HEALTHY INDIANA PLAN DEMONSTRATION

PROJECT NUMBER: 11-W-00296/5

SECTION 1115 QUARTERLY REPORT

State of Indiana

REPORTING PERIOD:

Demonstration Year: 1 (02/01/15 – 1/31/16)

Demonstration Quarter: 4/2016(11/2015-01/2016)

Date submitted to CMS: March 31, 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 the 4th quarter 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.**

The final quarter of HIP 2.0 culminated with a celebration to mark the 1-year anniversary. On January 27, 2016 Governor Pence, key stakeholders and HIP members gathered to celebrate the anniversary and to kick-off a series of anniversary enrollment events across the state. The end of the last quarter demonstrated continued growth in enrollment and a majority of individuals opting to make contributions to their POWER Accounts. At the end of January, over 370,000 individuals had been found eligible for HIP with an average of 70% making contributions over the first year to participate in HIP Plus.

The state also initiated efforts to prepare for the first HIP 2.0 cohort to go through the redetermination process and to process applications from the federal Marketplace that were transferring from Marketplace coverage to HIP 2.0. In addition, the state kicked off a quality improvement initiative for HIP 2.0. The state re-focused its efforts on improving customer service and ensuring clients and stakeholders receive support and guidance as they enroll in the program. A provider bulletin was released on December 8, 2015 to clarify and enhance education around independent member MCE selection and guidance on the process of member MCE selection. Clarification was also provided on the Fast Track pre-payment process and how payment is tied to MCE selection.

The fourth quarter also saw growth in the HIP Link program. The program added 16 employers for a total of 25 employers. In addition, the first 16 members were enrolled into the program. Please see item 7 below for additional information on HIP Link.

On October 30, 2015 the state submitted the Prior Claims Payment Program report which detailed the number of individuals with claims paid under the program and indicated that this program would be discontinued in January 2016, due to low utilization. In March, the state submitted updated data showing that during the last quarter, only 4.7% of the Low Income Caretaker population were eligible for the prior claims payment program and only 0.6% of the total Low Income Caretaker population had a claim paid through the program in the quarter.

The Provider Payment Report was submitted to CMS on Dec 29, 2015. The report outlines the State's findings that the differential in provider payment rates between the HIP 2.0 program and the Hoosier Healthwise (HHW) program have not resulted in unequal access to health care services and that the number of the most commonly used adult specialty care providers in HIP 2.0 and HHW are comparable. The state did not identify any corrective actions needed at this time.

Also during this quarter, legislation was introduced to formally codify the HIP 2.0 program and update the enabling legislation. Later reports will provide additional information on this effort.

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.

In this quarter, the State completed the annual redetermination cycle for the first HIP 2.0 cohort whose benefit periods ended on January 31, 2016. The first redetermination notices were sent on November 1,

2015 to provide 90-days advance notice of redetermination. 98,387 members were due for redeterminations starting February 1, 2016. While, an estimated 130,000 initially transitioned into HIP 2.0 when the program began, 15,835 of that number have terminated and 13,101 have moved to other Medicaid programs. Of the 98,387 members due for redetermination, 51,512 were able to be auto renewed based on existing data that validated current income. Auto renewed individuals did not need to return any documentation to gain a new 12-month benefit period. A total of 69,451 members (out of 98,387) were renewed with a new 12-month Benefit Period. Individuals who have not already renewed, have an additional 90 days to return their paperwork or submit a new application to restart their benefits, we anticipate that additional members will likely be renewed in the 90-day period.

During this same timeframe, Marketplace open enrollment led to additional applications and processing for the Division of Family Resources (DFR). Indiana received 46,299 applications from the Marketplace this year, a 9% increase when compared to last year. Despite the influx of applications along with the first cohort of redeterminations, the state continued its strong record for processing times. Processing times have continued to be well below the federal guidelines and even with the influx of applications, the state was able to exceed processing expectations as indicated in in Table 10 below.

In December of 2015, the state submitted the Presumptive Eligibility Standards Report to CMS. Additional questions regarding the operations of hospital based presumptive eligibility continued during the quarter and a revised PE standards report will be submitted to CMS. Previous data was updated to reflect different reporting sources and the system changes. Please see item 10 for additional information on PE data changes.

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 January 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 with income over 100% FPL continues to grow. In quarter four, 49,858 individuals (14.6% of enrollees) had income over 100% FPL, compared to 27,828 individuals (10.5%) in the second quarter and 34,894 individuals (11.6%) in the third quarter. While this number has increased, it is still lower than originally anticipated, due to the federal policy that does not require individuals between 100 and 138% FPL that are receiving tax credits through the Marketplace to enroll in HIP coverage. Data from a January 2016 Assistant Secretary for Planning and Evaluation (ASPE) enrollment report indicates that between November 1, 2015 and December 26, 2015 there were 38,973 individuals under 150% FPL that had made a Marketplace plan selection in Indiana. (ASPE Report, page 30) Many HIP 2.0 eligible individuals may not be made aware of HIP eligibility by the Marketplace.

For individuals fully enrolled in HIP during the fourth quarter, 221,665 or 65% were making their POWER Account contributions and receiving HIP Plus benefits. Basic members have the ability to move into HIP Plus at redetermination. For individuals below 100% FPL, 61% are electing to make a POWER Account contribution. The likelihood of making a POWER Account contribution increases as individual income increases from 58% of individuals under 23% of the federal poverty level to 69% of individuals between 76% and 100% of the federal poverty level.

Table 1
HIP 2.0 Enrollment
2/01/2015 – 1/31/2016

% FPL	Basic				Plus				Total
	State	Regular	Total	Percentage	State	Regular	Total	Percentage	
<23%	52,969	25,417	78,386	41.95%	58,121	50,329	108,450	58.05%	186,836
23%-50%	2,631	6,866	9,497	34.53%	4,111	13,898	18,009	65.47%	27,506
51%-75%	2,596	10,063	12,659	33.79%	4,500	20,300	24,800	66.21%	37,459
76%-100%	2,216	10,556	12,772	31.29%	4,432	23,613	28,045	68.71%	40,817
Total <101%	60,412	52,902	113,314	38.72%	71,164	108,140	179,304	61.28%	292,618
101%-138%	1,771	3,454	5,225	12.75%	6,003	29,764	35,767	87.25%	40,992
>138%	1,329	943	2,272	25.63%	2,361	4,233	6,594	74.37%	8,866
Grand Total	63,512	57,299	120,811	35.28%	79,528	142,137	221,665	64.72%	342,476

**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. Though there has been some growth in third party contributions, it remains a very small portion of the overall program. The number of employers electing to make POWER Account contributions in the fourth quarter was 31. These employers made contributions on behalf of 32 members. Also, during the fourth quarter, 34 non-profits made contributions on behalf of 1,054 members. 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** November 2015 – January 31, 2016	
	Total
Number of Employers Participating	31
Number of Members on Whose Behalf an Employer Makes a Contribution	32
Total Amount of Employer Contributions	$1,231.23
Average Amount of Employer Contributions	$191.85

*Source: OMPP Quality and Reporting

Table 3 **Non-Profit Organization Contributions** November 2015 – January 31, 2016	
	Total
Number of Non-Profit Organizations Participating	34
Number of Members on Whose Behalf a Non-Profit Makes a Contribution	1,054
Total Amount of Non-Profit Contributions	$12,432.98
Average Amount of Non-Profit Contributions	$102.52

*Source: OMPP Quality and Reporting

Table 5 documents that 22,206 individuals left the HIP 2.0 program during the fourth quarter. 3,822 were individuals who moved to a different Medicaid program. 18,384 individuals were closed out of the program. Tables 6, 7, and 8 below highlight the top reasons that individuals are closed.

Table 5 **HIP Closures** November 1, 2015 – January 31, 2016		
Closures by HIP Category	**Moved to Another Medicaid Category** (Non HIP)	**Moved Out of the Medicaid Program**
Regular Plus	1,494	3,472
Regular Basic	658	3,420
State Basic	1,257	8,147
State Plus	407	3,327
Other	6	18
Totals	**3,822**	**18,384**
Total		**22,206**

*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 income exceed the eligibility standard.

Table 6 **All HIP Closures – Top 5 Reasons** November 1, 2015 – January 31, 2016	
Number of Closures	**Reason for Closure**
8,011	Income exceeds program eligibility standards
5,720	Medicaid Category change
2,031	Not an Indiana resident
1,680	Failure to make payment to POWER Account (over 100% FPL only)
1,165	Failure 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. The majority of members under 100% are closed for failing to provide information or by moving to another Medicaid category. 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** November 1, 2015 – January 31, 2016	
Number of Closures	**Reason for Closure**
4,417	Category change
1,893	Not an Indiana resident
1,835	Income exceeds program eligibility standards
792	Failure to provide all required information
431	Written voluntary withdrawal from assistance

*Source: SSDW/EDW

Table 8 **HIP Closures over 100% FPL – Top 5 Reasons** November 1, 2015 – January 31, 2016	
Number of Closures	**Reason for Closure**
6,211	Income exceeds program eligibility standards
1,677	Failure to make payment to POWER Account
1,289	Category change
373	Failure to provide all required information
151	Individual acquired Medicare Part A or Part B.

*Source: SSDW/EDW

In the fourth quarter of HIP 2.0 program performance, 1,680 individuals were closed for failure to pay their POWER Account contribution, this represented 3.4% of all individuals over 100% of FPL.

Table 4
HIP 2.0 Closure for Failure to Pay POWER Account
November 1, 2015 – January 31, 2016

FPL	Count	Description
FPL > 100%	1,680	Failure to make payment to power account

*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 3. Reporting on ER utilization comes from actual claims experience, so data is delayed to allow for claims to be submitted and may vary over time as additional claims are submitted and adjudicated. The data show a continued significant reduction in non-emergent use of the ER in all HIP categories during this reporting period. The state has received approval of our ER Co-Payment Protocol and we will begin reporting on co-payment experience in the first quarter of demonstration year two.

Table 9
Emergency Room Utilization
July – September 2015
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	42,248	36,887	5,361	85	87.3%	12.7%
Basic	34,613	30,469	4,144	160	88.0%	12.0%
State Plan	68,903	60,547	8,356	108	87.9%	12.1%

*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. As mentioned above, the first HIP redetermination cohort and open enrollment on the Marketplace led to a significant increase in the number of applications that needed to be worked. The state was able to meet this challenge and exceed all timeliness requirements. On average, most individual applications are approved in less than 25 days. Eligibility begins the first day of the month in which payment is made. This table also reflects a change in how the data is reported in the third column "Number of days from HIP Authorization for full eligibility" to reflect a more accurate representation of the number of days from authorization to coverage being

effective. The previous method was measuring an operational processing time and not the actual time for a member to experience full coverage after their application was approved. Updated data from the previous quarters will be provided in annual report but below is the data for the fourth quarter.

Table 10
Eligibility Processing
Nov. 1, 2015 - Jan. 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	23.61	8	30,465
State Plan Basic	11.23	1	9
State Plan Plus	20.83	8	5,619
Regular Basic	25.77	4	1,544
MAHL	20.15	*NA	6

*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 is now fully operational and experiencing statewide growth in both employer and employee participation. Participation includes both large and small employers. The primary focus during the quarter was to enhance outreach to both potential employers and potential members. Outreach efforts directly targeted at employees of approved HIP Link employers proved successful as employee participation increased substantially. In addition to outreach, internal processes and procedures were examined and refined as this new influx of members entered the program. The employer portal used by employers to enroll in the program underwent several enhancements to allow for greater ease in employer enrollment. Plans have been made to increase staffing of the HIP Link team which will bolster outreach efforts as well as improve internal monitoring of applications and processes.

Enhanced outreach efforts appeared successful as the program showed growth in the quarter with 16 employer applications being approved, bringing the total enrolled employers to 25. HIP Link staff have worked closely with enrolled employers and employees to monitor their experience, assure that systems were processing applications correctly, and identify any areas where improvements were necessary. Efforts are currently being made to educate and train call center staff to better assist employers with application questions or concerns.

Table 11 HIP Link Enrollment		
	Quarter 11/1/15-1/31/16	Program to Date 6/1/15-1/31/16
Employer enrollment	16	25
Employee enrollment	16	16
Grievances	0	0
Participants moving from ESI to HIP Plus	0	0

Table 12 HIP Link POWER Account Balances November 1, 2015 to January 31, 2016	
POWER Account Balance	Number of Employees
$4,000-$3,000	16
$3,000-$2,000	0
$2,000-$1,000	0
$1,000-$0	0

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

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

The POWER Account Contributions and Copayments Monitoring Protocol was submitted to CMS on July 30, 2015, and outlines that the knowledge and impact of POWER account contributions and copayments would be assessed using survey data and included in the annual evaluation. The state's evaluation design was approved by CMS on December 22, 2015, and future reports will detail the evaluation results. On December 22, 2015 CMS also approved an extension of the NEMT waiver that runs through November 30, 2016.

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. During this quarter the state determined a data discrepancy issue on PE reporting. This did not impact the reporting on the total number of HPE applications submitted or approved, it did impact the information on the number and percent of IHCP applications approved. The state has resolved this concern and the below report reflects the updated information. The State is seeing a significant number of PE recipients that are being denied IHCP benefits at application with less than 20% being found eligible for full benefits. 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.

The State promulgated an administrative rule that became effective November 1, 2015. The rule establishes performance standards for all hospitals performing as qualified providers. The rule begins on page 24 of the document Rule 3.

Table 13
Presumptive Eligibility Applications and Performance
November 1, 2015 – January 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	29,223	22,200	75.97%	20,413	3,836	22.26%
Community Mental Health Center	1,362	1,089	79.96%	1,050	151	17.38%
Federally Qualified Health Center	3,459	2,938	84.94%	2,683	839	38.72%
Psychiatric Hospital	575	453	78.78%	428	61	17.68%
Rural Health Clinic	24	20	83.33%	18	9	50%
County Health Department	9	9	100%	7	5	100%
Grand Total	**34,652**	**26,709**	**77.07%**	**24,599**	**4,901**	**19.92%**

*****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. In this quarter, we are reporting only on those providers and locations that have been active in PE applications. In the past, we reported on all enrolled QPs regardless of their activity during the quarter. To this end, the numbers are slightly lower than the previous quarter with 168

active QPs operating in 231 locations in the state. The third column, "Total Potential Providers by Type" indicates the total number of specialty providers enrolled, for each type, in the Indiana Health Coverage Program.

Table 14
Presumptive Eligibility Qualified Providers
November 1, 2015 – January 31,2016

Provider Type	Number of Qualified Providers	Number of Qualified Provider Locations	Total Potential Provider by Type*
Acute Care Hospital	107	109	168
Community Mental Health Center	19	40	25
Federally Qualified Health Center	23	63	68
Psychiatric Hospital	13	13	32
Rural Health Clinic	4	4	66
County Health Department	2	2	57
Total	**168**	**231**	**416**

*Source: Indiana AIM

*This Column reflects the total number of providers of that type enrolled in the IHCP.