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: 1/2017 (02/2017-04/2017)

Date submitted to CMS: June 30, 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 one Healthy Indiana Plan 1115(a) demonstration report.

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KEY EVENTS

The State's new Medicaid Management Information System (*Core*MMIS) went live February 13, 2017. *Core*MMIS replaced a legacy system that had been in operation for more than 20 years. The transition to the new MMIS was a significant event that required high levels of collaboration between the State, the eligibility system, MMIS vendor, and the contracted Managed Care Entities (MCE). Assuring continuity of care to members with minimal disruption to providers was a top priority for all parties. The State simultaneously implemented a new provider healthcare portal, which provides greater online functionality for enrolled providers.

In addition to a new system, the State welcomed a new MCE to the HIP program. CareSource began serving HIP members on February 1, 2017.

In this quarter, the POWER Account Contribution Assessment was submitted. The evaluation was based on data from the start of HIP 2.0 (February 2015) through November 30, 2016. Key findings include that only 13,550 members (about 7%) who could lose coverage due to non-payment of POWER Account contribution were disenrolled for failure to pay. Please see below for further evaluation findings.

OPERATIONAL CHALLENGS & ACHIEVEMENTS

Operational challenges and achievements were centered on the go-live of the new MMIS and healthcare portal. As with any major system implementation, there were some unforeseen events that needed to be addressed. 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, managed care entities, 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.

ENROLLMENT BY INCOME LEVEL AND BENEFIT PLAN

Table 1 details HIP 2.0 enrollment by FPL and benefit plan. There were 411,129 fully enrolled members as of April 30, 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. The total number of enrollees into the program have increased by 9,331 since last quarter. There were 259,626 individuals (63.1%) making their POWER Account contributions and receiving HIP Plus benefits. We continue to see most of the lowest income members (59.6%), under 23% FPL making POWER Account contributions. At the end of the quarter, 64,269 individuals (15.6% of total enrollees) had income over 100% FPL.

Table 1: Enrollment at the End of Quarter 1 (April 30, 2017)

	Basic				Plus				Total HIP Enrollment
	State	Regular	Basic Total	Percentage of Basic Enrollment	State	Regular	Plus Total	Percentage of Plus Enrollment	
<23%	46,703	39,195	85,898	40.4%	67,939	58,603	126,542	59.6%	**212,440**
23-50%	3,975	9,934	13,909	40.6%	5,988	14,201	20,189	59.4%	**34,098**
51-75%	4,439	14,941	19,380	40.8%	6,935	21,155	28,090	59.2%	**47,470**
76-100%	3,984	15,933	19,917	37.7%	7,289	25,646	32,935	62.3%	**52,852**
Total <101%	**59,101**	**80,003**	**139,104**	**40.1%**	**88,151**	**119,605**	**207,756**	**59.9%**	**346,860**
101 - 138%	3,144	7,549	10,693	17.8%	11,344	38,163	49,507	82.2%	**60,200**
>138 %	1,644	62	1,706	41.9%	2,123	240	2,363	58.1%	**4,069**
Grand Total	**63,889**	**87,614**	**151,503**	**36.9%**	**101,618**	**158,008**	**259,626**	**63.1%**	**411,129**

*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 42 members. In this quarter, there was a significant increase in both the number of employers participating and the number of members receiving financial support, growing from 10 employers to 37 and from 12 members to 42. Also, there were 45 non-profit organizations that made contributions on behalf of 2,356 members, we see that this number has dropped from 55 to 45 since last quarter (Q4), but the number of members receiving contributions from these non-profits increased by 191 members, a 5% increase.

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 1 (Feb – April 2017)

	Total
Number of Employers Participating	37
Number of Members on Whose Behalf an Employer Makes a Contribution	42
Total Amount of Employer Contributions	$1,098.29
Average Amount of Employer Contributions	$26.15

*Source: OMPP Quality and Reporting

Table 3: Non-Profit Organization Power Account Contributions during Quarter 1 (Feb - April 2017)

	Total
Number of Non Profit Organizations Participating	45
Number of Members on Whose Behalf a Non Profit Makes a Contribution	2,356
Total Amount of Non Profit Contributions	$28,062
Average Amount of Non Profit Contributions	$11.91

*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 64,269 members with incomes over 100% of the FPL, 2,499 members were disenrolled, which is about 3.8 % of the population. In the last quarterly report, 4,602 members disenrolled out of 57,381, this is a 45.6% decrease in the disenrollment rate compared to this quarterly report.

Table 4: Closure for Failure to Pay Power Account during Quarter 1 (Feb – April 2017)

FPL	Count	Description
FPL >100%	2,499	Failure to make payment to power account

*Source: SSDW/EDW

CLOSURES & REASONS

Table 5 documents that 36,724 individuals left the HIP 2.0 program in Q1 2017. 4,208 of those were individuals who moved to a different Medicaid program outside of HIP. 32,516 individuals were closed out of the program all together, a 25% decrease from last quarter (Q4). 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 1 (Feb – April 2017)

HIP category	Moved to Another Medicaid Category (Non HIP)	Moved Out of the Medicaid Program
Regular Plus	1,383	12,819
Regular Basic	688	9,627
State Basic	627	4,418
State Plus	1,484	5,466
Other	26	186
Totals	4,208	32,516
Total	**36,724**	

*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, a decrease of 31% since last quarter (Q4). 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 (Feb – April 2017)

Number of Closures	Reason
12,661	Individual fails to comply with or complete redetermination
6,330	Individual income exceeds program eligibility standards
2,499	Individual failed to make POWER Account contribution
2,297	Individual is not an Indiana resident
834	Written voluntary withdrawal from assistance

*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 1 (Feb – April 2017)

Number of Closures	Reason
11,210	Individual fails to comply with or complete redetermination
2,097	Individual is not an Indiana resident
1,792	Individual income exceeds program eligibility standards
618	Individual eligible for SSI related income
834	Written voluntary withdrawal from assistance

*Source: SSDW/EDW

Table 8: Closures 100% FPL and Above – Top 5 Reasons in Quarter 1 (Feb – April 2017)

Number of Closures	Reason
4,538	Individual income exceeds program eligibility standards
2,499	Individual failed to make POWER Account contribution
1,451	Individual fails to comply with or complete redetermination
285	Written voluntary withdrawal from assistance
200	Individual eligible for SSI related income

*Source: SSDW/EDW

EMERGENCY ROOM UTILIZATION

Table 9 below documents the number of emergency room visits by HIP 2.0 members for calendar quarter 1. 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, Jan - March 2017 reporting period, shows the claims payment activity for the Oct- December 2016(Q4) experience period. In this quarter, we see that the number of ER visits has decreased since last quarter by 7%, however, the non-emergent visits have increased slightly.

Table 9: Emergency Room Utilization Calendar Quarter 1 (Jan – March 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	35,753	28,540	7,213	89	79.8%	20.2%
Basic	19,395	15,677	3,718	117	81%	19%
State Plan	54,798	43,716	11,082	147	79.8%	20.2%

*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, with HIP Link reporting an average of 25 days. In this quarter, we see a decrease in the number of pending applications.

Table 10: Eligibility Processing in Quarter 1 (Feb – April 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	19.78	6.15	9,632
Regular Basic	20.9	3.46	2,483
State Plan Plus	18.43	6.66	2,824
State Plan Basic	17.6	11.04	448
HIP Link	25.83	1	3

*Source: OMPP Quality and Reporting

HIP EMPLOYER LINK

In this quarter, employer participation in HIP Employer Link shows a significant drop after February compared with the relative increase in October through January, the same trend that was observed last year. This is likely due to employer benefit periods matching the calendar year and a lack of interest in employer sponsored health insurance initiatives post open enrollment. Even with that seasonal drop, employer enrollment was higher this quarter than this time last year.

Employee enrollment remained steady as outreach to approved employer groups continued. Members who are enrolled in HIP Employer Link appear to enjoy the program as many of them stayed enrolled into the second benefit period with their employer. We also 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 1 (Feb – April 2017)

	Quarter	Program to Date
Employer enrollment	11	96
Employee enrollment	12	63
Grievances	0	0
Participants moving from ESI to HIP Plus	2	7

*Source: OMPP HIP Employer Link

Table 12: HIP Employer Link POWER Account Balances in Quarter 1 (Feb – April 2017)

POWER Account Balance	Number of Employees
$4,000-$3,000	30
$3,000-$2,000	24
$2,000-$1,000	8
$1,000-$0	1

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

*Source: OMPP HIP Employer Link

POWER ACCOUNT CONTRIBUTIONS AND COPAYMENTS MONITORING PROTOCOLS

The Power Account Contribution Assessment was submitted to CMS on March 30th, 2017. The evaluation 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 healthcare?
- Are individuals aware of the non-payment penalty?

As mentioned above, just 7% of members who could lose coverage due to non-payment were disenrolled for non-payment. In addition, 58% of members who left coverage reported having similar access to healthcare services as currently enrolled members. Members also continue to view HIP as an affordable program with 59% never worried about having enough money to pay their PAC. The full evaluation "POWER Account Contribution Assessment" is published on the CMS demonstration website.

The ER co-pay evaluation is ongoing and will be submitted to CMS later in 2017.

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 the time of application, but the overall number remains low at approximately 52%. 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 1 (Feb – April 2017)

Provider Type	PE Applications Submitted	PE Applications Approved	% PE Applications Approved	IHCP Applications Submitted	IHCP Applications Approved*	% IHCP Applications Approved**
Acute Care Hospital	23,394	18,279	78.1%	8,311	4,134	49.7%
Community Mental Health Center	1,441	1,128	78.3%	468	250	53.4%
Federally Qualified	2,874	2,400	83.5%	1,386	811	58.5%

Health Center						
Psychiatric Hospital	618	492	79.6%	219	147	67.1%
Rural Health Clinic	54	33	61.1%	17	10	58.8%
County Health Department	44	36	81.8%	20	12	60%
Grand Total	**28,425**	**22,368**	**78.7%**	**10,421**	**5,364**	**51.5%**

*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. 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 1 (Feb – April 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 AIM