HEALTHY INDIANA PLAN DEMONSTRATION

PROJECT NUMBER: 11-W-00296/5

SECTION 1115 QUARTERLY REPORT

State of Indiana

REPORTING PERIOD:

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

Demonstration Quarter: 1/2016(2/2016-4/2016)

Date submitted to CMS: June 30, 2016

HIP 2.0

HEALTHY INDIANA PLAN℠

Health Coverage = Peace of Mind

Introduction:

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

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

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

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

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

Overview

The State of Indiana respectfully submits year two, quarter 1 Healthy Indiana Plan 1115(a) demonstration report.

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1. **A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, enrollment, quality of care, access, health plan financial performance that is relevant to the demonstration, the benefit package, and other operational issues.**

In the first quarter of the second demonstration year, the Indiana General Assembly passed Senate Enrolled Act (SEA) 165. This legislation codified the new Healthy Indiana Plan (HIP) 2.0 into law. Lawmakers lauded the program's achievements during the session and after passing both chambers of the legislature, the bill was sent to the Office of the Governor for his signature. SEA 165 was signed into law by Governor Mike Pence on March 21, 2016.

The first HIP 2.0 cohort began their second benefit period with the HIP program on February 1st, the state undertook efforts beyond the standard redetermination communication efforts to assure that people were aware of their redetermination for that first cohort and continues to do so for groups as they come up for redetermination. These additional efforts include:

- An outbound dialer campaign initiated by the State and each managed care entity (MCE) to alert individuals that did not return their redetermination mailers and were closed. These calls alert the individual that they have 90 days from the effective date of closure to return their mailer and have their eligibility considered for reinstatement. The 90-day period for the first set of redeterminations ended as of April 30, 2016 and at that time 2, 375 individuals had returned their paperwork and were determined to be eligible for HIP for another 12-month Benefit Period. Of individuals who missed their redetermination deadlines at the end of February, 915 returned paperwork within 90 days. For those due at the end of March, 490 have come back and returned paperwork.

- The state also provides the MCEs with listings of members who are coming up on their redetermination to allow the MCE to outreach to those members and assure that they are aware of the process and what actions they may need to take.

- Due to a system issue, the State extended the payment window to ensure that members and MCO's were aware of the opportunity to move to the HIP Plus program. For individuals that successfully redetermined and started new Benefit Periods in HIP Basic on February 1 and March 1, the State extended the Potential Plus period by 30 days to ensure adequate time to consider payments for HIP Plus.

The State also suspended the application of the 6-month disenrollment period for individuals who failed to comply with or complete redetermination activities.

In this quarter the state released a request for proposals (RFP) for a new marketing vendor to promote both HIP 2.0 and the HIP Link program. That process led to an award for Hirons in early June and a new marketing campaign will be out in early fall to promote HIP Link, HIP and overall health literacy

2. **A discussion of key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed.**

The State continues to hold regular meetings with all involved operational stakeholders including the managed care entities, fiscal agent, systems and eligibility teams to monitor operational status and

identify and implement solutions to operational challenges as they arise. This includes daily meetings on overall HIP 2.0 operations and calls specifically focused on addressing individual client issues.

During this quarter both the eligibility system and MMIS were enhanced with new edits that identified data files with suspect data to allow for the prompt and proactive resolution of these issues. Additionally, a Biweekly Reconciliation Report was initiated in February to monitor data in the eligibility system, Medicaid system, and MCE systems to ensure data consistency and quality. On a weekly basis, the State established a process that required the MCEs to send Application IDs that are not matched to the eligibility system. This new process ensured that duplicate applications, add-a-program applications, and similarly dispositioned applications were matched to the processed applications to couple payments made by the applicant to the appropriate application.

A challenge observed in this quarter was provider and stakeholder confusion regarding the Medically Frail determination process. CMS required the state to remove the medically frail questionnaire at the end of December 2015. Navigators, stakeholders, and providers indicated their preference for maintaining the questionnaire on the application and the state fielded many questions and concerns about this CMS directive. In order to educate the provider and stakeholder community a provider bulletin was release on April 5, 2016 to educate on the medically frail determination process. This publication has been well received and the number of inquiries on this issue has been reduced.

Also in this quarter, the state conducted the first audit of MCE performance in identifying Medically Frail members for the 2015 calendar year. Table 1 outlines the audit findings. Of the 38,655 individuals in 2015 that had a medically frail flag, a 10% audit sample of 3,865 were reviewed. Of those audited, there were 37 HIP medically frail members (unduplicated count) which could not be determined medically frail by the compliance audit team for the audit period. This resulted in a 0.96% error rate. Contract specifications state that if the State's auditor finds that inappropriate referrals to medically frail category have been made in greater than 10% of the audited cases, then liquidated damages would be assessed. The findings from the 2015 audit were significantly less than 10%.

Table 1

HIP Medically Frail Audit Findings – CY 2015 Audit Results Summary

	All	Anthem	MDwise	MHS
Total number of HIP fully eligible medically frail members unduplicated count in the audit period by MCE	38,655	11,946	15,765	10,944
Number of HIP medically frail members unduplicated count in the audit period by MCE	3,865	1,195	1,576	1,094
Number of HIP medically frail members unduplicated count in the audit period by MCE	37	21	9	7
Percent of members inappropriately identified as medically frail	0.96%	1.76%	0.57%	0.64%

*Source: OMPP Quality and Reporting

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

Table 2 below shows enrollment in HIP 2.0 at the end of April 2016. These numbers do not include those who are conditionally eligible and will move into Plus if they make a POWER Account contribution or Basic if they do not. The table shows that the number and proportion of individuals making a POWER Account contribution has increased. In this quarter, 237,648 individuals (66.5%) were making their contributions and receiving HIP Plus benefits. This is up from 221,665 (65%) in the last quarter. We continue to see a majority of the lowest income members, under 23% FPL making POWER Account contributions.

At the end of the quarter, 50,459 individuals (14.1% of enrollees) had income over 100% FPL. In quarter four of year one, 49,858 individuals (14.6% of enrollees) had income over 100% FPL, compared to 34,894 individuals (11.6%) in the third quarter and 27,828 individuals (10.5%) in the second quarter. Many HIP 2.0 eligible individuals may not be made aware of HIP eligibility by the Marketplace. Data from a March 2016 Assistant Secretary for Planning and Evaluation (ASPE) enrollment report indicates that between November 1, 2015 and February 1, 2016, there were 44,269 individuals under 150% FPL that had made a Marketplace plan selection in Indiana. (ASPE Report, page 30).

Table 2
HIP 2.0 Enrollment
4/31/2016

% FPL	Basic				Plus				Total
	State	Regular	Total	Percentage	State	Regular	Total	Percentage	
<23%	47,538	29,569	77,107	39.5%	59,335	58,822	118,157	60.5%	195,264
23%-50%	2,461	7,285	9,746	33.9%	4,176	14,812	18,988	66.1%	28,734
51%-75%	2,480	10,634	13,114	33.6%	4,307	21,666	25,973	66.4%	39,087
76%-100%	2,223	11,249	13,472	30.7%	4,517	25,883	30,400	69.3%	43,872
Total <101%	54,702	58,737	113,439	37%	72,335	121,183	193,518	63%	306,957
101%-138%	1,908	3,193	5,101	10.8%	6,608	35,480	42,088	89.2%	47,189
>138%**	1,206	22	1,228	37.6%	1,862	180	2,042	62.4%	3,270
Grand Total	57,816	61,952	119,768	33.5%	80,805	156,843	237,648	66.5%	357,416

**Individuals over 138% may continue on the program due to TMA or appeal status. *Source: SSDW/EDW

4. **Data related to POWER account including the number and average amount of contributions to POWER accounts from third parties, by type of entity, and by beneficiary income level, the HIP Plus and HIP Basic rollover numbers and amounts, and the rate of disenrollment for failure to pay POWER Account contributions.**

Tables 3 and 4 below outline POWER Account contributions that were made by either an employer or a non-profit organization. Third party contributions continue to represent a very small portion of the overall program. The number of employers electing to make POWER Account contributions in the quarter was 27. These employers made contributions on behalf of 34 members. Some growth was seen in the participation of non-profits as 42 non-profits made contributions on behalf of 2,322 members. This is up from 34 non-profits making contributions for 1,054 members in the last quarter. These numbers represent those groups that have made a formal arrangement with a Managed Care Entity (MCE) to pay on behalf of another individual. Some informal arrangements or payments on behalf of members may not be included in these numbers and the MCEs may not be aware of other payments made on behalf of members, including those from friends or relatives. The external evaluation does include a survey of HIP participants that evaluates if individuals are getting assistance from additional sources.

Table 3
Employer Power Account Contributions
February 1, 2016 – April 31, 2016

	Total
Number of Employers Participating	27
Number of Members on Whose Behalf an Employer Makes a Contribution	34
Total Amount of Employer Contributions	$847.85
Average Amount of Employer Contributions	$24.94

*Source: OMPP Quality and Reporting

Table 4
Non-Profit Organization Contributions
February 1, 2016 – April 31, 2016

	Total
Number of Non-Profit Organizations Participating	42
Number of Members on Whose Behalf a Non-Profit Makes a Contribution	2,322
Total Amount of Non-Profit Contributions	$24,286.64
Average Amount of Non-Profit Contributions	$10.46

*Source: OMPP Quality and Reporting

In this quarter, 3,375 individuals were dis-enrolled from the program for failure to pay their required POWER Account contribution.

Table 5 **HIP 2.0 Closure for Failure to Pay POWER Account** February 1, 2016-April 31, 2016		
FPL	**Count**	**Description**
FPL > 100%	3,375	Failure to make payment to power account

*Source: SSDW/EDW

Table 6 documents that 58,183 individuals left the HIP 2.0 program during the quarter. 8,706 of those were individuals who moved to a different Medicaid program. 49,477 individuals were closed out of the program. This number is the highest we have seen to date because it includes the first cohort to go through annual redetermination for the HIP 2.0 program as well as subsequent month redeterminations. The single largest reason for closure noted in table 7 below is the failure to comply with or complete redetermination. Redetermination is also a time when many individuals notify the state of a change in circumstance, such as increased income, that cause them to loose eligibility. The numbers below show closures and do not account for the members who may have come back to the state and been reopened. Upon termination, individuals can have their eligibility restored should they return their paperwork within 90 days. As noted in section #1 above, 3,780 members who did not meet their redetermination timeline at the end of January, February or March have come back within 90 days and had their eligibility restored.

Table 6 **HIP Closures** February 1, 2016 – April 31, 2016		
Closures by HIP Category	**Moved to Another Medicaid Category** (Non HIP)	**Moved Out of the Medicaid Program**
Regular Plus	2,818	17,702
Regular Basic	1,429	14,030
State Basic	1,783	9,762
State Plus	2,645	7,845
Other	31	138
Totals	**8,706**	**49,477**
Total		**58,183**

*Source: SSDW/EDW

The most frequent closure reasons for all HIP (above and below 100% FPL) are below. This table lists the Top 5 most cited reasons for a closure. There are many other closures for a variety of reasons and the below counts do not include all closures. The top reason for closure is that the individual failed to comply with or complete redetermination.

Table 7 All HIP Closures – Top 5 Reasons February 1, 2016-April 31, 2016	
Number of Closures	**Reason for Closure**
19,197	Individual failed to comply with or complete redetermination
8,114	Income exceeds program eligibility standards
4,331	Increase in earned or self-employment income
3,375	Failure to make payment to POWER Account (over 100% FPL only)
3,223	Not an Indiana resident

*Source: SSDW/EDW

When the closure reasons are broken out for those above and below 100% FPL there are some differences. As documented in table 8, the majority of members under 100% are closed for failing to provide information or by not being an Indiana resident. Table 9 shows that for those over 100% FPL a majority are due to the member's income exceeding program eligibility standards. These individuals are referred to the Marketplace for coverage.

Table 8 HIP Closures 100% FPL and Under – Top 5 Reasons February 1, 2016-April 31, 2016	
Number of Closures	**Reason for Closure**
17,400	Individual fails to comply with or complete redetermination
3,021	Not an Indiana resident
2,650	Income exceeds program eligibility standards
2,321	Failure to provide all required information
987	Individual is eligible for other Medicaid

*Source: SSDW/EDW

Table 9 HIP Closures over 100% FPL – Top 5 Reasons February 1, 2016 – April 31, 2016	
Number of Closures	**Reason for Closure**
5,464	Income exceeds program eligibility standards
3,891	Increase in earned or self-employment income
3,375	Failure to make payment to POWER Account
1,997	Individual fails to comply with or complete redetermination
840	Failure to provide all required information

*Source: SSDW/EDW

5. **Data related to emergency department use including the number of individuals by income level and a breakdown of the number of visits classified as an emergency vs. non-emergency by income level and benefit plan; the number of people who incurred the $8 and $25 copayments**.

Table 10 below documents the number of emergency room visits by HIP 2.0 members for calendar quarter 1. The data are collected on a paid basis not an incurred basis, meaning that this data reflects the claims paid during the experience period with a 90 day claims lag time. In this instance the January-March of 2016 reporting period, shows the claims payment activity for the October-December 2015 experience period. Previous reporting may not have clearly reflected the time period being represented by the data so we are re-submitted previous quarter reporting. The data show a small rise in the percentage of non-emergent visits to the ER in the most recent reporting period.

Table 10
Emergency Room Utilization
January 1, 2016-March 31, 2016 (report period)
Calendar Quarter 1

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	50,069	41,575	8,494	88.26	83%	17%
Basic	34,652	28,774	5,878	135.83	83%	17%
State Plan	86,279	69,578	16,701	116.64	80%	20%

*Source: OMPP Quality and Reporting

Table 11
Emergency Room Utilization
October 1, 2015-December 31, 2015 (report period)
Calendar Quarter 4

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	42,248	36,887	5,361	85	87%	13%
Basic	34,613	30,469	4,144	160	88%	12%
State Plan	68,903	60,547	8,356	108	88%	12%

*Source: OMPP Quality and Reporting

Table 12 Emergency Room Utilization July 1, 2015-September 30, 2015 (report period) Calendar Quarter 3						
Category	Number of ER visits in the period	Number of ER visits deemed emergent	Number of visits deemed non-emergent	Number of Adjudicated ER claims per 1,000 members	Percent of claims deemed emergent	Percent of claims deemed non-emergent
Plus	32,444	28,036	4,408	63	86%	14%
Basic	6,895	5,751	1,144	75	83%	17%
State Plan	52,640	45,811	6,829	86	87%	13%

*Source: OMPP Quality and Reporting

6. Reports on speed of eligibility determinations for HIP 2.0 eligible individuals, including the average number of days between the submission of an application and an eligibility determination, and the average number of days between an eligibility determination and HIP 2.0 plan enrollment.

The State continues to report excellent application processing times. On average, most individual applications are approved in less than 24 days. During this quarter the State received 311,852 applications. With a high of 119,862 applications in February 2016 alone. The State also received 17,262 applications from the FFM for processing. Despite these very large application numbers, the State has kept processing times well below CMS expectations.

Table 13 Eligibility Processing February 1, 2016-April 31, 2016			
	Number of days from application to authorization	Number of days from HIP Authorization for full eligibility	Number of pending HIP applications
Case Type	**Average Days**	**Average Days**	**Count**
Regular Plus	19.87	7.6	14,657
State Plan Basic	8.5	3.1	8
State Plan Plus	18.09	7.4	3,065
Regular Basic	23.33	4.1	1,056
MAHL	14.43	NA	3

*Source: ICES

7. A discussion of the HIP Link program, including but not limited to enrollment, HIP Account balance amounts, grievances, changes in employer contribution levels, participants moving from ESI coverage to HIP Plus or HIP Basic, other operational issues; and evaluation activities.

The HIP Link Alternative Benefit Plan continues to experience statewide growth in both employer and employee participation. We have seen an increased interest in school districts and have directed focused outreach efforts to this employer type. In addition to outreach, we continue to improve internal processes and procedures. Internal HIP Link staffing will be increased next quarter to enhance outreach efforts and standardize internal processes and procedures.

The majority of applications submitted by employers have been approved for HIP Link participation. Only four employer application have been denied. Three of those applications were denied for not covering a required service or offering elective abortion services. One was denied after a corporate restructuring changed the company intent to participate in the program. Conversely, we have had two employers change their health plans in order to participate. The two employer applications were initially denied due to not meeting the cost-effectiveness test. However, both employers chose to increase their employer premium contribution amounts which later resulted into their approved program eligibility.

Table 14
HIP Link Enrollment

	Quarter 2/1/16-4/30/16	Program to Date 6/1/15-4/31/16
Employer enrollment	5	31
Employee enrollment	5	21
Grievances	0	0
Participants moving from ESI to HIP Plus	0	0

*Source: OMPP HIP Link

Table 15
HIP Link POWER Account Balances
February 1, 2016 to April 31, 2016

POWER Account Balance	Number of Employees
$4,000-$3,000	14
$3,000-$2,000	7
$2,000-$1,000	0
$1,000-$0	0

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

*Source: OMPP HIP Link

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

Future reports will document progress in these areas.

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

During this quarter the state was given approval for the ER co-payment protocol. MCEs have undertaken the identification of members to enroll into that study. Future reports will document progress on that project and outcomes.

10. **The number of hospitals and other entities participating in Presumptive Eligibility, by type and the number of applications filed by each entity. The number of full applications filed and the number determined eligible, by entity.**

The Presumptive Eligibility program continues to be very active in Indiana. Table 16 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 is low at t 25%. Continued research into this data will be done to monitor the denial reasons for these applicants to understand if applicants are denied for procedural reasons, such as not providing documentation, or if they do not meet eligibility requirements.

Table 16
Presumptive Eligibility Applications and Performance
February 1, 2016 – April 31, 2016

Provider Type	HPE Applications Submitted	HPE Applications Approved	% PE Applications Approved	IHCP Applications Submitted	IHCP Applications Approved*	% IHCP Applications Approved**
Acute Care Hospital	31,083	22,688	73%	20,255	4,817	27.4%
Community Mental Health Center	1,468	1,137	77.5%	1,017	210	23.6%
Federally Qualified Health Center	3,687	3,098	84%	2,739	1,016	42.3%
Psychiatric Hospital	533	434	81.4%	385	82	25.2%
Rural Health Clinic	21	15	71.4%	13	2	15.4%
County Health Department	0	0	0	0	0	0
Grand Total	**36,792**	**27,372**	**74.4%**	**24,409**	**6,127**	**25.1%**

*****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 17 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, 208 out of 333 (62.5%) eligible entities are signed up to be a QP. We have updated our methodology in counting both QPs and the number of potential QPs by type. This update is a more accurate reflection of the number of providers who could participate in the program. The previous methodology vastly over reported the number of potential providers. For example, the previous methodology, one acute care hospital could be enrolled as a hospital, a rehabilitation unit, and a psych unit all under the acute care label. This would show up as three potential provider entities. In reality, all three are one provider entity in the same location and should be counted as one. We also updated the methodology to count potential provider entities in only one area. For example, one provider entity may be enrolled as both an acute care hospital and a psychiatric hospital, the new method will count the provider one time in their primary enrollment category. This updated methodology more accurately reflects the participation rate among providers and allows us to correctly identify entities who are not participating and target outreach efforts to those providers.

Table 17
Presumptive Eligibility Qualified Providers
February 1, 2016 – April 31, 2016

Provider Type	Number of Qualified Provider Entities (a)	Number of Qualified Provider Locations (b)	Total Potential Provider Entities by Type (c)
Acute Care Hospital	113	113	125
Community Mental Health Center	21	55	25
Federally Qualified Health Center	22	148	26
Psychiatric Hospital	20	20	41
Rural Health Clinic	22	22	67
County Health Department	10	10	49
Total	**208**	**368**	**333**

*Source: Indiana AIM