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: 2/2016(5/2016-7/2016)

Date submitted to CMS: September 30, 2016

HEALTHY INDIANA PLAN[SM]

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 two Healthy Indiana Plan 1115(a) demonstration report.

State Contact
Natalie Angel HIP Director Family and Social Services Administration W374 IGC-S, MS 07 402 W Washington St. Indianapolis, IN 46204-2739 Telephone: 317-234-5547 Facsimile: 317-232-7382 natalie.angel@fssa.in.gov

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 June 2016, the State announced the selection of four managed care entities (MCEs) to administer health care services for both the HIP and Hoosier Healthwise Programs (HHW). Starting January 1, 2017 the State will have one new MCE, joining three existing MCEs currently serving Medicaid members in the State. In this procurement, Indiana FSSA made a number of enhancements to the contracts including an increase in the payment tied to outcomes. Extensive efforts are underway to assure that MCEs are prepared to execute the contract activities prior to January 1, 2017. All MCEs must pass stringent readiness review criteria before they will be allowed to enroll members.

During this quarter, the State began meetings with a new marketing vendor to develop new strategies and goals for marketing in both the HIP 2.0 and HIP Link programs. New campaigns will be released in the fall of 2016 to promote awareness in both programs. Marketing efforts are anticipated to spur growth in enrollment in HIP 2.0 and HIP Link.

The state had many discussions in this quarter with CMS on the federal evaluation of the waiver. The state reviewed proposed surveys developed by CMS's evaluation contractor and provided verbal feedback to CMS on the proposed surveys on May 10, May 23, and May 25, followed by written feedback on June 3. The state also had several discussions with CMS on a Data Use Agreement for data shared with CMS's contractors to protect the personal health information of Hoosiers enrolled in the program.

On July 26, 2016, 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. Medicaid Director Joe Moser provided an update on the program, highlighting the information that was shared in the independent evaluation of the first year of the HIP 2.0 program. The presentation detailed the design, method and data used in developing the evaluation. He also highlighted many of the first year findings including the high rates of member satisfaction and members' knowledge of the program. Director Moser also provided information on the overall growth in provider access and trends in enrollment. HIP Director Natalie Angel provided an update on the Hospital Presumptive Eligibility program, highlighting the number of individuals who have gone through the process and the statewide access to immediate eligibility and coverage. This report can be found on the FSSA website at http://www.in.gov/fssa/hip/2543.htm.

Attendees at the public forum represented a variety of organizations from professional associations including the Indiana Rural Health Association, Indiana State Medical Association (ISMA), Indiana Primary Health Care Association, Indiana Hospital Association, Indiana University Health; community health providers including Jane Pauley Community Health Center, Mental Health America Indiana, Little Red Door, Franciscan St. Francis Health, Community Health Network, and Open Door Health Services; and advocacy organizations including Scott County Partnership and Covering Kids and Families. Also present were each of the three HIP 2.0 MCEs, MDwise, Anthem, and MHS.

After the state presentation, approximately 17 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. There were a few specific concerns raised by some stakeholders including challenges with the presumptive eligibility process and the need for improved member education to increase knowledge of HIP 2.0, its operations, and benefits. Public comments noted that HIP 2.0 has had a positive impact on

members, providers, and other community organizations. Many speakers recognized the efforts of the State and expressed their desire to continue working collaboratively with the State to support the ongoing implementation of HIP 2.0. Finally, HIP 2.0 was characterized as innovative and the State was praised for its successful implementation. Tanya Shelburne, of Little Red Door, said, "HIP 2.0 makes health care accessible and affordable to many low income Hoosiers who may never have had health insurance before."

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.

During this quarter, the state continued efforts to improve quality around the variety of files that pass between the state and the managed care plans. Additionally, improvements were made to the identification and processing of individuals with HIV/AIDS that are enrolled in the Ryan White program. The Indiana State Department of Health (ISDH), who operates the Ryan White program and the MCEs met to improve the process of invoicing and handling payment plans for Ryan White members. This process allows Ryan White members to be identified as Medically Frail by ISDH and FSSA and does not require the MCE to reconfirm this status.

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

Table 1 below shows enrollment in HIP 2.0 at the end of July 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, 253,002 individuals (68.2%) were making their contributions and receiving HIP Plus benefits. This is up from 237,648 (66.5%) in the last quarter. We continue to see a majority of the lowest income members, those under 23% FPL, making POWER Account contributions.

At the end of the quarter, 53,666 individuals (14.5% of enrollees) had income over 100% FPL. This percentage seems to have stabilized as the past three quarters have shown 14.1%-14.6% of enrollees over 100% FPL.

Table 1
HIP 2.0 Enrollment
July 31, 2016

% FPL	Basic				Plus				Total
	State	Regular	Total	Percentage	State	Regular	Total	Percentage	
<23%	46,192	29,963	76,155	37.5%	65,583	61,439	127,022	62.5%	203,177
23%-50%	2,353	7,255	9,608	32.9%	4,208	15,424	19,632	67.1%	29,240
51%-75%	2,336	10,329	12,665	31.7%	4,764	22,502	27,266	68.3%	39,931
76%-100%	2,112	11,115	13,227	29.3%	4,942	27,004	31,946	70.7%	45,173

Total <101%	52,993	58,662	111,655	35.2%	79,497	126,369	205,866	64.8%	317,521
101%-138%	1,906	3,446	5,352	10.6%	7,554	37,648	45,202	89.4%	50,554
>138%**	1,168	10	1,178	37.9%	1,832	102	1,934	62.1%	3,112
Grand Total	56,067	62,118	118,185	31.8%	88,883	164,119	253,002	68.2%	371,187

**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 2 and 3 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 24. These employers made contributions on behalf of 32 members. Growth was seen in the participation of non-profits as 76 non-profits made contributions on behalf of 2,270 members. This is up from 42 non-profits making contributions for 2,270 members in the last quarter. Please note that reporting timelines on employer and non-profit contributions have changed to match the calendar quarter. Previously, they were reported on a demonstration year quarter. This means that the data for the month of April was reported in the last quarterly report and is included in this report. 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.

Table 2
Employer Power Account Contributions

April 1, 2016 – June 30, 2016

	Total
Number of Employers Participating	24
Number of Members on Whose Behalf an Employer Makes a Contribution	32
Total Amount of Employer Contributions	$1,179.62
Average Amount of Employer Contributions	$36.86

*Source: OMPP Quality and Reporting

Table 3 Non Profit Organization Power Account Contributions April 1, 2016 – June 30, 2016	
	Total
Number of Non Profit Organizations Participating	76
Number of Members on Whose Behalf a Non Profit Makes a Contribution	2,270
Total Amount of Non Profit Contributions	$22,398.55
Average Amount of Non Profit Contributions	$9.87

*Source: OMPP Quality and Reporting

In this quarter, 3,069 individuals were dis-enrolled from the program for failure to pay their required POWER Account contribution of out more than 53,000 individuals over 100% FPL. This is slightly down from last quarter when 3,375 were dis-enrolled.

Table 4 HIP 2.0 Closure for Failure to Pay POWER Account May 1, 2016 – July 31, 2016		
FPL	**Count**	**Description**
FPL > 100%	3,069	Failure to make payment to power account

*Source: SSDW/EDW

Table 5 documents that 46,646 individuals left the HIP 2.0 program during the quarter. Of those who left HIP, 6,443 were individuals who moved to a different Medicaid program and 40,203 individuals were closed out of the program. This number is down from 49,477 who closed out of the program in the last quarter. 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 should they return their paperwork within 90 days.

Table 5 HIP Closures May 1, 2016 – July 31, 2016		
Closures by HIP Category	**Moved to Another Medicaid Category** (Non HIP)	**Moved Out of the Medicaid Program**
Regular Plus	2,199	14,881
Regular Basic	1,222	13,318

State Basic	1,016	6,226
State Plus	1,989	5,678
Other	17	100
Totals	**6,443**	**40,203**
Total		**46,646**

*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 in this quarter was an income change that left the member ineligible. The second most common closure reason is that the individual failed to comply with or complete redetermination.

Table 6
All HIP Closures – Top 5 Reasons
May 1, 2016-July 31, 2016

Number of Closures	Reason for Closure
12,471	Income exceeds program eligibility standards
11,902	Individual failed to comply with or complete redetermination
6,077	Individual is eligible for another Medicaid category
4,032	Not an Indiana resident
3,738	Individual failed to provide all required information

*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 7, the majority of members under 100% are closed for failing to provide information. Table 8 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 7
HIP Closures 100% FPL and Under – Top 5 Reasons
May 1, 2016-July 31, 2016

Number of Closures	Reason for Closure
10,923	Individual fails to comply with or complete redetermination
4,880	Individual is eligible for another Medicaid category
3,700	Individual is not an Indiana resident
2,788	Individual failed to provide all required information
2,638	Individual income exceeds program eligibility standards

*Source: SSDW/EDW

Table 8 HIP Closures over 100% FPL – Top 5 Reasons May 1, 2016 – July 31, 2016	
Number of Closures	**Reason for Closure**
9,389	Income exceeds program eligibility standards
3,069	Individual failed to make POWER Account contribution
1,159	Individual is eligible for another Medicaid category
979	Individual fails to comply with or complete redetermination
950	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 9 below documents the number of emergency room visits by HIP 2.0 members for calendar quarter 2. 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 April-June 2016 reporting period, shows the claims payment activity for the January-March 2016 experience period.

Table 9 Emergency Room Utilization April – June 2016 (report period) 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	38,794	29,157	9,637	99	75.2%	24.8%
Basic	36,572	28,859	7,713	213	78.9%	21.1%
State Plan	58,226	42,252	15,974	166	72.6%	27.4%

*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 23 days.

Table 10 Eligibility Processing May 1, 2016-July 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	18.98	7.2	13,333
State Plan Basic	10	14.09	92
State Plan Plus	17.82	7.61	3,131
Regular Basic	22.29	5.24	1,450
HIP Link	22.32	1.67	10

*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.

In this past quarter, the State has seen increased participation among manufacturers. Interest from social service and healthcare organizations continues to be strong and six new companies from that sector were enrolled in the quarter.

Internal processes and procedures are running smoothly due to system enhancements, quality control measures, and additional trainings. Additional staff in the HIP Link unit has allowed for increased outreach activity and a reduction in employer application processing timelines.

As mentioned in the first section of this report, a new marketing/public relations vendor is working on marketing materials to advertise HIP Link, which will increase overall awareness of the program throughout Indiana. Also, many employer open enrollment periods will occur in the last calendar quarter of the year. Both of these will lead to increases in both employee and employer approvals.

Table 11 HIP Link Enrollment		
	Quarter 5/1/16-7/31/16	Program to Date 6/1/15-7/31/16
Employer enrollment	16	50
Employee enrollment	14	37
Grievances	0	0
Participants moving from ESI to HIP Plus	0	0

*Source: OMPP HIP Link

Table 12 HIP Link POWER Account Balances May 1, 2016 to July 31, 2016	
POWER Account Balance	Number of Employees
$4,000-$3,000	23
$3,000-$2,000	7
$2,000-$1,000	6
$1,000-$0	1

**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.**

During this quarter, the State engaged a vendor to perform a survey regarding non-emergency medical transportation (NEMT). The vendor's survey results and evaluation will be submitted to the State in the early fall. The State will submit this report to CMS.

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 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 continues to fall below target goals at 31%. 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 13 Presumptive Eligibility Applications and Performance May 1, 2016 – July 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	28,872	20,495	71%	18,165	4,905	29.5%
Community Mental	1,301	1,022	78.6%	917	219	26.7%

Health Center						
Federally Qualified Health Center	2,912	2,443	83.9%	2,199	918	42.3%
Medical Clinic	6	5	83.3%	5	3	75%
Psychiatric Hospital	542	409	75.5%	343	88	27.7%
Rural Health Clinic	9	5	71.4%	5	2	15.4%
County Health Department	7	6	55.6%	5	0	0%
Grand Total	**33,649**	**24,385**	**72.5%**	**21,639**	**6,135**	**31%**

*****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, 208 out of 333 (62.5%) eligible entities are signed up to be a QP.

Table 14
Presumptive Eligibility Qualified Providers
May 1, 2016 – July 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