should HIP Link ends in 2017. To date, we still have never had a member grievance filed in this program. **Tables 11 and 12** outline program details.

Table 11: HIP Employer Link Enrollment in Quarter 3 (Aug – October 2017)

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

*Source: SSDW/EDW

Table 12: HIP Employer Link POWER Account Balances in Quarter 3 (Aug – October 2017)

POWER Account Balance	Number of Employees
$4,000-$3,000	21
$3,000-$2,000	15
$2,000-$1,000	20
$1,000-$0	5

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

*Source: DXC HIP Employer Link

POWER ACCOUNT CONTRIBUTIONS AND COPAYMENTS MONITORING PROTOCOLS

Per the Special Terms and Conditions (STCs) for Indiana's section 1115 demonstration, Indiana must conduct an independent evaluation of the ER co-pay policy. The *Healthy Indiana Plan 2.0: 2016 Emergency Room Co-Payment Assessment* was completed by The Lewin Group and submitted to CMS on October 4, 2017. The Assessment evaluated data for the period of January 1, 2016 –

December 31, 2016, examining the following variables of interest to illustrate the results of the ER co-pay policy:

- Demographic characteristics of the sample (composed of test and control group members)
- ER utilization
- Member payment of ER co-payments
- Nurse hotline use
- Urgent and primary care utilization

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 number of full IHCP applications submitted for individuals with PE remains strong at 84.1%, but the rate of approval for those full applications for Medicaid remains low at approximately 37.4%. 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 3 (Aug – October 2017)

Provider Type	PE Applications Submitted	PE Applications Approved	% PE Applications Approved	IHCP Applications Submitted	IHCP Applications Approved*	% IHCP Applications Approved**
Acute Care Hospital	19,583	16,374	83.6%	7,646	2,637	34.5%
Community Mental Health Center	1,686	1,383	82.0%	374	121	32.4%
Federally Qualified Health Center	2,987	2,636	88.2%	1,418	772	54.4%
Psychiatric Hospital	744	629	84.5%	260	86	33.1%
Rural Health Clinic	70	54	77.1%	32	16	50.0%
County Health Department	38	34	89.5%	29	22	75.9%

Grand Total	**25,108**	**21,110**	**84.1%**	**9,759**	**3,654**	**37.4%**

*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. To date, 212 out of 333 (63.7%) eligible entities are signed up to be a QP.

Table 14: PRESUMPTIVE ELIGIBILITY QUALIFIED PROVIDERS in Quarter 3 (Aug – October 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: CORE MMIS