STATE OF INDIANA
OFFICE OF THE GOVERNOR
State House, Second Floor
Indianapolis, Indiana 46204

Michael R. Pence
Governor

June 30, 2014

The Honorable Secretary Sylvia Burwell
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Burwell,

On behalf of the people of Indiana, I respectfully submit this application to extend the Healthy Indiana Plan Section 1115 demonstration waiver for three years.

The Healthy Indiana Plan, which today serves about 45,000 individuals, has achieved positive results over the course of its six-year history. Because the consumer-driven model incentivizes patients to take greater ownership over their health care decisions, Healthy Indiana Plan members utilize health care services in a more responsible manner than traditional Medicaid. The program is also very popular in our state among Healthy Indiana Plan members and non-members alike.

In the coming days, the State of Indiana will submit a waiver to expand the Healthy Indiana Plan to provide coverage to more Hoosiers. As you know, this expansion waiver is the product of many months of productive, good faith discussions between the State of Indiana and the U.S. Department of Health and Human Services. While we are encouraged by the progress we have made to date, our first priority must be the protection of the Healthy Indiana Plan for current enrollees. For this reason, we are concurrently submitting a waiver to extend the Healthy Indiana Plan.

I look forward to working with you further to ensure the successful future of the Healthy Indiana Plan.

Sincerely,

[redacted]

Governor

Indiana Family and Social Services Administration

Healthy Indiana Plan 1115 Waiver Extension Application

HEALTHY INDIANA PLAN SM

Health Coverage = Peace of Mind

Submitted
6/30/2014

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Section 1: Executive Summary

The Healthy Indiana Plan (HIP), which passed the Indiana General Assembly in 2007 with bipartisan support, builds upon the state's long and successful history with consumer-driven health plans. Indiana pioneered the concept of medical savings accounts in the commercial market and is the first and only State to apply the consumer-driven model to a Medicaid population. Provided by private health insurance carriers, HIP offers its members a High Deductible Health Plan (HDHP) paired with the Personal Wellness and Responsibility (POWER) account, which operates similarly to a Health Savings Account (HSA).

The private health insurance experience provides an alternative to traditional Medicaid and promotes consumerism by requiring members to make contributions into their account. This gives members "skin in the game," which empowers them to demand price and quality transparency as they make cost-conscious health care decisions and take responsibility for their health. In addition, the infusion of market principles works to educate members and prepare them to participate in the private market when they are able to transition off the program.

This waiver application is submitted concurrently with a separate 1115 Demonstration waiver (HIP 2.0 Waiver). The HIP 2.0 Waiver seeks to expand HIP to all non-disabled adult Hoosiers below 138% of the federal poverty level (FPL), as well as to implement key enhancements based on the first six years of HIP program experience. If approved, the HIP 2.0 Waiver will eliminate the coverage gap created by the Patient Protection and Affordable Care Act (ACA), providing an affordable health insurance product to all low-income individuals who would otherwise be ineligible for both Medicaid and the premium tax credits available through the Marketplace. If the Centers for Medicare and Medicaid (CMS) does not approve the HIP 2.0 Waiver request, the State submits this request as an alternative application to preserve the current HIP program for the current enrollees who rely on the program.

Through this waiver request, the State aims to at least continue the HIP program for the maximum waiver renewal period of three years in its current form, with no new changes.

Section 2: Program Description

Traditional Medicaid programs offer coverage to vulnerable individuals, but numerous studies indicate poor health outcomes in spite of high spending. A University of Virginia study found that Medicaid patients are almost twice as likely to die after an inpatient surgery, stay in the hospital forty-two percent (42%) longer, and cost twenty-six percent (26%) more than individuals with private health insurance.[1] A study conducted by Johns Hopkins similarly found higher mortality rates among Medicaid patients, indicating they are twenty-nine percent (29%) more likely to die within three years following receipt of a lung transplant.[2]

The HIP model was developed as an alternative to traditional Medicaid in order to harness the success of the private health insurance market to lower costs and improve health outcomes for Hoosiers. The program utilizes an account similar to an HSA that empowers enrollees to become

[1] Avik, Roy. (2012). The Medicaid Mess: How Obamacare Makes It Worse. Retrieved from http://www.manhattan-institute.org/html/ir_8.htm.
[2] *Id*.

active consumers of health care services and to evaluate cost and quality of services. Six years later, HIP has demonstrated significant success in achieving this goal.

HIP's consumer-driven design creates incentives for members to exercise personal responsibility and live healthy lifestyles. This design encourages members to take control of their health care spending and to be active purchasers of health care services. While other efforts aimed at bending the health care cost curve are aimed at providers and insurers, HIP brings the member directly into the equation, aligning incentives across all parties and uniquely empowering the individual to demand cost and quality transparency. Through the introduction of these market forces, HIP is able to yield superior results compared to traditional Medicaid.

2.1 Eligibility

HIP targets non-disabled adults between the ages of 19 and 64 with a household income less than 100% FPL who are not otherwise eligible for Medicaid. Currently, Section 1931 parents and caretaker relatives are not eligible for HIP. This population is instead placed in the Hoosier Healthwise (HHW) program - Indiana's full benefit Medicaid program for children, parents, pregnant women, and certain caretaker relatives. While HIP does not limit enrollment for parents and caretaker relatives with income below 100% FPL, the State does impose a firm enrollment cap of 36,500 on the number of non-caretakers allowed to participate in HIP.

2.1.1 Populations Ineligible HIP

Individuals eligible for services under traditional Medicaid are described below in Table 2.1.1 (A).

Table 2.1.1 (A): Current Medicaid Populations Ineligible for HIP

1. Mandatory categorically needy low-income families and children eligible under section 1925 for Transitional Medical Assistance.
2. Mandatory categorically needy poverty level infants eligible under 1902(a)(10)(A)(i)(IV).
3. Mandatory categorically needy poverty level children aged 1 up to age 6 eligible under 1902(a)(10)(A)(i)(VI).
4. Mandatory categorically needy poverty level children aged 6 up to age 19 eligible under 1902(a)(10)(A)(i)(VII).
5. Optional categorically needy poverty level pregnant women eligible under 1902(a)(10)(A)(ii)(IX).
6. Optional categorically needy poverty level infants eligible under 1902(a)(10)(A)(ii)(IX).
7. Optional categorically needy AFDC-related families and children eligible under 1902(a)(10)(A)(ii)(I).
8. Mandatory categorically needy low-income parents eligible under 1931 of the Act.
9. Mandatory categorically needy pregnant women eligible under 1902(a)(10)(A)(i)(IV) or another section under 1902(a)(10)(A)(i).
10. Individuals qualifying for Medicaid on the basis of blindness.
11. Individuals qualifying for Medicaid on the basis of disability.
12. Institutionalized individuals assessed a patient contribution toward the cost of care under 1902(f).
13. Individuals dually eligible for Medicare and Medicaid (42 CFR §440.315).
14. Children receiving foster care or adoption assistance under title IV-E of the Act.

15. Women needing treatment for breast or cervical cancer who are eligible under 1902(a)(10)(A)(ii)(XVIII).
16. Illegal or otherwise ineligible aliens who are only covered for emergency medical services under section 1903(v).

The current HIP program also excludes the following individuals from HIP coverage.

Table 2.1.1 (B): Individuals Currently Ineligible for HIP (2014)

1. Those eligible for Medicaid under the state plan with the exception of the family planning option, as described in Table 2.1.1.1(A) above.
2. Those eligible for Medicare.
3. Pregnant women for the purpose of pregnancy-related services.
4. Those otherwise eligible for medical assistance.
5. Those with income in excess of 100% FPL.
6. Those who fail to pay a POWER account contribution within 60 days (not inclusive of the first POWER account contribution) are excluded from HIP eligibility for 12 months if they fail to pay.

2.1.2 Populations Eligible for HIP

Individuals eligible for services under traditional Medicaid are described below in Table 2.1.2.

Table 2.1.2: Current Populations Eligible for HIP

Description	FPL and/or other qualifying criteria	Demonstration Eligibility Group(s)	Consistent with below group(s) prior to January 1, 2014
Adults age 19 to 64 who are not otherwise eligible for comprehensive Medicaid benefits or Medicare.	Income under 100% FPL per the Modified Adjusted Gross Income (MAGI) guidelines with 5% disregard, payment of POWER account contribution, no resource limit.	Adults (As described in the final rule at 42 CFR 435.119. "The adult group" of Section 1931 parents and caretaker relatives will not be in HIP, but will be eligible for HHW coverage.)	Parents and Caretakers, Non-Caretaker Adults

2.1.3 Enrollment Limit

The Indiana Code makes clear that HIP is not an entitlement program, and that the State may not enroll new participants if revenues from the cigarette tax cannot support additional clients. The waiver addresses sustainability by (i) eliminating the income disregard for HIP caretakers and

(ii) placing an enrollment cap on HIP non-caretaker adults. The cap on non-caretaker adults is reinforced by CMS as part of the federal budget neutrality agreement. While HIP does not limit enrollment for parents and caretaker relatives with income below 100% FPL, the waiver imposes a firm enrollment cap of 36,500 on the number of non-caretakers allowed to participate in HIP. In accordance with the current Special Terms and Conditions (STCs), the State requests continuation of its authority to modify eligibility criteria for new entrants during the demonstration if the State projects that expenditures for the program will exceed annually authorized and appropriated State funds.

2.2 Benefits

The HIP program provides comprehensive benefits (set forth in Table 2.2 below) including physician, inpatient, outpatient, mental health services, pharmaceuticals, laboratory services, and other therapies through a Secretary-approved plan. The plan does not cover non-emergency transportation, dental, or vision services for adults. Pregnancy-related services are also excluded, as pregnant HIP members are transferred to the HHW program for the duration of the pregnancy. Preventive services, such as annual examinations, smoking cessation programs, and mammograms are covered without charge to the member up to $500, and are not included in the deductible amount. After the deductible is met through the POWER account funds, the HIP program includes a comprehensive benefit package, covering up to $300,000 in services annually and a lifetime benefit limit of $1 million.

Table 2.2: HIP Benefits

Benefit	Limits/Inclusions (as applicable)
Inpatient Facility	
Medical/Surgical	
Mental Health/Substance Abuse	Covered same as any other service.
Skilled Nursing Facilities	Subject to a 60-day maximum.
Outpatient Facility	
Surgery	
Emergency Department	For HIP Caretakers: $3 Co-payment for services determined to be non-emergency. For HIP Adults: $25 Co-payment for services determined to be non-emergency.
Urgent Care	
Physical/Occupational/Speech Therapy	25-visit annual maximum for each type of therapy.
Radiology/Pathology	
Pharmacy and Blood	Generic preference; but brands allowed when no generic is available.
Professional Services	
Inpatient/Outpatient Surgery	
Inpatient/Outpatient ER Visits	
Office Visits/Consults	
Preventive Services	At least $500 annual first dollar coverage.

Physical/Occupational/Speech Therapy	25-visit annual maximum for each type of therapy.
Radiology/Pathology	
Outpatient Mental Health/ Substance Abuse	Covered the same as any other illness.
Ancillary Services	
Prescription Drug	Brand name drugs are not covered where a generic substitute is available.
Home Health	Excludes long term care.
Hospice	
Emergency Transportation	
Durable Medical Equipment/Supplies/Prosthetics	
Family Planning Services	Excludes abortion or abortifacients. Includes contraceptives and sexually transmitted disease testing as described in Medicaid law (42 USC 1396).
Lead Screening Services	Under 21 Years of Age.
Hearing Aids	
Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services	Subject to the HIP benefit coverage limits.
Disease Management Services	

In August 2010, Milliman certified that the current HIP benefits do not meet the benchmark equivalent standard based on the ACA coverage requirements, and as such, HIP would be considered Secretary approved coverage.[3] The State seeks approval for the current HIP benefit package described above to continue to be designated Secretary-approved coverage; and requests an ongoing waiver for the requirement to provide non-emergency transportation coverage. Current HIP benefits will continue to be subject to the $300,000 annual and $1 million lifetime limits.

2.3 Cost-Sharing

Currently, HIP utilizes two forms of cost-sharing. First, HIP requires individuals to contribute to their POWER account. Second, HIP requires individuals pay co-payments for non-emergency usage of hospital emergency departments (ED). The State sets POWER account contribution rates on a sliding fee scale, reflecting approximately 2% of the participant's household income. Consistent with the CMS standard, members do not pay more than 5% of their annual income in combined cost-sharing (POWER account contributions and ED co-payments). Non-caretaker adults in the current HIP program pay a flat $25 co-payment for all non-emergency ED visits.

Per CMS rules for HIP parents and caretaker relatives, the total aggregate amount of (1) POWER account contributions, (2) HIP co-payments, (3) Medicaid cost-sharing requirements, and (4) CHIP cost-sharing requirements may not exceed 5% of family income. If a member approaches

[3] Analysis of the Healthy Indiana Plan benefits in comparison to Indiana's Essential Health Benefits and the Medicaid State Plan has also been completed. These additional analyses are available upon request.

the cost-sharing limit, the health plan verifies the member's cost-sharing documentation and notifies the HIP program manager that the member (1) has reached the 5% maximum contribution amount and (2) the date 5% limit is reached. The member is not required to pay any further POWER account contributions or ED co-payments for the rest of the 12-month benefit period.

2.3.1 Co-Payments

Consistent with the 2014 STCs, HIP members may be charged co-payments for non-emergency use of a hospital ED in accordance with the table below.

Table 2.3.1: HIP Non-Urgent Use of ED Co-Payment Schedule

POPULATION	CO-PAYMENT AMOUNT
HIP Caretakers with Incomes Above the AFDC Income Limit as Indicated in the State Plan through 100% FPL	$3.00 per visit
HIP Non-Custodial Parents and Childless Adults	$25.00 per visit

Other than ED co-payments, the only other cost-sharing to which HIP members will be subject is the monthly POWER account contribution set forth in Section 2.3.2.

2.3.2 POWER Accounts

Modeled in the spirit of an HSA, HIP provides each member a POWER account valued at $1,100 per member. This account is comprised of individual and State contributions and is used to pay the member's deductible expenses - also $1,100. Instead of traditional cost-sharing of premiums and co-payments, HIP members must make monthly contributions to their POWER account, with the contribution no more than 2% of income. The State contributes the remainder of the POWER account funding up to the deductible amount. In order to ensure the POWER account is fully funded on the first day of service, the State prefunds the account. The health plans are required to pay claims for all service costs after the deductible is met. Table 2.3.2 indicates the individual POWER account contribution amounts.

Table 2.3.2: POWER Account Contributions

Annual Household Income	Maximum POWER Account Contribution	Estimated maximum annual/monthly contribution Individual	Estimated maximum annual /monthly contribution Family of 4
All enrollees less than 25% FPL	Not more than 2% of income	$54.46 / $4.54	$111.76 / $9.31
All enrollees between 25% and 50% FPL	Not more than 2% of income	$108.90 / $9.08	$223.50 / $18.63
All enrollees between 50% and 75% FPL	Not more than 2% of income	$163.36 / $13.61	$335.26 / $27.94
All enrollees between 75% and 100% percent FPL	Not more than 2% of income	$217.80 / $18.15	$447.00 / $37.25

HIP members may also receive contribution assistance from their employers and not-for-profit organizations. Employers are permitted to pay up to 50% of their employee's required POWER account contribution; and not-for-profit organizations are permitted to contribute up to 75% of the individual's required POWER account contribution.

After completing an application and meeting the financial and other eligibility criteria, members are "conditionally eligible" for the HIP program. They do not become fully eligible until they make their first POWER account contribution. Once fully enrolled, members must continue to make monthly contributions to maintain their HIP eligibility. If they fail to make this contribution within a sixty (60) day grace period, they are dis-enrolled from HIP and must wait twelve (12) months to re-apply.

Unlike traditional premiums or co-payments, HIP members own their contributions and are entitled to any unused contributions if they leave the program. Additionally, HIP members who receive required preventive services are rewarded by allowing any remaining balance (including the State's contribution) in their POWER account to roll over and offset required contributions in the next year. If individuals do not complete the required preventive services, only the pro-rated balance of the member's contribution rolls over; and the State share of the contribution will return to the State. Any rollover amount can reduce required contributions in the following year. The incentive is designed to increase the use of preventive care as well as to encourage prudent use of account dollars. In the long term, the regular use of preventive services under the HIP program should reduce costs and improve the health of the individual members and the total HIP population.

Section 3: Historical Narrative

Indiana has a long and rich history with consumer-driven healthcare programs. In 1992, Indiana-based Golden Rule Insurance Company executive, J. Patrick Rooney, pioneered the concept of medical savings accounts with his own employees. Based on its success encouraging his employees to make more cost-conscious health care decisions, Rooney began selling medical savings account plans in 1996 and played an integral role in securing Congressional authorization for tax advantaged HSAs in 2003.

Since then, Indiana employers have increasingly adopted HSAs for employee health plans. In 2006, the State of Indiana introduced consumer-driven health plan options to its nearly 30,000 employees and their dependents. By 2010, eighty-five percent (85%) of state employees elected to enroll in a HDHP plan option attached to an HSA. In 2013, ninety-six percent (96%) of state employees chose a consumer-driven health plan option.

The number of consumer-driven plans in the Indiana commercial health insurance market has also continued to increase. As of January 2013, 420,643 Hoosiers were covered by HDHPs/HSAs, representing nine percent (9%) of commercial market enrollment (greater than the U.S. average of seven percent (7%)). Among all states, Indiana ranked seventh in the percentage of HDHP/HSA enrollees under age 65 with private health insurance.

Given Indiana's rich history and proven track record of success with consumer-driven health care, the State turned to these principles to develop a plan to address its uninsured residents and

their health needs. Prior to HIP, the Indiana Medicaid program had one of the lowest eligibility thresholds in the nation. There was little support to expand the State's traditional Medicaid program as an open-ended entitlement that would strain the State's budget in future years. Additionally, a traditional Medicaid plan appeared unlikely to significantly improve participant health status given its lack of incentives for appropriate healthcare utilization.

Following input from numerous stakeholder meetings and bipartisan collaboration, the State of Indiana, under the leadership of Governor Mitch Daniels, designed the Healthy Indiana Plan (HIP) to introduce healthcare consumerism and private market principles to the Medicaid program. As the program was funded largely by an increase in the cigarette tax, it was designed to maintain limited enrollment in order to ensure a balanced State budget. During the 2007 legislative session, Rep. Charlie Brown authored and Sen. Patricia Miller sponsored a bipartisan bill enabling HIP. After the bill was passed with wide bipartisan support in April 2007, the Indiana Family and Social Services Administration (FSSA) immediately moved to develop an implementation plan and began negotiations with CMS to obtain federal waiver approval. On January 1, 2008, HIP began enrolling working-age, uninsured adults in coverage.

In 2011, following the passage of the ACA, the Indiana General Assembly reinforced its support for HIP by calling for HIP to be the coverage vehicle for a Medicaid expansion. The legislature passed Senate Enrolled Act 461 (codified at Indiana Code §12-15-44.2), which made several conforming changes related to the ACA, including revising program eligibility thresholds to align with the Marketplace coverage options available to individuals beginning in 2014. In addition, the legislation included a provision authorizing the Secretary of the Family and Social Services Administration to "amend [HIP] in a manner that would allow Indiana to use the plan to cover individuals eligible for Medicaid resulting from the passage of the [ACA]."

The State has repeatedly sought approval to expand and extend HIP coverage. In December 2011, after four successful years of administering HIP and entering the fifth and final year of its original demonstration period, the State submitted a three year waiver extension request. Although CMS did not accept all of the requested legislative modifications to the program, in September 2012, CMS granted a one year extension. In April 2013, the State requested an additional three year extension. This request was again approved in September 2013 for another one year term to run through December 31, 2014.

In the most recent waiver request, CMS granted the State several modifications to HIP eligibility. The waiver contained specific language that allows the State to adjust eligibility levels to control enrollment. Beginning in 2014, HIP eligibility was reduced to cover individuals with household income up to 100% FPL, recognizing that individuals above 100% FPL who were previously eligible for HIP would have new coverage options and access to premium tax credits and cost-sharing reductions via the federal Marketplace. Further, consistent with the changes in the HIP legislation, requirements that an individual be uninsured for at least six months and lack access to employer-sponsored insurance were removed from the HIP eligibility criteria effective January 1, 2014.

The more recent series of one-year, temporary extensions of the HIP program have resulted in a substantial amount of uncertainty for current enrollees lacking alternative coverage options.

During this time, the State has consistently sought guidance from CMS regarding the long-term future of HIP and its potential expansion. The State remains committed to the promise of the HIP coverage model improving cost and quality of healthcare services.

Concurrent with this waiver, the State is submitting the HIP 2.0 Waiver proposal. While the State prefers to move forward with the program enhancements detailed in the HIP 2.0 Waiver, the State seeks to extend the current HIP program as it is currently structured if CMS does not approve the HIP 2.0 proposal. As detailed in Sections 3 and 4 of this waiver proposal, the HIP demonstration project has conformed to its applicable STCs, and has effectively adapted to a changing healthcare market and regulatory landscape while achieving its foundational goals and objectives. Therefore, the State seeks, at minimum, a three year waiver renewal of the existing HIP program without modification. Approval would ensure ongoing coverage and provide certainty and continuity of care for the thousands of Hoosiers currently utilizing HIP's affordable coverage option.

3.1 HIP Operations & Managed Care Entities

The HIP program has evolved over the course of the demonstration, with several key changes. At the beginning of the program, HIP contracted with two managed care entities (MCEs) - Anthem and MDwise - and had a third Enhanced Services Plan (ESP) that was operated by the State's high risk pool, the Indiana Comprehensive Health Insurance Association (ICHIA), to provide coordinated coverage for HIP members with high risk conditions. The ESP plan is discussed in more detail in Section 3.2 below. During the initial contracting period in 2007, the State selected two managed care plans Anthem and MDwise in collaboration with AmeriChoice, which leveraged commercial experience and HSA experience. However, since then, MDwise has changed billing and claims subcontractors. During the first three and a half years of the program, the contracts governing the State's relationship with Anthem and MDwise were modified to contain costs, improve member service, streamline ESP, and ensure that the MCEs remained financially stable.

In 2008, both Anthem and MDwise ended the year with losses as the capitation rates did not reflect the pent-up demand for services and high disease burden of a previously uninsured population. Actuarial analysis conducted on the first year of program claims encouraged the State to make significant contract modifications. The claims experience showed that parents and caretaker relatives had a twenty-five percent (25%) higher risk-adjusted relative morbidity than the commercially-insured population; and non-caretaker adults had an even higher morbidity - calculated to be sixty-five percent (65%) greater than a comparable commercially-insured population. HIP members also used services at a much higher rate when compared to a commercially-insured population. Parents and caretaker relatives initially had 38% more inpatient hospital days and 181% more ED visits; and non-caretakers had 155% more inpatient hospital days and 269% more ED visits than their commercially-insured counterparts. Over the course of the first year of enrollment, HIP members increased their use of pharmacy services and decreased their use of all other services, with the decline in utilization beginning in approximately the third month of enrollment.[4]

[4] Damler, R. (2009). Experience under the Healthy Indiana Plan: The short-term cost challenges of expanding coverage to the uninsured.

The pent-up demand for services has been challenging for health plans to manage. However, over the life of the program, costs have decreased as the health plans have seen high inpatient costs replaced with more outpatient visits and use of prescription drugs. The State amended the risk-sharing arrangements in their 2009 HIP contracts. The amended contracts included higher monthly capitated rates for parents and caretaker relatives and a stop-loss provision for non-caretaker adults (effective retroactively to January 2009), and new selection criteria for the high risk pool. CMS approved the amended contracts in mid-December 2009.

The 2010, HIP contracts included a carve-out for most pharmacy services so the State could take advantage of pharmacy rebates - a funding source that would not be available if the services were included in the managed care contracts. The ACA has since allowed states to claim rebates even for pharmacy services provided through managed care plans. The carve-out for pharmacy costs helped the State meet and exceed budget neutrality requirements. The State consolidated all pharmacy purchasing for Medicaid programs into one contract. This consolidation maximized rebate savings available to the State and achieved administrative simplifications, subsequently increasing savings on prescribing, dispensing, claims submission, program analytics, and prior authorization for pharmaceuticals.

The negotiations for the 2011 health plan contracts addressed the costs of care. Both Anthem and MDwise reported declines in utilization and more predictable costs due to sustained member access to routine and preventive health care services. The 2011 contracts represented the first time the State combined HIP and HHW (which serves the State's non-waiver Medicaid managed care populations) into one contract. The State's intent was to integrate contracts to gain some program efficiencies and to make the programs seamless for families who have some members in HHW and others in HIP. In this way, the programs become more family-friendly, as family members have the ability to access care within the same provider network, even though individual family members may be covered by different programs. The new contract effectively integrates coverage; and the plans maintain a single call center for both HIP and HHW members -- a way of offering 'one stop shopping' to families. Unifying the programs has also simplified program administration for providers, as the new contract aligned all policies and procedures for the two programs (although provider reimbursement remains based on Medicare rates in HIP).

Also in 2011, the State selected a third MCE to serve HIP members. Anthem and MDwise continue to serve HIP; and the State added Managed Health Services (MHS), which has traditionally served Indiana's Medicaid HHW population. In an additional effort to improve the consumer experience, the plans were required to implement a debit swipe card for HIP members to use at the point-of-service to verify eligibility, service coverage, and provider participation in HIP. The card linked to member POWER accounts, and members could compare the estimated cost of service to the estimated balance in the POWER account. Debit cards were designed to provide the full $1,100.00 upon determination of eligibility, regardless of the amount paid by the member at that point. The debit card is intended to enhance the member experience, using the POWER account and promoting consumer-driven health care. MHS operationalized the card on January 1, 2011 and the other MCEs followed later in the year. Both Anthem and MDwise currently issue a single swipe card that functions as both member identification card and debit card, while MHS issues separate member identification and debit cards.

No substantial changes have occurred with the contracts since 2011; with recent contract negotiations focused primarily on rates, particularly as impacted by the ESP changes detailed below. HIP performance metrics and measures have not changed over these contracting periods.

3.2 Enhanced Services Plan (ESP)

The ESP was designed to reduce health plan risk and lower capitation rates. Initially, ESP participants were expected to represent the top 1% of risk in the HIP population. Through modifications to the ESP program, this population currently represents the top 3% to 5% of risk in the HIP population. While this high risk group received all the same HIP services and benefits as other members, the State's high risk plan, ICHIA, managed this population on an Administrative Services Only basis. In 2014, ACA provisions reduced the need for a state high risk plan, and ICHIA dissolved. The MCEs now manage both the high risk pool ESP members and regular HIP members; and the capitation rate has been adjusted to accommodate the higher cost of the ESP individuals.

HIP's higher-than-expected initial cost of care resulting from pent-up demand and higher morbidity and co-morbidities of a previously-uninsured population, urged the State to identify ways to reduce the risk to the health plans. First, the State expanded the list of conditions that would qualify an individual to participate in the ESP; and the State simplified referral processes to make ESP determinations timelier. Originally, HIP members waited for a high risk condition to be reported; at which point the condition was verified by a State-contracted vendor that interviewed the patient to determine if the ESP placement was appropriate. To improve access to ESP, the State altered several enrollment policies and expanded the list of qualifying conditions in July 2009. Since mid-2009, when HIP applicants check one of the qualifying conditions on the application, they are automatically enrolled in the ESP and stay enrolled until their eligibility is redetermined. If member claims history at redetermination confirms ESP eligibility, he or she will stay with the ESP. If the member no longer has one or more qualifying condition, he or she will transition to one of the other health plans. In addition, the plans now have more time to refer a member to ESP - six months as opposed to sixty (60) days in 2008. In July 2009, when the new policies took effect, Anthem and MDwise reviewed their claims records, applied Milliman's underwriting guidelines, and scored their members. Those members with an ESP-qualifying condition and a risk score at or above a certain threshold were transferred to the ESP. However, due to the dissolution of ICHIA, starting in 2014, MCEs no longer refer members to a separate plan, but, rather include those members in the general HIP pool and continue to manage their care while receiving a higher capitation rate from the State for doing so.

3.3 Application Processing

The State's vendor struggled to keep up with the flow of applications —receiving more than 120,000 in CY 2008 (yielding more than 35,000 enrollees). High enthusiasm for the program, assertive outreach and advertising, and pent-up demand led to more than 18,000 applications submitted in just the first month of the program. The State's vendor adjusted staffing to accommodate the initial surge of applications, but the queue lengthened again the second half of 2008. An initiative to upgrade enrollment and eligibility business processes impacted HIP application processing the first year and affected all other public assistance programs operated by FSSA. To address the issue, the vendor hired additional eligibility staff January 2009. The application processing delays seen in the first demonstration year did not substantially slow

enrollment. For example, by March 2009 HIP was approaching the enrollment cap (34,000) for non-caretaker adults - a level the State had not expected to reach until the third or fourth year of the demonstration. To manage enrollment levels and ensure the State could maintain budget neutrality, the State closed enrollment for non-caretakers in March 2009.

In 2009, the State made significant progress with the HIP application backlog. HIP operations staff resolved issues and identified possible solutions. In January 2010, 18 additional state eligibility consultants (SECs) joined the State staff to assist with application processing, increasing timely application processing from seventy-one percent (71%) in May 2009 to almost ninety-one percent (91%) as of September 2012. The State also developed a revised enrollment dashboard in 2009, including more information on HIP application processing and showcasing different aspects of the HIP program. This dashboard still helps the State manage application processing; however, HIP application processing has operated smoothly since the changes made in 2010. In 2013, eighty-nine percent (89%) of the total 73,171 applications were processed in a timely manner.

3.4 Non-caretaker Waitlist

The original HIP waiver agreement imposed a cap on the number of non-caretaker adults who could enroll in the program. On March 12, 2009, HIP closed enrollment to non-caretaker adults. At that time, the number of non-caretaker members had reached 32,000, just below the 34,000 cap established in the STCs. Enrollment for non-caretakers was closed before the cap was reached to ensure applicants (1) pending eligibility determination, (2) appealing denied applications or (3) losing HHW coverage after giving birth could be enrolled in HIP without exceeding the cap. Although enrollment closed, all new non-caretaker applications were reviewed for eligibility and placed on a waiting list if determined eligible. In the fall of 2009, CMS agreed to raise the cap by 2,500 individuals for an overall limit of 36,500 non-caretakers; and the State opened 5,000 non-caretaker slots and sent letters to the first 5,000 applicants on the waitlist. The invited applicants reapplied for HIP to verify program eligibility.

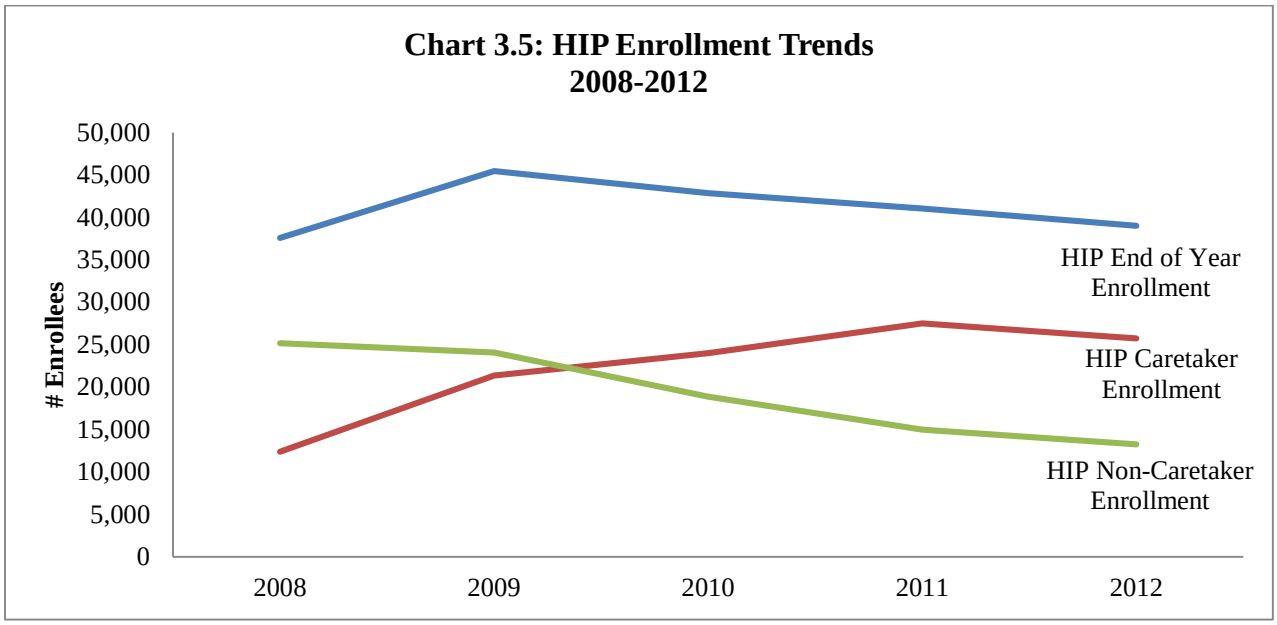
When the ACA passed in March 2010, HIP enrollment of non-caretaker adults remained closed due to legislative Maintenance of Effort (MOE) provisions and a concern that, since the program could not be closed to caretakers, the State could be forced to cover costs beyond the funds available from the cigarette tax fund. When non-caretaker enrollment declined, in August 2011, the State opened 8,000 more slots to individuals on the waitlist. During the first quarter of 2012, 18,800 letters invited non-caretakers on the waitlist to reapply for the program. Only 1,587 individuals responded and enrolled (generating an 8.4 percent response rate). Most of the letters generated no response, suggesting possible changes in applicant financial or living situations, including a possible change in address. In April 2012, after the push for new enrollment, the waitlist closed and no additional individuals were added between April and December. At the end of 2012, the waitlist consisted of 46,388 non-caretaker adults.

In 2013, HIP eligibility guidelines changed to align with the federal Marketplace. Starting in 2014, individuals above 100% FPL received State and MCE assistance to find coverage through the federal Marketplace, and nearly 50,000 individuals on the waitlist were invited to re-apply to HIP and/or seek coverage on the federal Marketplace, depending on the financial eligibility information on file. HIP members and HIP waitlist members under 100% FPL maintained or

gained coverage on HIP and the waitlist was eliminated. Further, the State does not anticipate reinstating a waitlist for the program in future years.

3.5 Enrollment Trends

From 2008 through December 2013, the State received 483,561[5] valid applications and 105,135 unique members have been enrolled. In 2008 - the first year of program operations - the State received 120,313 applications. Applications declined in 2009 with only 72,282 submitted; but applications increased again in 2010 with 117,252 submissions. In subsequent years, between 70,000 and 80,000 new applications have been received each year - specifically 78,641 applications in 2011; 75,172 applications in 2012; and 71,993 applications in 2013.



The chart above shows the year-end enrollment trends for the first three years of the HIP program. The image clearly shows the decline in non-caretaker enrollment and the increase in caretaker enrollment. HIP enrollment was 37,568 at the end of 2008, 45,460 at the end of 2009, 42,872 at the end of 2010 and current enrollment at the end of 2012 was 39,005. As the program progressed the percentage of caretakers ever enrolled increased in comparison to non-caretakers. For those ever enrolled in HIP in 2010, fifty-six percent (56%) were caretakers and forty-four percent (44%) were non-caretakers. By comparison, at the end of 2008, sixty-seven percent (67%) of enrollees were non-caretakers and thirty-three percent (33%) of enrollees were caretakers. As of the end of 2013, approximately seventy percent (70%) of enrollees (totaling 24,544) were caretakers and approximately thirty percent (30%) of enrollees (totaling 10,390) were non-caretakers.[6]

[5] Valid applications exclude duplicate and incomplete applications received. HIP Dashboard, December 2013.

[6] Annual data from annual HIP reports, and HIP Dashboard December 2013.

Over the course of the HIP program the majority of members have been under 100% FPL. Member distribution by FPL in December 2013 is consistent with the previous trend: seventy-two percent (72%) of HIP enrollees are currently at or below 100% FPL. On average, only ten percent (10%) of HIP enrollees are above 150% FPL. In 2014, the eligibility criteria changed due to the availability of Marketplace plans and premium tax credits for individuals over 100% FPL. Therefore, in 2014, all HIP members are below 100% FPL.

Table 3.5 (A): HIP Enrollee Distribution by FPL[7]

FPL	2008	2009	2010	December 2011	December 2012	December 2013
<100% FPL	26,969 72%	41,795 71%	37,061 62%	27,533 69.0%	27,276 69.9%	25,348 72.6%
101 – 150% FPL	6,955 19%	11,432 19%	13,849 23.1%	8,288 20.7%	7,767 19.9%	6,290 18%
>150% FPL	3,620 10%	6,079 10%	9,015 15%	4,075 10.2%	3,966 10.2%	3,296 9.4%
TOTAL	**37,544 100%**	**59,306 100%**	**59,945 100%**	**39,896 100%**	**39,005 100%**	**34,934 100%**

Following an eligibility determination, HIP members may select Anthem, MDwise or MHS as their plan. Over the first three years of the program (2008 to 2010), approximately seventy percent (70%) of members enrolled in Anthem and approximately thirty percent (30%) enrolled in MDwise. The third demonstration year (2011) was the first year the HIP program offered a third managed care entity option for members to choose. At the end of 2011 approximately five percent (5%) of HIP members selected the MHS plan. Enrollment in MHS has increased over time. As of February 2014, Anthem maintained approximately fifty-nine percent (59%) of HIP enrollments, MDwise had approximately twenty-six percent (26%), and MHS managed fifteen percent (15%) of HIP enrollment.[8]

In spite of some policy and operational changes over time, program enrollee demographics are relatively consistent. Over the course of the HIP program, member distribution by gender has been steady, though women enroll in significantly higher numbers. As of 2013, sixty-eight percent (68%) of enrollees are female and thirty-two percent (32%) are male. Geographically, HIP members are distributed throughout the state, with enrollment mirroring the general population density patterns in the state.[9] Similarly, member distribution by race has, over the course of the program, closely aligned with the distribution of working age uninsured adults under 200% FPL in Indiana.[10] Over the course of the HIP program, the percentage of enrollees identifying as White averages around eighty-three percent (83%) and the members identifying as Black average ten percent (10%); with Hispanic, Native American, and Other making up the

[7] Data from HIP Annual Reports 2008-2010. HIP Dashboards December 31, 2011, December 31, 2012, and December 2013.
[8] HIP Dashboard February 28, 2014.

[9] HIP Year 3 Annual Report, Pg. 29-30.
[10] HIP Year 1 Annual Report, pg. 20.

remainder. Age distribution has also been relatively steady throughout the course of the program. To date, member age distribution has consistently skewed toward more aged individuals with those under 30 representing the smallest proportion of HIP members.

3.6 Benefit Limit

HIP includes a $300,000 annual and $1 million lifetime benefit limit. Over the course of the program, few members have reached or come close to reaching these limits. The HIP program monitors members to ensure that members are able to be transferred to another program if they are close to reaching $300,000 in annual limits or $1,000,000 in lifetime limits, ensuring members are not denied necessary services. If a member does reach, or comes close to reaching these limits, the State assesses the member for potential traditional Medicaid eligibility. All members coming within $100,000 of the $300,000 annual benefit limit were transferred to ESP, Medicaid, or other programs. The number of members meeting the benefit limits for each demonstration year are displayed below. No members have met the lifetime $1,000,000 limit.

Table 3.6: HIP Members at Benefit Limit

Year	Members at $200,000	Members at $300,000	Members at $1,000,000	Total
2008	1	0	0	**1**
2009	17	2	0	**19**
2010	1	0	0	**1**
2011	3	0	0	**3**
2012	0	0	0	**0**
Total	**22**	**2**	**0**	**24**

3.7 Disenrollments

Enrollees can disenroll or be terminated from HIP for any of the following reasons: (1) electing to disenroll, (2) failing to pay a POWER account contribution, (3) failing to complete the redetermination process, or (4) no longer meeting eligibility requirements. Between 2008 and 2010, 35,323 members left HIP. Approximately fifty-seven percent (57%) of enrollees left within a month of the annual redetermination process period. Of the remaining disenrollments, eight percent (8%) of members (totaling 6,199) failed to pay a POWER account contribution. In 2011, only 1,843 of disenrollments were due to not making a subsequent POWER account payment. Individuals no longer meeting eligibility requirements comprise the remaining disenrollments, and may include a pregnant woman who transfers to traditional Medicaid for the duration of her pregnancy (and may reenter HIP afterward), a member who becomes eligible for Medicaid disability, a member who passes away or moves out of State.[11]

HIP has not experienced problems with affordability. The 2013 Mathematica survey of HIP members found that seventy-six percent (76%) of contributors considered the amount of their POWER account contribution to be 'just right', while nine percent (9%) indicated they would pay an even greater contribution.[12]

[11] Data from DMA Data Request #8790, ran October 18, 2012.
[12] Mathematica. (2014). 2013 Survey of HIP Members.

Further, the program ensures that no member pays more than five percent of his or her income, consistent with CMS rules. In some cases, this results in situations where members are not required to make any monthly contributions and the State funds the entire account. Non-contributing HIP participation may occur in two ways: (i) the family has exceeded its 5% of income limitation due to payment of CHIP premiums; or (ii) the member has no income. For these members, POWER accounts are 100% state-funded. For 2008, approximately thirty-five percent (35%) of HIP enrollees did not contribute to their POWER account. Over the course of the program this percentage has decreased and stabilized, and has consistently been between twenty percent (20%) to twenty-two percent (22%) between 2010 and 2013.

Section 4: Program Evaluation

Over the course of the demonstration, HIP has made substantial progress toward meeting program goals. In accordance with CMS's Special Terms and Conditions (STCs), the State performs an annual evaluation of the HIP program, including claims and administrative data analysis, External Quality Reviews, and survey data collection. In annual reports, the State provides detailed information on program progress and documents the quality and improved access to services under the demonstration.

The HIP program is independently evaluated by Mathematica Policy Research (HIP contracted evaluator), Milliman, Inc. (State actuarial partner), and Burns & Associates (External Quality Review team for both the HIP and HHW programs). The most recent annual report (2012) was submitted to CMS in 2013. Outcome data in the annual report highlights HIP's many successes and lends support to the effectiveness of the program's design. The following section summarizes HIP's key accomplishments in the initial demonstration period and outlines new goals for the future of the program.

4.1 Progress on Program Goals

4.1.1 Reducing the number of low income Hoosiers

Since its inception, HIP has offered an important safety net for its members who would have otherwise been uninsured. As of December 31, 2013, HIP served 116,765 unique Hoosiers over the six years of the program.

4.1.2 Improving access to appropriate, quality-based healthcare services for low income Hoosiers

The HIP program reimburses health care providers at Medicare rates - a key feature designed to increase the number of providers accepting HIP, thus broadening the primary and specialty care networks. As a result of these incentives, HIP meets and exceeds access standards statewide. According to the 2013 Burns & Associates External Quality Review focus study on access to care, the access rate among HIP adults was higher in every region than the corresponding age and region cohort in the HHW program, the Medicaid program covering pregnant women, children, and parents and caretaker relatives eligible for Medicaid.

Two years of Consumer Assessment of Health care Providers and Systems (CAHPS) data indicate a high level of member satisfaction with health plan performance. In 2012, all three managed care entities (MCEs) offering HIP coverage received higher ratings for overall healthcare experience, personal doctor, ability to get needed care, ability to get care quickly, doctor communication, and health education than the benchmarks from the year before. Survey

data supports the CAHPS results and indicates a high level of member satisfaction with the program. According to the 2013 Mathematica survey, approximately ninety-five percent (95%) of members reported they were either somewhat or very satisfied with their overall experience with HIP. Further, ninety-eight percent (98%) of members reported they would choose to re-enroll if they left the program but became eligible again.

Mathematica's 2010 HIP member survey suggests improved access to care following enrollment into HIP. When survey respondents enrolled in HIP one month prior were asked to compare their current access to care to when they were uninsured, they reported being:

- More likely to have a primary medical provider (PMP) and more likely to use a doctor's office or clinic as their usual source of care rather than the hospital emergency department;
- More likely to receive preventive care, acute care, specialty care, and prescription medications; and
- Less likely to have an unmet need for healthcare.

Further, the proportion of members reporting not seeking necessary preventive care, treatment for an acute accident, illness or injury, or specialty care in the previous six months due to cost was drastically lower in established members than new members.

4.1.3 Promoting value-based decisions making and personal health responsibility

HIP has successfully demonstrated that financial incentives encourage members to be thoughtful healthcare purchasers and take personal responsibility for their health care decisions. These incentives begin with enrollment, when most HIP members are required to contribute to their POWER account to fund a portion of their deductible expenses as a condition of ongoing coverage. Each year of the demonstration, the proportion of members making their initial contributions to complete the enrollment process has increased. In 2008 - the first year of the program - about eighty-nine percent (89%) of conditionally eligible members required to make contributions, thus becoming fully enrolled. In 2012, ninety-four percent (94%) of conditionally eligible members completed this requirement. The annual rate of members failing to make subsequent required monthly contributions never exceeded seven percent (7%).

Generally, HIP members indicate a willingness to accept even more responsibility for the cost of their health care and report that the required contributions are affordable. According to the 2013 Mathematica survey, seventy-six percent (76%) of members feel the amount of their monthly POWER account contribution was the right amount and nine percent (9%) felt that is was, in fact, too low. Additionally, about eighty-two percent (82%) of HIP members are willing to pay $5 more per month to remain enrolled in HIP, and seventy-five percent (75%) are willing to pay $10 more. Members also prefer the POWER account contribution method over making co-payments. The survey found that eighty-three percent (83%) of members preferred to pay a fixed monthly amount up front with the opportunity to receive unspent funds back over making co-payments each time they visited a health professional, pharmacy, or hospital. The POWER account rollover incentive appears to motivate members to consider the value of the services they seek and spend their funds carefully.

HIP members demonstrate active engagement in managing their health care dollars and understanding the cost of services. According to Mathematica's 2013 survey of HIP participants, thirty percent (30%) of participants indicated they ask their provider about the cost of their care when they seek treatment; more than three quarters (77%) of members had a basic understanding of the POWER account; and nearly sixty percent (60%) reported checking the account balance at least monthly. A 2009 Product Acceptance Research survey of HIP members showed that sixty percent (60%) of respondents think differently about how or where they get health care since enrolling in HIP.

HIP member eligibility is reassessed annually, and enrollees are required to complete a redetermination application and return it in a timely manner to maintain eligibility. Over the first two years of the demonstration, eighty-five percent (85%) of members returned their application packet in a timely manner, and by the end of 2012, the return rate increased to ninety-two percent (92%). Providing redetermination paperwork in a timely manner fosters a higher continuity of care and improved health outcomes.

Claims data shows the effort to prevent non-emergent visits to the emergency department (ED) through co-payments effectively deters inappropriate use. Co-payments ($25 for non-caretakers and $3 for caretakers) cannot be made from the POWER account. According to a Milliman analysis, in 2012 only thirty-two percent (32%) of HIP members visited the ED, compared to thirty-eight percent (38%) of comparable traditional Medicaid participants (pregnant women, parents and caretaker relatives eligible for Medicaid).

Notably, non-caretaker member use of the ED has declined steadily over the course of the demonstration. Between 2009 and 2013, there was a seventeen percent (17%) decrease the percentage of non-caretaker HIP members visiting the ED; and the number of non-caretaker ED visits per 1,000 members dropped by thirty-four percent (34%) in the same timeframe. The disease burden is high among non-caretaker members, and the declining ED utilization rates may reflect the required co-payment's effectiveness in deterring inappropriate use and promoting use of services in non-emergent, primary care settings.

Required contributions to the POWER account and having "skin in the game," may also improve ED utilization rates. According to a Milliman analysis, members making POWER account contributions visited the ED at a rate of 556 visits per 1,000 members; while members not required to make POWER account contributions visited the ED at a rate of 869 visits per 1,000 members. Even though co-payments for non-emergent use of the ED cannot be made from the POWER account, those who contribute to the account appear to exhibit more cost-conscious and responsible ED use behaviors.

4.1.4 Promoting primary prevention

HIP rewards preventive care use by allowing the entire POWER account balance (State and individual contributions) to roll over and offset the amount of the required contribution in the next benefit year if the member receives at least one age- and gender-appropriate service. This policy incentivizes members making POWER account contributions to receive preventive care in order to reduce their annual contributions. Additionally, HIP's policy to cover the first $500 of preventive services without drawing from the POWER account drastically reduces barriers to preventive care access. HIP members receive preventive care at rates similar to a commercially

insured population. Between 2010 and 2012, the percentage of all HIP members receiving preventive services increased from fifty-six percent (56%) to sixty percent (60%). Preventive service utilization rates by age and gender remained constant or rose slightly in all groups except for females ages 19-34. Overall, the utilization rates for at least one preventive service increased with age; and women were far more likely than men to receive preventive care (69% versus 39% in 2012). In 2012, sixty-one percent (61%) of HIP members required to make POWER account contributions received at least one recommended service, while only fifty-three percent (53%) of non-contributors received preventive care. This indicates that member investment and benefits linked to preventive service utilization may both pay a part in reinforcing preventive care use over emergency department use.

4.1.5 Ensuring State fiscal responsibility and efficient management of the program

HIP continues to stay well within its federally-mandated waiver budget neutrality margin, and the enabling state legislation requires costs not exceed the revenue generated by the cigarette tax designated for the program. According to Milliman estimates, the state maintained a waiver margin well above the total CMS-approved limit between 2008 and 2011. These margins were based on per member, per month (PMPM) costs for HHW caretakers, children, and pregnant women that grew at a slower rate than the projected Medicaid spending established in the STCs of the HIP waiver. In 2012, however, increased hospital reimbursement rates under a hospital assessment fee program (established by the State legislature in 2007) effectively raised the PMPM costs for HHW participants and reduced the waiver margin to a negative figure. Cumulatively, however, the waiver margin has been maintained well below the five-year budget neutrality requirement.

Over the first three years of the demonstration, CMS also required the State to implement cost-saving initiatives for the program. These initiatives were in the areas of third-party liability cost recoveries, estate recovery, and collections through identified fraud and abuse. Together, these initiatives generated savings of nearly $20 million. This level of savings exceeded the requirements set forth in the STCs for the first five years of the demonstration ($15 million). In 2012, CMS also approved two cost-saving projects related to strategic purchasing agreements for incontinence supplies and hemophilia blood factor products. That same year, the State began to carve out pharmacy benefits, consolidating all state-administered pharmacy services into one contract to achieve additional savings. Because of the pharmacy carve out, the waiver margin increased by $72 million from 2010 to 2011. Through 2012, the State diverted approximately $50 million of Disproportionate Hospital Share (DSH) funds to the HIP program annually. In 2013, the cost-saving initiatives generated sufficient savings to make the DSH fund re-allocation unnecessary.

By design, revenue generated from the cigarette tax serves as the major financing mechanism for HIP. In State Fiscal Year 2013, the cigarette tax generated $430 million, of which $123 million was allocated to HIP with the remainder allocated to other public health programs. The amount of cigarette tax revenue allocated to HIP has fluctuated annually over course of the demonstration, ranging from $120 to $130 million each year.

Section 4.2 Future Goals

If the HIP program is approved in its current form, the State will continue to pursue the goals identified above and will conduct further study of these areas. Additional study and time to

collect data will help the State understand the long-term impact of HIP. The State intends to continue investigating the effects of consumer-directed health plan design on enrollee care-seeking behavior.

Section 4.3 Health Plan Performance-External Quality Review

In 2013, Burns & Associates, Inc. (B&A) conducted an external quality review (EQR) of Anthem, MDwise, and MHS for calendar year 2012. The EQR assessed the performance of the health plans; and the EQR report did not suggest the plans have any systematic issues related to their performance. The recommendations and suggestions made to the plans recognized a level of competency at the plans, citing several items as best practices. In addition to validating (auditing) of performance measures and performance improvement projects for the MCEs, the EQR identified two focus studies completed as part of the review, covering: (1) access to primary care and (2) mental health care utilization and care coordination.

4.3.1 Access to Care

In consultation with the State, B&A constructed a focus study on access to care including both quantitative and qualitative components. The analysis expanded the study population beyond the limits defined by the HEDIS® measures for access to primary care but limited the study to primary care office visits conducted in a physician office, federally qualified health clinic (FQHC), or rural health clinic (RHC). Analyses examined the sample population by age, race/ethnicity and geographical region.

The qualitative component to this focus study included interviews with the MCE Provider Services staff in June to learn more about their approach to conducting outreach. B&A then conducted 59 interviews with provider entities contracted with the MCEs. The interviews spanned ten weeks and included representatives of all provider specialties in each region of the state. In total, B&A conducted interviews at 29 primary medical provider (PMP) offices, 10 FQHC (Federally Qualified Health Centers), 10 RHCs (Rural Health Centers), and 10 community mental health centers (CMHCs).

The study revealed that MHS provided the greatest access to primary care among the three MCEs. According to the study, access to primary care for African-American members in HIP was higher than other race/ethnicities. There were fewer differences in the rate of access to primary care for adults across the regions than was found for children. Further, the access rates were usually similar across the MCEs within a region. The access rate among HIP adults was higher for every MCE in every region than the corresponding age/region cohort in HHW. This is probably due to the higher provider reimbursement rates provided by HIP.

Provider feedback pertaining to HHW, HIP, and MCEs was mixed. B&A analyzed the key factors related to provider satisfaction, including (1) quality of the MCEs provider field staff, (2) quality of assistance and training office staff received from the MCEs, and (3) ease in getting paid by the MCE. The key factor related to dissatisfaction from providers related to inconsistency across MCEs and programs (i.e., prior authorization submission and adjudication, a single Medicaid manual rather than one for fee-for-service (FFS) Medicaid and separate manuals for each MCE, consistent and accurate claims processing, and consistent responses from customer service representatives).

4.3.2 Mental Health Care Utilization and Coordination

B&A developed a focus study for the 2012 EQR continuing the 2011 EQR study. In this year's EQR, B&A conducted a broad review of mental health utilization across all members of HHW and HIP.

Of all HIP members enrolled in CY 2012, 28.9% had a mental health diagnosis reported on an encounter. A greater proportion of Caucasian HIP members were diagnosed with a mental health disorder than other races and ethnicities. According to the study, 31.3% of Caucasian members were diagnosed with mental health diagnosis on an encounter compared to 20.2% of African-American and 16.6% of Hispanics. Among the HIP population, three diagnoses comprised half of all mental health diagnoses—tobacco use disorder (19.6% of total), attention deficit disorder (15.5% of total), and major depressive or bipolar disorder (14.9% of total). Outpatient mental health clinics and CMHCs play an important role in the delivery of these services since more than eighty percent (80%) of all services were billed by these two provider types. Community mental health providers delivered less than ten percent (10%) of the services (except in Anthem HIP).

Section 5: Requested Program Changes

The State is not requesting any revisions to the HIP program in this waiver. All of the requested program changes are set forth in the HIP 2.0 Waiver, which is submitted concurrently, and in the alternative with this waiver extension application. In the event the HIP 2.0 Waiver is not approved by CMS, the State submits this waiver requesting the extension of the 2014 STCs without change.

Section 6: Evaluation Plan

Since the State has not requested any changes to the waiver, the State does not propose any changes to its evaluation plan for the duration of the demonstration extension. Mathematica developed an evaluation plan for HIP during the HIP initial demonstration period. HIP meets its program goals and provides quality care to clients, as described in Section 3. During the extension period, Indiana may seek to make some slight modifications to the evaluation design in order to focus on new areas of study. All evaluation reports will continue to address HIP's progress on program goals in addition to the evaluation questions present in the STCs.

Evaluation reports will include evaluation on the following HIP goals:

- Reduce the number of uninsured low income Hoosiers.
- Reduce barriers and improve statewide access to health care services for low income Hoosiers.
- Promote value-based decision making and personal health responsibility.
- Promote primary prevention.
- Prevent chronic disease progression with secondary prevention.
- Provide appropriate quality-based health care services.
- Assure State fiscal responsibility and efficient management of the program.

During the waiver extension period evaluation reports will continue to include responses to the following STC evaluation questions:

1. How many HIP participants reach their $300,000 annual benefit limit each year? How do these individuals meet their health care needs after they exhaust the annual benefit limit and before the next coverage term begins?

2. How many HIP participants reach their $1,000,000 lifetime benefit maximum? How do they meet their health care needs after their HIP benefits are exhausted?

3. What are the consequences of limiting participants' ability to switch plans after they have made an initial POWER Account contribution? What percentage of HIP applicants are auto-assigned to an MCE?

4. What percentage of the potentially eligible population enrolls in HIP? How does the percentage vary by major population subgroups (HIP Caretakers, HIP Non-Caretakers) and income level?

5. What are the consequences of requiring HIP participants with family income less than 100% FPL to pay monthly premiums? How many of these participants fail to make their first POWER Account contribution? How many of these participants are disenrolled for failure to pay their contributions?

6. To what extent has HIP impacted the uninsurance rate in Indiana?

7. To what extent has HIP reduced uncompensated care provided by Indiana's federally-funded health clinics?

8. How many enrollees exhaust their POWER account each year? How many enrollees are able to roll-over a sufficient POWER account balance to reduce their subsequent year's required contribution by at least half? How many enrollees are able to achieve a $0 contribution by this means?

Section 7: End Stage Renal Disease Enrollees

To be eligible for a kidney transplant in Indiana, individuals must have insurance supplemental to their Medicare coverage. Individuals with end stage renal disease (ESRD) are not eligible for Medigap or Medicare Advantage. Additionally, due to their Medicare eligibility they are ineligible to receive a tax credit to purchase insurance on the federal Marketplace. Medicaid coverage, therefore, is the only supplemental coverage option available to ensure continued placement on a kidney transplant list. In May 2014, Indiana amended the HIP waiver to provide continued Medicaid eligibility to individuals with ESRD who had been on spend-down prior to the State's transition to 1634 status.

Indiana is in the process of developing a 1915(i) state plan program for individuals with ESRD who meet the needs-based and target criteria outlined in the state plan and have income up to 300% of the federal poverty level (FPL). The 1915(i) program will provide coverage to the

majority of individuals who were originally authorized for continued Medicaid eligibility through the May 2014 1115 waiver amendment. The State proposes to provide continued Medicaid coverage through the Healthy Indiana Plan (HIP) Section 1115 waiver for a subset of individuals with ESRD who meet the eligibility criteria described below.

7.1 Eligibility Criteria

The State intends to provide coverage to Medicare eligible individuals who have income over 300% FPL, with a diagnosis of ESRD, who were eligible under the Section 1115 waiver as of December 31, 2014. These individuals may not reside in a long-term care facility or receive services through a HCBS waiver. Individuals must have countable resources below $1,500 (single recipients) or $2,250 (married recipients) and be otherwise eligible for Medicaid.

7.2 Delivery System

Individuals in this population will be served under the fee-for-service delivery system and will not be considered Healthy Indiana Plan (HIP) or Hoosier Healthwise (HHW) enrollees. They will be a group separate and distinct from the HIP and HHW populations.

7.3 Cost-Sharing Requirements

This population will not be subject to the HIP POWER account requirements. Individuals in this group will have an ESRD liability. The liability will be calculated using spend-down methodology based on incurred medical costs. Individuals that incur medical expenses that bring their income to the Supplemental Security Income (SSI) federal benefit rate (FBR) will have no further incurred costs subject to the ESRD liability. Other cost sharing requirements for these enrollees are stipulated in the Medicaid state plan.

7.4 Covered Benefits

Individuals in this population will be eligible for full Medicaid state plan benefits afforded to categorically needy eligibility groups as outlined in Indiana's state plan.

Section 8: Public Comment

FSSA held public hearings for this three-year Section 1115 waiver renewal application pursuant to the requirements set forth at 42 CFR 431.408. A copy of the full public notice that announced the two public hearings is included in Appendix A of this waiver application. The notice was posted on the agency's website at the web address of the Section 1115 waiver program's homepage: HIP.in.gov. In addition, notice was also published in the Indiana Register on May 21, 2014. OMPP also published notice in the Indiana Health Care Provider (ICHP) Bulletin, which was sent electronically to all IHCP providers. Electronic copies of all documents related to the HIP waiver renewal application were also available on the HIP website.

On June 4, 2014, FSSA presented this HIP waiver application to the Medicaid Advisory Committee, the State's Medical Care Advisory Committee that operates in accordance with 42 USC §431.12. Also, pursuant to state law, the HIP waiver renewal application was presented to the Indiana Budget Committee on June 20, 2014. During the meeting, legislators active on the Budget Committee were able to review and comment on the waiver.

In accordance with the notice, public hearings were conducted on May 28 and May 29, 2014 as scheduled and publicized, at the Indiana Government Center Conference facilities and the Indiana State House. Two individuals testified at the two public hearings. A court reporter transcribed both hearings. Both hearings were made available to the public via a telephone conference line and a live, free webcast. The notice provided the option for any individual, regardless of whether he/she attended the public hearing, to submit written feedback to the State by email or by USPS mail. A total of eight (8) written comments were received. The below summary combines the ten (10) total comments offered through the public hearings and through writing via mail and email.

8.1 Summary of Public Comments

The majority of commenters offered general support for the HIP renewal waiver application, although, all supporters expressed a preference for the HIP 2.0 waiver application. These commenters encouraged CMS to renew the State's existing HIP waiver as set forth in this HIP waiver renewal application only in the event CMS denies or delays the HIP 2.0 waiver application. One commenter reinforced the importance of continuity of care for the tens of thousands of Hoosiers who currently rely on HIP.

Only two (2) commenters were opposed to the design of the current HIP program. One commenter urged revision of the HIP waiver renewal application, stating that the extension of the temporary waiver granted in 2014 was not approvable. Another commenter stated that HIP should not be extended due to the problems affecting the program, including long wait lists and lack of comprehensive coverage.

Another commenter expressed serious concerns regarding low physician reimbursement under the program, warning that an expansion of Medicaid will only lead to more problems with access. He suggests increasing physician reimbursement.

8.2 Summary of State Response

The State appreciates all comments received. The waiver request as written addresses many comments received, and the State has made no changes to this application, at this time, in response to the public comments received during the thirty day public comment period. However, all comments will continue to inform the State in its discussions with CMS and the potential development of the Special Terms and Conditions.

Other than the inclusion an of additional waiver related individuals above 300% FPL with End Stage Renal Disease (ESRD) as set forth in Section 7 of this waiver application and a few technical revisions to the requested waivers listed in Section 9, the content of this application is identical to the copy of the HIP waiver renewal application initially posted on the FSSA website on May 15, 2014.

Section 9: Types of waivers being requested

FSSA requests the following waivers:

9.1 Title XIX Waivers

1. **Amount, Duration, and Scope and Comparability** **Section 1902(a)(10)(B)**

To the extent necessary to enable Indiana to vary the services offered to individuals, within eligibility groups or within the categorical eligible population, based on differing managed care arrangements or on the absence of managed care arrangements. Individuals enrolled in the HHW program receive additional benefits such as case management and health education that may not be available to other Medicaid beneficiaries not enrolled in HHW.

2. **Freedom of Choice** **Section 1902(a)(23)**

To the extent necessary to enable Indiana to restrict the freedom of choice of providers for the demonstration eligibility groups.

3. **Reasonable Promptness** **Section 1902(a)(3)/Section 1902(a)(8)**

To the extent necessary to enable Indiana to prohibit reenrollment for 12 months for individuals in Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults) who are disenrolled for failure to make POWER account contributions.

To the extent necessary to enable Indiana to delay provision of medical assistance until the first day of the month following an individual's first contribution to the POWER account.

4. **Methods of Administration: Transportation** **Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53**

To the extent necessary to enable Indiana not to assure transportation to and from providers for Demonstration Population 4 (HIP Caretakers) or Demonstration Population 5 (HIP Adults).

5. **Eligibility Section** **Section 1902(a)(10)(A)**

To the extent necessary to allow Indiana not to provide medical assistance for Demonstration Population 4 (HIP Caretakers) or Demonstration Population 5 (HIP Adults) until the first day of the month following an individual's first contribution to the POWER account.

6. **Amount, Duration, and Scope of Services** **Section 1902(a)(10)(B)**

To the extent necessary to permit Indiana to offer to Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults), known as "the adult group" in the proposed rule at 435.119, benefits that differ from the benefits offered to the categorically needy group.

To the extent necessary to enable Indiana to vary the amount, duration and scope of services offered to individuals in the Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults) who meet the annual maximum benefit of $300,000.

7. **Retroactive Eligibility** **Section 1902(a)(34)**

To the extent necessary to allow Indiana to not provide medical assistance to Demonstration Population 4 (HIP Caretakers) or to Demonstration Population 5 (HIP Adults) for any time prior to the first of the month following an individual's first contribution to the POWER account.

8. **Prepayment Review** **Section 1902(a)(37)(B)**

To the extent necessary to allow Indiana not to ensure that prepayment review be available for disbursements by members of Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults) to their providers.

9. **Cost-Sharing** **Section 1902(a)(14); insofar as it incorporates Section 1916 and 1916A**

To the extent necessary to enable Indiana to charge required POWER account contributions and co-payments up to 5% of family income for Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults).

10. **Dental and Vision Coverage** **Section 1902(a)(43)**

To the extent necessary to enable Indiana not to cover certain vision and dental services described in sections 1905(r)(2) and 1905(r)(3) of the Act to 19 and 20 year-old members of Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults).

11. **Income and Resource Test** **Section 1902(a)(10)(c)**

To the extent necessary to enable Indiana to exclude funds in the POWER account from the income and resource test established under state and federal law for purposes of determining Medicaid eligible for Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults).

12. **Statewideness/Uniformity** **Section 1902(a)(1)**

To the extent necessary to enable Indiana to operate the Demonstration and provide managed care plans or certain types of managed care plans, including provider-sponsored networks, only in certain geographical areas.

9.2 Costs Not Otherwise Matchable

FSSA requests that the following expenditures be regarded as expenditures under the State's Medicaid Title XIX state plan.

1. **Costs of ESRD Eligibility Group**

   Costs associated with providing coverage to Medicare eligible individuals who have income over 300% FPL, with a diagnosis of ESRD, who were eligible under the Section 1115 waiver as of December 31, 2014. These individuals may not reside in a long-term care facility or receive services through a HCBS waiver. Individuals must have countable resources below $1,500 (single recipients) or $2,250 (married recipients) and be otherwise eligible for Medicaid.

2. **Expenditures Related to MCO Enrollment and Disenrollment**
   Expenditures made under contracts that do not meet the requirements in Section 1903(m) of the Act, as specified below. Indiana managed care plans which serve HIP members will be required to meet all requirements of section 1903(m) of the Act except the following:

   Section 1903(m)(2)(A)(vi) and (xi) insofar as they incorporate federal regulations at 42 CFR 438.56, to the extent that the rules in section 1932(a)(4) of the Act are inconsistent with the HIP disenrollment rules (as contained in paragraph 26 of the demonstration's 2014 Special Terms and Conditions), such as restricting an enrollee's right to disenroll within 90 days of enrollment in a new managed care organization (MCO). Enrollees may change MCOs without cause within 60 days of enrollment in an MCO or before they make their first POWER account contribution, whichever occurs first. Enrollees may disenroll from an MCO with cause at any time.

Section 10: Financing Reports

Please see attached financing report prepared by Milliman Inc.

Appendix A: 2014 Notice of Public Hearing

Indiana Family and Social Services Administration

Notice of Public Hearing and Public Comment Period

Pursuant to 42 CFR Part 431.408, notice is hereby given that**: (1) on May 28, 2014, at 9:00 a.m., at the Indiana Government Center South, Conference Center Room B, 402 West Washington Street, Indianapolis, Indiana 46204-2744; and (2) on May 29, 2014, at 1:00 p.m., at the Indiana State House, Room 156-B, 200 West Washington Street, Indianapolis, Indiana 46204-2786**, the Indiana Family and Social Services Administration ("FSSA") will hold public hearings on the extension of the existing Healthy Indiana Plan 1115 waiver request ("HIP Extension Waiver") that will be submitted to the Centers for Medicare and Medicaid Services ("CMS") to extend the current Healthy Indiana Plan ("HIP") for calendar years 2015 through 2017. Both public hearings will be accessible via web conference at http://www.webinar.in.gov/hip/. In addition, FSSA will present the HIP Extension Waiver to the Medicaid Advisory Committee on Wednesday, June 4, 2014 at 10:00 a.m. at the Indiana War Memorial, Shoup Hall, 431 North Meridian Street, Indianapolis, IN 46204.

This notice also serves to open the **30-day public comment period, which closes June 21, 2014 at 4:30 pm.**

The Healthy Indiana Plan ("HIP"), which passed the Indiana General Assembly in 2007 with bipartisan support, builds upon the state's long and successful history with consumer-driven health plans. Individuals eligible for HIP are non-disabled adults between the ages of 19 and 64 with household income below 100% of the federal poverty limit ("FPL"). HIP, via private health insurance carriers, offers its members a High Deductible Health Plan ("HDHP") paired with a Personal Wellness and Responsibility ("POWER") account, which operates similarly to a Health Savings Account ("HSA"). This private health insurance experience provides an alternative to traditional Medicaid and promotes consumerism by requiring members to have "skin in the game," which empowers them to demand price and quality transparency as they make cost-conscious health care decisions and take responsibility for their health. HIP, in its current form, is scheduled to expire on December 31, 2014.

FSSA is submitting the HIP Extension Waiver concurrently with a separate HIP 2.0 1115 waiver ("HIP 2.0 Waiver") application. The HIP 2.0 Waiver seeks to expand HIP to all non-disabled Hoosiers between the ages of 19 and 64 with household income below 138% of the FPL. FSSA is submitting the HIP Extension Waiver as an alternative to the HIP 2.0 Waiver in order to preserve the current HIP program in the event CMS does not approve the HIP 2.0 Waiver. FSSA is not requesting any changes or modifications in the HIP Extension Waiver.

OBJECTIVES

Seven objectives have driven the implementation of HIP in Indiana: 1) reduce the number of low-income uninsured Hoosiers; 2) improve access to appropriate, quality-based health care to low-income Hoosiers; 3) reduce barriers and improve statewide access to health care services for low income Hoosiers; 4) promote value-based decision-making and personal health responsibility; 5) promote better health outcomes through preventative care; 6) prevent chronic disease progression with secondary prevention; and 7) ensure State fiscal responsibility through efficient management of the program.

BENEFICIARIES, ELIGIBILITY, & FINANCING

HIP offers health care coverage to non-disabled individuals between the ages of 19 and 64, who have household incomes below 100% of the FPL and who are not otherwise eligible for Medicaid or Medicare. Income eligibility for HIP is determined using the modified adjusted gross income ("MAGI") methodology with a 5% disregard. While HIP does not limit enrollment for parents and caretakers with household income below 100% FPL, it imposes an enrollment cap of 36,500 for non-caretaker individuals.

From 2008 through December 2013, the State received 483,561 valid applications and 105,135 unique members have been enrolled in HIP since the program's inception. HIP currently covers approximately 41,000 individuals. Due to the elimination of the waitlist, HIP enrollment is expected to reach the enrollment target of 45,000 in 2014,

comprised of approximately 25,000 caretakers and 20,000 non-caretakers. Enrollment is projected to remain at these levels through the three year renewal period.

The purpose of the HIP Extension Waiver is to continue HIP for three years without change, in the event that the HIP 2.0 waiver is not approved. Over the three-year demonstration period (2015-2017), the extension of the HIP waiver in its current form is expected to cost approximately $3.6 billion in state funds, and $10.6 billion in total combined state and federal funds. The table below provides the estimated state and federal costs divided by year.

Estimated State and Federal Program Costs 2015-2017 (in millions)

Calendar Year	Demonstration Year	Expenditures without Waiver	Total Waiver Expenditures	State Share of Expenditures	Waiver Margin	Cumulative Margin
2015	8	$ 3,153.7	$ 3,298.9	$1,104.5	($ 145.3)	$ 907.4
2016	9	$ 3,385.4	$ 3,531.4	$1,182.3	($ 146.0)	$ 761.4
2017	10	$ 3,634.6	$ 3,781.0	$1,265.9	($ 146.4)	$ 615.0

BENEFITS AND HEALTH CARE DELIVERY SYSTEM

HIP offers a comprehensive Secretary-approved benefits plan. Preventive services, such as annual examinations, smoking cessation programs, and mammograms are covered without charge to the member up to $500 and are not included in the deductible amount. After the $1,100 deductible is met through the utilization of POWER account funds, the HIP program includes a comprehensive benefit package, covering up to $300,000 in services annually and a lifetime benefit limit of $1 million for care services, home health services, physician services, inpatient/outpatient hospital services, maternity services, emergency transportation, prescription drugs, diagnostic services, durable medical equipment and medical supplies, rehabilitative services, home health services, and mental health and substance abuse services. Non-emergency transportation, dental, and vision services are not covered. Pregnancy-related services are also excluded, as pregnant HIP members are transferred to the HHW program for the duration of the pregnancy. FSSA is requesting a waiver of the requirements to offer non-emergency transportation services and Early Periodic Screening, Diagnoses, and Testing ("EPSDT") services to individuals between the ages of 19 and 21 in order to standardize the benefit package for members.

All HIP medical benefits are currently provided through three managed care entities ("MCE"), Anthem, MDwise, and Managed Health Services. At the time of application, HIP members have access to enrollment brokers, who provide counseling on the full spectrum of available MCE choices, to assist with their MCE selection. Once an MCE has been selected, the member must remain in the MCO for 12 months, with limited exceptions. Members who do not select an MCE will be auto-assigned to an MCE but will have the opportunity to change the assigned MCE before the first POWER account contribution is made.

COST SHARING REQUIREMENTS

HIP utilizes two forms of cost-sharing. First, members must contribute to their POWER account to help fund the $1,100 deductible. POWER account contribution rates are based on a sliding fee scale, reflecting approximately 2% of the member's household income. At the end of a 12-month coverage term, any remaining funds in the POWER account may be carried forward to the next coverage term to reduce the member's required POWER account contribution for that term. Second, members must pay co-payments for non-emergency use of hospital emergency departments (ED). Non-caretaker members are required to pay a $25 co-payment for non-emergency ED visits. Parent and caretaker members with household incomes above the AFDC limit as set forth in the State Medicaid Plan up to and including 100% of the FPL are charged a $3 co-payment for non-emergency ED visits. Consistent with the CMS standard, members will not pay more than 5% of their annual income for combined cost-sharing (POWER account contributions and ED co-payments).

HYPOTHESES & EVALUATION

Since the FSSA will not request any changes in the HIP Extension Waiver, FSSA does not propose any changes to its hypotheses and evaluation plan for the duration of the demonstration extension.

Evaluation reports will include evaluation of the following HIP hypotheses:

- Reduction in the number of uninsured low income Hoosiers.
- Reduction of barriers and improvement in statewide access to health care services for low income Hoosiers.
- Increased value-based decision making and personal health responsibility.
- Promotion of primary prevention.
- Prevention of chronic disease progression with secondary prevention.
- Provision of appropriate quality-based health care services.
- Assurance of State fiscal responsibility and efficient management of the program.

During the waiver extension period evaluation reports will continue to include responses to the following evaluation questions:

1. How many HIP members reach their $300,000 annual benefit limit each year? How do these individuals meet their health care needs after they exhaust the annual benefit limit and before the next coverage term begins?

2. How many HIP members reach their $1,000,000 lifetime benefit maximum? How do they meet their health care needs after their HIP benefits are exhausted?

3. What are the consequences of limiting members' ability to switch plans after they have made an initial POWER Account contribution? What percentage of HIP applicants are auto-assigned to an MCE?

4. What percentage of the potentially eligible population enrolls in HIP? How does the percentage vary by major population subgroups (HIP Caretakers, HIP Non-caretakers) and income level?

5. What are the consequences of requiring HIP members with household income less than 100% of the FPL to pay monthly premiums? How many of these members fail to make their first POWER Account contribution? How many of these members are disenrolled for failure to pay their contributions?

6. To what extent has HIP impacted the uninsurance rate in Indiana?

7. To what extent has HIP reduced uncompensated care provided by Indiana's federally-funded health clinics?

8. How many members exhaust their POWER account each year? How many members are able to roll-over a sufficient POWER account balance to reduce their subsequent year's required contribution by at least half? How many members are able to achieve a $0 contribution by this means?

WAIVER & EXPENDITURE AUTHORITIES

The following includes a list of waiver and expenditure authorities for the HIP Extension Waiver:

1. **Amount, Duration, and Scope and Comparability** **Section 1902(a)(10)(B)**
   To the extent necessary to enable Indiana to vary the services offered to individuals, within eligibility groups or within the categorical eligible population, based on differing managed care arrangements or on the absence of managed care arrangements. Individuals enrolled in the HHW program receive additional benefits such as case management and health education that may not be available to other Medicaid beneficiaries not enrolled in HHW.

2. **Freedom of Choice** **Section 1902(a)(23)**

To the extent necessary to enable Indiana to restrict the freedom of choice of providers for the demonstration eligibility groups.

3. **Reasonable Promptness** **Section 1902(a)(3)/Section 1902(a)(8)**
To the extent necessary to enable Indiana to prohibit reenrollment for 12 months for individuals in Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults) who are disenrolled for failure to make POWER account contributions.

To the extent necessary to enable Indiana to delay provision of medical assistance until the first day of the month following an individual's first contribution to the POWER account.

4. **Methods of Administration: Transportation** **Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53**
To the extent necessary to enable Indiana not to ensure transportation to and from providers for Demonstration Population 4 (HIP Caretakers) or Demonstration Population 5 (HIP Adults).

5. **Eligibility Section** **Section 1902(a)(10)(A)**
To the extent necessary to allow Indiana not to provide medical assistance for Demonstration Population 4 (HIP Caretakers) or Demonstration Population 5 (HIP Adults) until the first day of the month following an individual's first contribution to the POWER account.

6. **Amount, Duration, and Scope of Services** **Section 1902(a)(10)(B)**
To the extent necessary to permit Indiana to offer to Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults), known as "the adult group" at 42 CFR 435.119, benefits that differ from the benefits offered to the categorically needy group.

To the extent necessary to enable Indiana to vary the amount, duration and scope of services offered to individuals in the Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults) who meet the annual maximum benefit of $300,000.

7. **Retroactive Eligibility** **Section 1902(a)(34)**
To the extent necessary to allow Indiana to not provide medical assistance to Demonstration Population 4 (HIP Caretakers) or to Demonstration Population 5 (HIP Adults) for any time prior to the first of the month following an individual's first contribution to the POWER account.

8. **Prepayment Review** **Section 1902(a)(37)(B)**
To the extent necessary to allow Indiana not to ensure that prepayment review be available for disbursements by members of Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults) to their providers.

9. **Cost-Sharing** **Section 1916A; Section 1902(a)(14) insofar as it incorporates Section 1916(a)(1)**
To the extent necessary to enable Indiana to charge required POWER account contributions and co-payments up to 5% of family income for Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults).

10. **Dental and Vision Coverage** **Section 1902(a)(43)**

To the extent necessary to enable Indiana not to cover certain vision and dental services described in sections 1905(r)(2) and 1905(r)(3) of the Act to 19 and 20 year-old members of Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults).

11. **Income and Resource Test** **Section 1902(a)(10)(c)**
To the extent necessary to enable Indiana to exclude funds in the POWER account from the income and resource test established under state and federal law for purposes of determining Medicaid eligible for Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults).

12. **Statewideness/Uniformity** **Section 1902(a)(1)**
To the extent necessary to enable Indiana to operate the Demonstration and provide managed care plans or certain types of managed care plans, including provider-sponsored networks, only in certain geographical areas.

REVIEW OF DOCUMENTS AND SUBMISSION OF COMMENTS

The proposed HIP Extension Waiver documents are available for public review at the FSSA, Office of General Counsel, 402 W. Washington Street, Room W451, Indianapolis, Indiana 46204. The documents may also be viewed online at www.HIP.in.gov.

Written comments regarding the HIP 2.0 Waiver may be sent to the FSSA via mail at 402 West Washington Street, Room W374, Indianapolis, Indiana 46204, Attention: Steve Holt or via electronic mail at HIP.Renewal@fssa.in.gov **through June 21, 2014**.

FSSA will publish a summary of the written comments, once compiled, for public review at www.HIP.in.gov.

1115 Waiver Status Quo Renewal

Healthy Indiana Plan

Budget Neutrality Projections

State of Indiana

Family and Social Services Administration

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EXECUTIVE SUMMARY

BACKGROUND

The Healthy Indiana Plan 1115 Waiver was originally approved for a five year period from January 2008 through December 2012. It was extended for two one-year periods: for calendar year 2013 (DY 06), and then again for calendar year 2014 (DY 07).

This document describes a request for a three year renewal, for calendar years 2015 through 2017 (DY 08 through DY 10), with no material changes in the program. The status quo renewal described by this document will only be requested in the event that the HIP 2.0 expansion is not approved. The status quo renewal projects HIP to continue in its current form, with enrollment limited to 45,000 and income capped at 100% FPL (105% with MAGI). Budget Neutrality projections have been developed to support the submission:

Indiana is transitioning from 209(b) status to 1634 status as of June 1, 2014. As part of the 1634 transition, Indiana will no longer be required to maintain a spend down program for higher income individuals with significant medical needs. To mitigate the impact on members, Indiana raised the disability income standard for full Medicaid eligibility to 100% FPL and also raised the income standards for the Medicare Savings Program.

Medicare enrollees with End Stage Renal Disease (ESRD) have significantly higher cost sharing than other Medicare enrollees. More significantly, Medicare supplement insurance of some kind (such as Medicaid) is required for members to maintain active status on kidney transplant lists.

To allow members with ESRD to remain on kidney transplant lists, Indiana is proposing a 1915(i) that will cover these members. Until Indiana is able to implement this program, Indiana proposes to cover these members through an amendment to its existing 1115 waiver. It is estimated that ESRD members will be able to transfer to the new 1915(i) program on October 1, 2014 (anticipated effective date). However, only those enrollees with income at or below 300% FPL will be able to participate in a new 1915 (i) waiver. There are estimated 50 members who will remain on the 1115 waiver due to income of higher than 300% of FPL as of December 31, 2014.

BUDGET NEUTRALITY

Initial Waiver Period and Approved Renewals (DY01 – DY07)

Table 1 illustrates the Waiver Margin for the first seven years of the Demonstration, using data through December 31, 2013. Values for 2014 are projected. Values for CY 2013 include an adjustment for estimated completion.

As illustrated in Table 1, the waiver margin gradually increased each year until DY 05, when provider reimbursement increases were implemented.

In DY 07, the waiver margin is projected to become more negative for the following reasons:

- Projected enrollment increase for HIP Adults. Expenditures for this population are only included in the With Waiver expenditures, not in the Without Waiver expenditures, so increased enrollment reduces the margin directly
- Reflection of reimbursement increases (expiration of rate reductions) in the 2014 capitation rates
- Reflection of the cost for the Health Insurer Tax (HIT) in 2014, mandated under ACA Section 9010
- Addition of the 400 ESRD eligible members

Table 1 State of Indiana, Family and Social Services Administration 1115 HIP Waiver Budget Neutrality Summary Initial Waiver Period and Approved Renewals (Values in $Millions)					
Calendar Year	Demonstration Year	Without Waiver Expenditures	With Waiver Expenditures	Waiver Margin	Cumulative Waiver Margin
2008	1	$ 1,723.3	$ 1,591.2	$ 132.1	$ 132.1
2009	2	$ 1,974.8	$ 1,858.2	$ 116.6	$ 248.7
2010	3	$ 2,171.7	$ 1,789.2	$ 382.6	$ 631.3
2011	4	$ 2,262.6	$ 1,665.4	$ 597.2	$ 1,228.4
2012	5	$ 2,371.0	$ 2,411.1	$ (40.1)	$ 1,188.3
2013	6	$ 2,340.2	$ 2,321.2	$ 19.0	$ 1,207.4
2014	7	$ 2,666.8	$ 2,822.3	$ (155.5)	$ 1,051.9

The projected waiver margin does not reflect the State's proposed amendment capping Non-Caretaker enrollment as of July 1, 2014.

Renewal with Continuation of HIP Status Quo (DY08 – DY10)

Table 2 illustrates the projected Waiver Margin for 2015 through 2017 under continuation of HIP Status Quo.

The annual waiver margin is projected to improve gradually. We have assumed the Without Waiver trends are at 5.10%. With Waiver cost trends for the mandatory populations are assumed the same as without waiver cost trends. However, we have assumed that actual cost trend for HIP populations is held to 3.50% per year due to program design and the import to utilization of health care services. In addition, 50 ESRD members with income of 300% of FPL or higher will remain on the 1115 waiver with anticipated annual cost trend of 3.0%. No significant reimbursement increases are projected.

Table 2
State of Indiana, Family and Social Services Administration
1115 HIP Waiver Budget Neutrality Summary
Three Year Renewal with Continuation of HIP Status Quo
(Values in $Millions)

Calendar Year	Demonstration Year	Without Waiver Expenditures	With Waiver Expenditures	Waiver Margin	Cumulative Waiver Margin
2015	8	$ 3,153.7	$ 3,299.1	$ (145.4)	$ 906.5
2016	9	$ 3,385.4	$ 3,531.5	$ (146.1)	$ 760.3
2017	10	$ 3,634.6	$ 3,781.1	$ (146.5)	$ 613.9

The enclosure illustrates additional detail, including enrollment and expenditures for each population.

We have also included an Excel file version of the development of the waiver budget neutrality exhibit: “HIP Budget Neutrality – 2015 HIP Status Quo Renewal.xlsx”.

DATA, ASSUMPTIONS, AND METHODOLOGY

This section provides additional detail on the data, assumptions, and methodology associated with the 1115 waiver budget neutrality filing.

DATA

Historical Enrollment – Current Waiver Populations

For DY 01 through DY 06, Data through December 31, 2013 was used to prepare the budget neutrality exhibits for this filing. Enrollment was summarized from the State of Indiana's Enterprise Data Warehouse for each 1115 Waiver population, by month from January 2008 through December 2013.

Historical Expenditures – Current Waiver Populations

For DY 01 through DY 06, actual to-date expenditures were provided by FSSA, as reported on the Form CMS 64.9 Waiver, project number 11-W-00237. These were summarized by demonstration year (calendar year), according to dates of service.

ESRD Enrollment

ESRD members who will be eligible for the proposed 1915(i) must meet the following conditions:

- Dual eligible (non-dual eligible members are eligible for commercial exchange coverage)
- Spend down status with income below 300% FPL (those with income below 150% FPL are already eligible for appropriate coverage)
- ESRD diagnosis (diagnosis code 585.6)

Members with spend down status and Medicare eligibility were identified from the Medicaid enrollment data. Those with an ESRD diagnosis were identified from Medicaid claims data from the prior year. The list of members who met these requirements was provided to the Indiana's Division of Family Resources (DFR), which is responsible for eligibility determinations. They matched ESRD members to income data, and were able to determine that there were approximately 400 dual eligible ESRD members with income above 150% FPL.

Projected Enrollment

To develop estimates of the eligible but unenrolled populations that may enroll in regular Medicaid in 2014, Milliman developed population summaries by income range, health coverage status, age, and parental status. This analysis was performed using Indiana-specific data from the ACS Data sample provided by the U.S. Census Bureau.

ASSUMPTIONS AND METHODOLOGY

Baseline Budget Neutrality Model

We utilized the budget neutrality model, "IN HIP BN with 36500 noted.xls" Excel workbook provided by CMS. We have updated the model for historical experience through December 31, 2013, as reported by Indiana in Schedule C of the Form CMS 64.

Enrollment Growth – Mandatory Populations

For the mandatory populations, HHW Caretakers, HHW Children, and HHW Pregnant Women, actual enrollment was used through December 2013 (DY 06). Baseline enrollment growth for DY 07 and the three year renewal period was developed using the average enrollment growth rate during DY 01 through DY 06 (CY 2008 through CY 2013).

Eligible but Unenrolled: Using ACS data, we have assumed there are approximately 122,000 individuals (106,000 children and 16,000 adults) in the State of Indiana who are eligible for Medicaid but not currently enrolled. We have assumed 75% or approximately 91,000 of these individuals will ultimately enroll. This reflects national coverage changes anticipated to begin January 2014, including the individual mandate, referrals from the exchange, and potential shifts in employer coverage. To reflect gradual enrollment of this population, we have reflected three quarters of this increase in DY 07, and the remaining one quarter in DY 08.

HIP Enrollment Projections

Due to the elimination of the waitlist for Non-Caretakers and other enrollment restrictions, HIP enrollment is assumed to reach the enrollment target of 45,000 in DY 07, with approximately 25,000 Caretakers and 20,000 Non-Caretakers. It is projected to remain at this level through the renewal period.

ESRD Enrollment Projections

Due to the implementation of 1915(i) waiver for the ESRD eligible member, only those with income above 300% of FPL will remain as part of the 1115 waiver (estimated 50 members as of December 31, 2014) and will lapse off the waiver at a rate of 25% a year due to a receipt of transplant or death.

Without Waiver Trend Rate

The Without Waiver projection model requires a baseline trend rate to project future PMPM expenditures for the Mandatory and Optional populations. For DY 01 to DY 06, a 4.40% annual trend rate was used for all waiver populations. For DY07, the 4.40% trend rate was reduced to 1.94% per year for children, but retained at 4.40% per year for adult populations.

For the renewal (DY 08 through DY 10), we have assumed the without waiver trend rates reflect the President's Budget Trend rate, illustrated as 5.10%.

With Waiver Cost Per Eligible

With Waiver cost per eligible is illustrated using actual expenditures through DY 06 (CY 2013), although adjustments have been made to DY 06 to project estimated claims completion.

For mandatory populations, the With Waiver trend reflects the expected trend in the Hoosier Healthwise population. However, for Healthy Indiana Plan populations, the, With Waiver PMPM values were projected using an annual trend rate of 3.50% instead of 5.10%. This reflects our expectation that the Healthy Indiana Plan design will support more thoughtful utilization of health care services.

In addition, the following adjustments were made:

- Supplemental expenditures for the Primary Care Fee Schedule increase, effective for CY 2013 and CY 2014, have been excluded from the budget neutrality exhibits, as allowed by CMS in the STCs.
- DY 07 PMPM values reflect actual 2014 capitation rate increases. Increases for DY 07 were higher than historical norms, due to inclusion of fee-for-service reimbursement increases related to expiration of temporary rate reductions.
- As of DY 07 (CY 2014), all PMPM values were increased by an additional 2.0% to account for payment of the Health Insurer Fee required under section 9010 of the Affordable Care Act.

The average cost for members with ESRD is estimated as $315.54 and includes the following components:

- $104.90 per month for the Medicare Part B premium
- $86.07 for the Medicare clawback payment
- $124.57 for other Medicaid costs (after meeting spend down).

Average Medicaid cost after spend down is based on recent historical experience for this population. PMPM values for DY 08 through DY 10 were projected using 3.0% annual trend rate.

Diverted Disproportionate Share Hospital (DSH) Payments

The initial waiver filing provided for diverting a portion of Indiana's DSH payments in order to maintain budget neutrality. This was discontinued as of DY 06.

LIMITATIONS

The information contained in this report has been prepared for the State of Indiana, Family and Social Services Administration (FSSA) and the Office of Medicaid Policy and Planning (OMPP). This report has been developed to assist in the development of the 1115 waiver filing to be submitted to the Centers for Medicaid and Medicare Services (CMS) associated with the Healthy Indiana Plan. The data and information presented may not be appropriate for any other purpose.

It is our understanding that the information contained in this report may be utilized in a public document. To the extent that the information contained in this correspondence is provided to any third parties, the correspondence should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this correspondence to third parties. Likewise, third parties are instructed that they are to place no reliance upon this correspondence prepared for OMPP by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

Milliman has relied upon certain data and information provided by the State of Indiana, Family and Social Services Administration and their vendors. The values presented in this letter are dependent upon this reliance. To the extent that the data was not complete or was inaccurate, the values presented in our report will need to be reviewed for consistency and revised to meet any revised data.

The services provided for this project were performed under the signed Consulting Services Agreement between Milliman and OMPP, approved May 14, 2010, and last amended December 30, 2013.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries, and meet the qualification standards for performing the analyses in this report.

Enclosure 1

Budget Neutrality Exhibits

Continuation of HIP Status Quo

Healthy Indiana Plan | ***Summary Budget Neutrality Estimates - Waiver Renewal - DRAFT***

Scenario: Includes Experience through December 31, 2013
Updated June 23, 2014

Without Waiver Summary	DY 01	DY 02	DY 03	DY 04	DY 05	DY 01 - DY 05
XIX - Mandatory Populations	1,616,049,521	1,802,640,241	1,961,741,870	2,049,208,435	2,146,914,464	9,576,554,531
HIP Parents	22,229,213	70,694,055	107,253,382	117,392,639	120,421,477	437,990,766
HIP Adults	-	-	-	-	-	
DSH	85,001,705	101,417,834	102,754,618	96,003,617	103,648,918	488,826,691
Total	***1,723,280,439***	***1,974,752,130***	***2,171,749,871***	***2,262,604,690***	***2,370,984,859***	***10,503,371,989***

With Waiver Summary	DY 01	DY 02	DY 03	DY 04	DY 05	DY 01 - DY 05
XIX - Mandatory Populations	1,503,594,121	1,634,301,054	1,525,588,718	1,460,215,147	2,220,583,063	8,344,282,104
HIP Parents	29,206,820	72,749,845	120,440,480	115,478,395	107,605,576	445,481,117
HIP Adult Optional Population	-	-	-	-	-	-
HIP Adult Waiver Population	58,331,939	151,090,998	143,034,516	89,582,245	82,734,445	524,774,143
ESRD Members	-	-	-	-	-	-
Waiver Administrative Expenditures	19,108	56,476	107,593	144,085	163,400	490,662
Total	***1,591,151,988***	***1,858,198,374***	***1,789,171,307***	***1,665,419,872***	***2,411,086,484***	***9,315,028,026***
Waiver Margin	***132,128,450***	***116,553,756***	***382,578,564***	***597,184,818***	***(40,101,625)***	***1,188,343,963***

Coverage Estimates	DY 01	DY 02	DY 03	DY 04	DY 05	DY 01 - DY 05
Test A						
Limit	1,701,051,226	1,904,058,075	2,064,496,489	2,145,212,051	2,250,563,382	10,065,381,223
Expenditures	1,561,945,168	1,785,448,528	1,668,730,827	1,549,941,477	2,303,480,908	8,869,546,909
Limit less Expenditures	139,106,058	118,609,546	395,765,662	595,270,574	(52,917,526)	1,195,834,314
Test B						
Limit	22,229,213	70,694,055	107,253,382	117,392,639	120,421,477	437,990,766
Expenditures	29,206,820	72,749,845	120,440,480	115,478,395	107,605,576	445,481,117
Limit less Expenditures	(6,977,608)	(2,055,790)	(13,187,098)	1,914,244	12,815,901	(7,490,351)
Combined Test A and Test B	132,128,450	116,553,756	382,578,564	597,184,818	(40,101,625)	1,188,343,963
Cumulative Combined Test	132,128,450	248,682,206	631,260,770	1,228,445,588	1,188,343,963	

Healthy Indiana Plan *Summary Budget Neutrality Estimates - Waiver Renewal - DRAFT*

Scenario: Includes Experience through December 31, 2013
Updated June 23, 2014

Without Waiver Summary	DY 06	DY 07	DY 01 - DY 07
XIX - Mandatory Populations	2,223,870,922	2,545,374,484	14,345,799,937
HIP Parents	116,364,090	121,422,000	675,776,857
HIP Adults	-	-	-
	-	-	488,826,691
Total	***2,340,235,012***	***2,666,796,484***	***15,510,403,485***

With Waiver Summary	DY 06	DY 07	DY 01 - DY 07
XIX - Mandatory Populations	2,104,476,982	2,517,352,665	12,966,111,750
HIP Parents	126,470,309	135,768,000	707,719,426
HIP Adult Optional Population	-	-	-
HIP Adult Waiver Population	90,089,635	168,388,800	783,252,578
ESRD Members	-	757,305	757,305
Waiver Administrative Expenditures	160,940	14,798	666,399
Total	***2,321,197,865***	***2,822,281,568***	***14,458,507,458***
Waiver Margin	***19,037,147***	***(155,485,084)***	***1,051,896,026***

Coverage Estimates	DY 06	DY 07	DY 01 - DY 07
Test A			
Limit	2,223,870,922	2,545,374,484	14,834,626,628
Expenditures	2,194,727,556	2,686,513,568	13,750,788,032
Limit less Expenditures	29,143,366	(141,139,084)	1,083,838,596
Test B			
Limit	116,364,090	121,422,000	675,776,857
Expenditures	126,470,309	135,768,000	707,719,426
Limit less Expenditures	(10,106,219)	(14,346,000)	(31,942,569)
Combined Test A and Test B	19,037,147	(155,485,084)	1,051,896,026
Cumulative Combined Test	1,207,381,110	1,051,896,026	

Healthy Indiana Plan *Summary Budget Neutrality Estimates - Waiver Renewal - DRAFT*

Scenario: Includes Experience through December 31, 2013
Updated June 23, 2014

Without Waiver Summary	DY 08	DY 09	DY 10	DY 01 - DY 10
XIX - Mandatory Populations	3,026,059,072	3,251,266,475	3,493,657,783	24,116,783,266
HIP Parents	127,614,000	134,121,000	140,961,000	1,078,472,857
HIP Adults	-	-	-	-
DSH	-	-		488,826,691
Total	***3,153,673,072***	***3,385,387,475***	***3,634,618,783***	***25,684,082,814***

With Waiver Summary	DY 08	DY 09	DY 10	DY 01 - DY 10
XIX - Mandatory Populations	2,984,142,317	3,205,567,546	3,443,752,919	22,599,574,532
HIP Parents	140,520,000	145,437,000	150,528,000	1,144,204,426
HIP Adult Optional Population	-	-	-	-
HIP Adult Waiver Population	174,283,200	180,384,000	186,698,400	1,324,618,178
ESRD Members	154,399	119,439	92,181	1,123,324
Waiver Administrative Expenditures				666,399
Total	***3,299,099,916***	***3,531,507,985***	***3,781,071,500***	***25,070,186,860***
Waiver Margin	***(145,426,844)***	***(146,120,511)***	***(146,452,718)***	***613,895,954***

Coverage Estimates	DY 08	DY 09	DY 10	DY 01 - DY 10
Test A				
Limit	3,026,059,072	3,251,266,475	3,493,657,783	24,605,609,957
Expenditures	3,158,579,916	3,386,070,985	3,630,543,500	23,925,982,434
Limit less Expenditures	(132,520,844)	(134,804,511)	(136,885,718)	679,627,524
Test B				
Limit	127,614,000	134,121,000	140,961,000	1,078,472,857
Expenditures	140,520,000	145,437,000	150,528,000	1,144,204,426
Limit less Expenditures	(12,906,000)	(11,316,000)	(9,567,000)	(65,731,569)
Combined Test A and Test B	(145,426,844)	(146,120,511)	(146,452,718)	613,895,954
Cumulative Combined Test	906,469,182	760,348,672	613,895,954	

Enclosure 2

Without Waiver Projections

Healthy Indiana Plan

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION

CY 2008

MANDATORY POPULATIONS											
ELIGIBILITY GROUP	TREND		DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL WW
HHW Caretakers								
Eligible Member Months		30	1,267,393	1,321,085	1,358,352	1,348,869	1,337,306	
Total Cost Per Eligible	4.40%	30	$ 328.07	$ 342.50	$ 357.57	$ 373.30	$ 389.73	
Total Expenditure			$ 415,793,622	$ 452,471,613	$ 485,705,925	$ 503,532,798	$ 521,188,267	$ 2,378,692,224
HHW Children								
Eligible Member Months		30	5,766,985	6,234,677	6,574,005	6,635,026	6,692,151	
Total Cost Per Eligible	4.40%	30	$ 180.51	$ 188.45	$ 196.74	$ 205.40	$ 214.44	
Total Expenditure			$ 1,040,998,462	$ 1,174,924,881	$ 1,293,369,744	$ 1,362,834,340	$ 1,435,064,860	$ 6,307,192,288
HHW Pregnant Women								
Eligible Member Months		30	334,455	352,518	351,958	337,451	337,054	
Total Cost Per Eligible	4.40%	30	$ 476.17	$ 497.12	$ 519.00	$ 541.83	$ 565.67	
Total Expenditure			$ 159,257,437	$ 175,243,748	$ 182,666,202	$ 182,841,296	$ 190,661,336	$ 890,670,020

OPTIONAL POPULATIONS								
ELIGIBILITY GROUP	TREND		DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL WW
HIP Caretakers								
Eligible Member Months			71,113	216,627	314,803	330,042	324,289	
Total Cost Per Eligible			$ 312.59	$ 326.34	$ 340.70	$ 355.69	$ 371.34	
Total Expenditure			$ 22,229,213	$ 70,694,055	$ 107,253,382	$ 117,392,639	$ 120,421,477	$ 437,990,766

Healthy Indiana Plan **DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION**

	CY 2013		CY 2014
MANDATORY POPULATIONS			
ELIGIBILITY GROUP	**DY 06**	**TREND RATE**	**DY 07**
HHW Caretakers			
Eligible Member Months	1,336,336	10.49%	1,476,568
Total Cost Per Eligible	$ 406.88	4.40%	$ 424.78
Total Expenditure	$ 543,728,392		$ 627,216,555
HHW Children			
Eligible Member Months	6,642,974	13.30%	7,526,533
Total Cost Per Eligible	$ 223.88	1.94%	$ 228.22
Total Expenditure	$ 1,487,229,019		$ 1,717,705,361
HHW Pregnant Women			
Eligible Member Months	326,662	-0.47%	325,125
Total Cost Per Eligible	$ 590.56	4.40%	$ 616.54
Total Expenditure	$ 192,913,511		$ 200,452,568

OPTIONAL POPULATIONS			
ELIGIBILITY GROUP	**DY 06**	**TREND RATE**	**DY 07**
HIP Caretakers			
Eligible Member Months	300,155	-0.05%	300,000
Total Cost Per Eligible	$ 387.68	4.40%	$ 404.74
Total Expenditure	$ 116,364,090		$ 121,422,000

Healthy Indiana Plan **DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION**

CY 2015

MANDATORY POPULATIONS						
ELIGIBILITY GROUP	**TREND RATE**	**DY 08**	**TREND RATE**	**DY 09**	**DY 10**	**TOTAL WW**
HHW Caretakers						
Eligible Member Months	3.82%	1,532,952	1.07%	1,549,278	1,565,778	
Total Cost Per Eligible	5.10%	$ 446.44	5.10%	$ 469.21	$ 493.14	
Total Expenditure		$ 684,371,091		$ 726,936,730	$ 772,147,763	$ 5,733,092,755
HHW Children						
Eligible Member Months	18.10%	8,888,536	2.87%	9,143,511	9,405,800	
Total Cost Per Eligible	5.10%	$ 239.86	5.10%	$ 252.09	$ 264.95	
Total Expenditure		$ 2,132,004,245		$ 2,304,987,688	$ 2,492,066,710	$ 16,441,185,311
HHW Pregnant Women						
Eligible Member Months	-0.47%	323,596	-0.47%	322,074	320,559	
Total Cost Per Eligible	5.10%	$ 647.98	5.10%	$ 681.03	$ 715.76	
Total Expenditure		$ 209,683,736		$ 219,342,056	$ 229,443,310	$ 1,942,505,200

OPTIONAL POPULATIONS						
ELIGIBILITY GROUP	**TREND RATE**	**DY 08**	**TREND RATE**	**DY 09**	**DY 10**	**TOTAL WW**
HIP Caretakers						
Eligible Member Months	0.00%	300,000	0.00%	300,000	300,000	
Total Cost Per Eligible	5.10%	$ 425.38	5.10%	$ 447.07	$ 469.87	
Total Expenditure		$ 127,614,000		$ 134,121,000	$ 140,961,000	$ 1,078,472,857

Enclosure 3

With Waiver Projections

Healthy Indiana Plan

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION

CY 2008

MANDATORY POPULATIONS						
ELIGIBILITY GROUP	**DEMONSTRATION YEARS (DY)**					**TOTAL**
	DY 01	**DY 02**	**DY 03**	**DY 04**	**DY 05**	**WW**
HHW Caretakers						
Eligible Member Months	1,267,393	1,321,085	1,358,352	1,348,869	1,337,306	
Total Cost Per Eligible	$ 320.07	$ 329.53	$ 292.59	$ 277.99	$ 464.29	
Total Expenditure	$ 405,654,478	$ 435,337,140	$ 397,440,212	$ 374,972,093	$ 620,897,803	$ 2,234,301,725
HHW Children						
Eligible Member Months	5,766,985	6,234,677	6,574,005	6,635,026	6,692,151	
Total Cost Per Eligible	$ 164.50	$ 166.30	$ 149.68	$ 140.46	$ 204.11	
Total Expenditure	$ 948,669,033	$ 1,036,826,785	$ 983,997,068	$ 931,955,752	$ 1,365,934,941	$ 5,267,383,579
HHW Pregnant Women						
Eligible Member Months	334,455	352,518	351,958	337,451	337,054	
Total Cost Per Eligible	$ 446.31	$ 459.94	$ 409.57	$ 454.25	$ 693.51	
Total Expenditure	$ 149,270,611	$ 162,137,129	$ 144,151,438	$ 153,287,302	$ 233,750,320	$ 842,596,800

OPTIONAL POPULATIONS						
ELIGIBILITY GROUP	**DEMONSTRATION YEARS (DY)**					**TOTAL**
	DY 01	**DY 02**	**DY 03**	**DY 04**	**DY 05**	**WW**
HIP Caretakers						
Eligible Member Months	71,113	216,627	314,803	330,042	324,289	
Total Cost Per Eligible	$ 410.71	$ 335.83	$ 382.59	$ 349.89	$ 331.82	
Total Expenditure	$ 29,206,820	$ 72,749,845	$ 120,440,480	$ 115,478,395	$ 107,605,576	$ 445,481,117

WAIVER POPULATIONS						
ELIGIBILITY GROUP	**DEMONSTRATION YEARS (DY)**					**TOTAL**
	DY 01	**DY 02**	**DY 03**	**DY 04**	**DY 05**	**WW**
HIP Adults						
Eligible Member Months	112,673	316,527	226,367	168,762	170,946	
Total Cost Per Eligible	$ 517.71	$ 477.34	$ 631.87	$ 530.82	$ 483.98	
Total Expenditure	$ 58,331,939	$ 151,090,998	$ 143,034,516	$ 89,582,245	$ 82,734,445	$ 524,774,143
ESRD Members						
Eligible Member Months						
Total Cost Per Eligible						
Total Expenditure						

Healthy Indiana Plan

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION

	CY 2013		CY 2014	
MANDATORY POPULATIONS				
ELIGIBILITY GROUP	**DY 06**	**TREND RATE**		**DY 07**
HHW Caretakers				
Eligible Member Months	1,336,336	10.49%		1,476,568
Total Cost Per Eligible	$ 474.20	7.20%	$	508.35
Total Expenditure	$ 633,690,531		$	750,613,343
HHW Children				
Eligible Member Months	6,642,974	13.30%		7,526,533
Total Cost Per Eligible	$ 201.33	7.20%	$	215.83
Total Expenditure	$ 1,337,429,955		$	1,624,451,617
HHW Pregnant Women				
Eligible Member Months	326,662	-0.47%		325,125
Total Cost Per Eligible	$ 408.24	7.20%	$	437.64
Total Expenditure	$ 133,356,495		$	142,287,705
OPTIONAL POPULATIONS				
ELIGIBILITY GROUP	**DY 06**	**TREND RATE**		**DY 07**
HIP Caretakers				
Eligible Member Months	300,155	-0.05%		300,000
Total Cost Per Eligible	$ 421.35	7.41%	$	452.56
Total Expenditure	$ 126,470,309		$	135,768,000
WAIVER POPULATIONS				
ELIGIBILITY GROUP	**DY 06**	**TREND RATE**		**DY 07**
HIP Adults				
Eligible Member Months	137,912	74.02%		240,000
Total Cost Per Eligible	$ 653.24	7.41%	$	701.62
Total Expenditure	$ 90,089,635		$	168,388,800
ESRD Members				
Eligible Member Months				2,400
Total Cost Per Eligible			$	315.54
Total Expenditure			$	757,305

Healthy Indiana Plan

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION

CY 2015

MANDATORY POPULATIONS						
ELIGIBILITY GROUP	**TREND RATE**	**DY 08**	**TREND RATE**	**DY 09**	**DY 10**	**TOTAL WW**
HHW Caretakers						
Eligible Member Months	3.82%	1,532,952	1.07%	1,549,278	1,565,778	
Total Cost Per Eligible	5.10%	$ 534.28	5.10%	$ 561.53	$ 590.17	
Total Expenditure		$ 819,025,595		$ 869,966,075	$ 924,075,202	$ 6,231,672,471
HHW Children						
Eligible Member Months	18.10%	8,888,536	2.87%	9,143,511	9,405,800	
Total Cost Per Eligible	5.10%	$ 226.84	5.10%	$ 238.41	$ 250.57	
Total Expenditure		$ 2,016,275,506		$ 2,179,904,458	$ 2,356,811,306	$ 14,782,256,421
HHW Pregnant Women						
Eligible Member Months	-0.47%	323,596	-0.47%	322,074	320,559	
Total Cost Per Eligible	5.10%	$ 459.96	5.10%	$ 483.42	$ 508.07	
Total Expenditure		$ 148,841,216		$ 155,697,013	$ 162,866,411	$ 1,585,645,640

OPTIONAL POPULATIONS						
ELIGIBILITY GROUP	**TREND RATE**	**DY 08**	**TREND RATE**	**DY 09**	**DY 10**	**TOTAL WW**
HIP Caretakers						
Eligible Member Months	0.00%	300,000	0.00%	300,000	300,000	
Total Cost Per Eligible	3.50%	$ 468.40	3.50%	$ 484.79	$ 501.76	
Total Expenditure		$ 140,520,000		$ 145,437,000	$ 150,528,000	$ 1,144,204,426

WAIVER POPULATIONS						
ELIGIBILITY GROUP	**TREND RATE**	**DY 08**	**TREND RATE**	**DY 09**	**DY 10**	**TOTAL WW**
HIP Adults						
Eligible Member Months	0.00%	240,000	0.00%	240,000	240,000	
Total Cost Per Eligible	3.50%	$ 726.18	3.50%	$ 751.60	$ 777.91	
Total Expenditure		$ 174,283,200		$ 180,384,000	$ 186,698,400	$ 1,324,618,178
ESRD Members						
Eligible Member Months		478	-25.00%	359	269	
Total Cost Per Eligible	TREND	$ 323.01	3.00%	$ 332.70	$ 342.68	
Total Expenditure		$ 154,399		$ 119,439	$ 92,181	$ 1,123,324

Indiana Family and Social Services Administration

Notice of Tribal Comment Period for Indiana HIP Extension 1115 Waiver

Pursuant to 42 CFR Part 431.408(b), notice is hereby given to the Pokagon Band of the Potawatomi that within sixty (60) days of the date of this notice, the Indiana Family and Social Services Administration ("FSSA") will submit a waiver to the Centers for Medicare and Medicaid Services ("CMS") to extend the current Healthy Indiana Plan for calendar years 2015 through 2017.

This notice also serves to open the **30-day public comment period, which closes August 22, 2014 at 5:00 pm.**

The Healthy Indiana Plan ("HIP"), which passed the Indiana General Assembly in 2007 with bipartisan support, builds upon the state's long and successful history with consumer-driven health plans. Individuals eligible for HIP are non-disabled adults between the ages of 19 and 64 with household income below 100% of the federal poverty limit ("FPL"). HIP, via private health insurance carriers, offers its members a High Deductible Health Plan ("HDHP") paired with a Personal Wellness and Responsibility ("POWER") account, which operates similarly to a Health Savings Account ("HSA"). This private health insurance experience provides an alternative to traditional Medicaid and promotes consumerism by requiring members to have "skin in the game," which empowers them to demand price and quality transparency as they make cost-conscious health care decisions and take responsibility for their health. HIP, in its current form, is scheduled to expire on December 31, 2014.

FSSA is submitting the HIP Extension Waiver concurrently with a separate HIP 2.0 1115 waiver ("HIP 2.0 Waiver") application. The HIP 2.0 Waiver seeks to expand HIP to all non-disabled Hoosiers between the ages of 19 and 64 with household income below 138% of the FPL. FSSA is submitting the HIP Extension Waiver as an alternative to the HIP 2.0 Waiver in order to preserve the current HIP program in the event CMS does not approve the HIP 2.0 Waiver. FSSA is not requesting any changes or modifications in the HIP Extension Waiver.

OBJECTIVES

Seven objectives have driven the implementation of HIP in Indiana: 1) reduce the number of low-income uninsured Hoosiers; 2) improve access to appropriate, quality-based health care to low-income Hoosiers; 3) reduce barriers and improve statewide access to health care services for low income Hoosiers; 4) promote value-based decision-making and personal health responsibility; 5) promote better health outcomes through preventative care; 6) prevent chronic disease progression with secondary prevention; and 7) ensure State fiscal responsibility through efficient management of the program.

BENEFICIARIES, ELIGIBILITY, & FINANCING

HIP offers health care coverage to non-disabled individuals between the ages of 19 and 64, who have household incomes below 100% of the FPL and who are not otherwise eligible for Medicaid or Medicare. Income eligibility for HIP is determined using the modified adjusted gross income ("MAGI") methodology with a 5% disregard. While HIP does not limit enrollment for parents and caretakers with household income below 100% FPL, it imposes an enrollment cap of 36,500 for non-caretaker individuals.

From 2008 through December 2013, the State received 483,561 valid applications and 105,135 unique members have been enrolled in HIP since the program's inception. HIP currently covers approximately 41,000 individuals. Due to the elimination of the waitlist, HIP enrollment is expected to reach the enrollment target of 45,000 in 2014, comprised of approximately 25,000 caretakers and 20,000 non-caretakers. Enrollment is projected to remain at these levels through the three year renewal period.

The purpose of the HIP Extension Waiver is to continue HIP for three years without change, in the event that the HIP 2.0 waiver is not approved. Over the three-year demonstration period (2015-2017), the extension of the HIP waiver in its current form is expected to cost approximately $3.6 billion in state funds, and $10.6 billion in total combined state and federal funds. The table below provides the estimated state and federal costs divided by year.

Estimated State and Federal Program Costs 2015-2017 (in millions)

Calendar Year	Demonstration Year	Expenditures without Waiver	Total Waiver Expenditures	State Share of Expenditures	Waiver Margin	Cumulative Margin
2015	8	$ 3,153.7	$ 3,298.9	$1,104.5	($ 145.3)	$ 907.4
2016	9	$ 3,385.4	$ 3,531.4	$1,182.3	($ 146.0)	$ 761.4
2017	10	$ 3,634.6	$ 3,781.0	$1,265.9	($ 146.4)	$ 615.0

BENEFITS AND HEALTH CARE DELIVERY SYSTEM

HIP offers a comprehensive Secretary-approved benefits plan. Preventive services, such as annual examinations, smoking cessation programs, and mammograms are covered without charge to the member up to $500 and are not included in the deductible amount. After the $1,100 deductible is met through the utilization of POWER account funds, the HIP program includes a comprehensive benefit package, covering up to $300,000 in services annually and a lifetime benefit limit of $1 million for care services, home health services, physician services, inpatient/outpatient hospital services, maternity services, emergency transportation, prescription drugs, diagnostic services, durable medical equipment and medical supplies, rehabilitative services, home health services, and mental health and substance abuse services. Non-emergency transportation, dental, and vision services are not covered. Pregnancy-related services are also excluded, as pregnant HIP members are transferred to the HHW program for the duration of the pregnancy. FSSA is requesting a waiver of the requirements to offer non-emergency transportation services and Early Periodic Screening, Diagnoses, and Testing ("EPSDT") services to individuals between the ages of 19 and 21 in order to standardize the benefit package for members.

All HIP medical benefits are currently provided through three managed care entities ("MCE"), Anthem, MDwise, and Managed Health Services. At the time of application, HIP members have access to enrollment brokers, who provide counseling on the full spectrum of available MCE choices, to assist with their MCE selection. Once an MCE has been selected, the member must remain in the MCO for 12 months, with limited exceptions. Members who do not select an MCE will be auto-assigned to an MCE but will have the opportunity to change the assigned MCE before the first POWER account contribution is made.

COST SHARING REQUIREMENTS

HIP utilizes two forms of cost-sharing. First, members must contribute to their POWER account to help fund the $1,100 deductible. POWER account contribution rates are based on a sliding fee scale, reflecting approximately 2% of the member's household income. At the end of a 12-month coverage term, any remaining funds in the POWER account may be carried forward to the next coverage term to reduce the member's required POWER account contribution for that term. Second, members must pay co-payments for non-emergency use of hospital emergency departments (ED). Non-caretaker members are required to pay a $25 co-payment for non-emergency ED visits. Parent and caretaker members with household incomes above the AFDC limit as set forth in the State Medicaid Plan up to and including 100% of the FPL are charged a $3 co-payment for non-emergency ED visits. Consistent with the CMS standard, members will not pay more than 5% of their annual income for combined cost-sharing (POWER account contributions and ED co-payments).

HYPOTHESES & EVALUATION

Since the FSSA will not request any changes in the HIP Extension Waiver, FSSA does not propose any changes to its hypotheses and evaluation plan for the duration of the demonstration extension.

Evaluation reports will include evaluation of the following HIP hypotheses:

- Reduction in the number of uninsured low income Hoosiers.
- Reduction of barriers and improvement in statewide access to health care services for low income Hoosiers.
- Increased value-based decision making and personal health responsibility.
- Promotion of primary prevention.

- Prevention of chronic disease progression with secondary prevention.
- Provision of appropriate quality-based health care services.
- Assurance of State fiscal responsibility and efficient management of the program.

During the waiver extension period evaluation reports will continue to include responses to the following evaluation questions:

1. How many HIP members reach their $300,000 annual benefit limit each year? How do these individuals meet their health care needs after they exhaust the annual benefit limit and before the next coverage term begins?

2. How many HIP members reach their $1,000,000 lifetime benefit maximum? How do they meet their health care needs after their HIP benefits are exhausted?

3. What are the consequences of limiting members' ability to switch plans after they have made an initial POWER Account contribution? What percentage of HIP applicants are auto-assigned to an MCE?

4. What percentage of the potentially eligible population enrolls in HIP? How does the percentage vary by major population subgroups (HIP Caretakers, HIP Non-caretakers) and income level?

5. What are the consequences of requiring HIP members with household income less than 100% of the FPL to pay monthly premiums? How many of these members fail to make their first POWER Account contribution? How many of these members are disenrolled for failure to pay their contributions?

6. To what extent has HIP impacted the uninsurance rate in Indiana?

7. To what extent has HIP reduced uncompensated care provided by Indiana's federally-funded health clinics?

8. How many members exhaust their POWER account each year? How many members are able to roll-over a sufficient POWER account balance to reduce their subsequent year's required contribution by at least half? How many members are able to achieve a $0 contribution by this means?

WAIVER & EXPENDITURE AUTHORITIES

The following includes a list of waiver and expenditure authorities for the HIP Extension Waiver:

1. **Amount, Duration, and Scope and Comparability** **Section 1902(a)(10)(B)**

   To the extent necessary to enable Indiana to vary the services offered to individuals, within eligibility groups or within the categorical eligible population, based on differing managed care arrangements or on the absence of managed care arrangements. Individuals enrolled in the HHW program receive additional benefits such as case management and health education that may not be available to other Medicaid beneficiaries not enrolled in HHW.

2. **Freedom of Choice** **Section 1902(a)(23)**

   To the extent necessary to enable Indiana to restrict the freedom of choice of providers for the demonstration eligibility groups.

3. **Reasonable Promptness** **Section 1902(a)(3)/Section 1902(a)(8)**

   To the extent necessary to enable Indiana to prohibit reenrollment for 12 months for individuals in Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults) who are disenrolled for failure to make POWER account contributions.

To the extent necessary to enable Indiana to delay provision of medical assistance until the first day of the month following an individual's first contribution to the POWER account.

4. **Methods of Administration: Transportation Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53**

To the extent necessary to enable Indiana not to ensure transportation to and from providers for Demonstration Population 4 (HIP Caretakers) or Demonstration Population 5 (HIP Adults).

5. **Eligibility Section Section 1902(a)(10)(A)**

To the extent necessary to allow Indiana not to provide medical assistance for Demonstration Population 4 (HIP Caretakers) or Demonstration Population 5 (HIP Adults) until the first day of the month following an individual's first contribution to the POWER account.

6. **Amount, Duration, and Scope of Services Section 1902(a)(10)(B)**

To the extent necessary to permit Indiana to offer to Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults), known as "the adult group" at 42 CFR 435.119, benefits that differ from the benefits offered to the categorically needy group.

To the extent necessary to enable Indiana to vary the amount, duration and scope of services offered to individuals in the Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults) who meet the annual maximum benefit of $300,000.

7. **Retroactive Eligibility Section 1902(a)(34)**

To the extent necessary to allow Indiana to not provide medical assistance to Demonstration Population 4 (HIP Caretakers) or to Demonstration Population 5 (HIP Adults) for any time prior to the first of the month following an individual's first contribution to the POWER account.

8. **Prepayment Review Section 1902(a)(37)(B)**

To the extent necessary to allow Indiana not to ensure that prepayment review be available for disbursements by members of Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults) to their providers.

9. **Cost-Sharing Section 1916A; Section 1902(a)(14) insofar as it incorporates Section 1916(a)(1)**

To the extent necessary to enable Indiana to charge required POWER account contributions and co-payments up to 5% of family income for Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults).

10. **Dental and Vision Coverage Section 1902(a)(43)**

To the extent necessary to enable Indiana not to cover certain vision and dental services described in sections 1905(r)(2) and 1905(r)(3) of the Act to 19 and 20 year-old members of Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults).

11. **Income and Resource Test Section 1902(a)(10)(c)**

To the extent necessary to enable Indiana to exclude funds in the POWER account from the income and resource test established under state and federal law for purposes of determining Medicaid eligible for Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults).

12. **Statewideness/Uniformity** **Section 1902(a)(1)**

To the extent necessary to enable Indiana to operate the Demonstration and provide managed care plans or certain types of managed care plans, including provider-sponsored networks, only in certain geographical areas.

TRIBAL IMPACT

Members of the Pokagon Band of the Potawatomi located in Indiana between the ages of 19 and 64, who have household incomes below 100% of the FPL, as determined using the modified adjusted gross income ("MAGI") methodology with a 5% disregard, will be eligible to participate in the HIP as described above. Notwithstanding the foregoing, all eligible tribal members will receive HIP services in a manner consistent with federal regulations, including the American Recovery and Reinvestment Act of 2009, which in relevant part precludes States from imposing Medicaid premiums or other cost-sharing on members of federally-recognized Indian tribes.

SUBMISSION OF COMMENTS

A copy of the proposed HIP Extension Waiver documents will be provided to you during our in-person consultation meeting. The waiver documents may also be viewed online in advance of our meeting at www.HIP.in.gov.

Written comments regarding the HIP Extension Waiver may be sent to the FSSA via mail at 402 West Washington Street, Room W374, Indianapolis, Indiana 46204, Attention: Steve Holt or via electronic mail at HIP.Renewal@fssa.in.gov **through August 22, 2014**.

HEALTHY INDIANA PLAN

SECTION 1115 DEMONSTRATION

PROJECT NUMBER: 11-W-00237/5

2013 ANNUAL REPORT

and

INTERIM EVALUATION REPORT

Centers for Medicare and Medicaid Services

HEALTHY INDIANA PLAN SM

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Submitted by the Indiana Office of Medicaid Policy and Planning

October 2014

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SECTION 1: EXECUTIVE SUMMARY

Seven months after the Indiana General Assembly passed bipartisan legislation to create the program, the Healthy Indiana Plan (HIP) began to enroll working-age, uninsured adults on January 1, 2008. HIP was created to reduce the number of uninsured Hoosiers by offering affordable health care coverage to low-income adults ages 19 through 64. Provided by private health insurance carriers, HIP offers its members a High Deductible Health Plan (HDHP) paired with the Personal Wellness and Responsibility (POWER) account, which operates similarly to a Health Savings Account (HSA). The plan requires enrollee contributions, encourages enrollees to be responsible health care consumers, and promotes preventive health care. The original five year demonstration waiver continued through December 31, 2012, and has had two subsequent one-year extensions. The current demonstration waiver is set to expire on December 31, 2014.

HIP is the nation's first HDHP with HSA model for Medicaid recipients. The State and HIP beneficiaries jointly make contributions to a Personal Wellness and Responsibility (POWER) account which provides funding to meet an eleven hundred dollar ($1,100) annual deductible. The required amount of member contribution varies by income level. Most HIP members are required to make a monthly contribution to their HSA-styled POWER account. The monthly contributions and POWER accounts are designed to encourage HIP members to take responsibility for their health care. Covered services are initially paid by the POWER account funds until the deductible limit is reached. However, to encourage use of preventive health care, the first $500 in preventive care services provided to the member are not charged against the member's POWER account.

Through the introduction of consumer driven principles, HIP has been able to empower members to become active consumers of health care services and to evaluate the cost and quality of services. HIP's unique design creates incentives for members to exercise personal responsibility and encourages members to take control of their health care spending and to be active purchasers of health care services. While other efforts aimed at bending the health care cost curve are aimed at providers and insurers, HIP brings the member directly into the equation, aligning incentives across all parties and uniquely empowering the individual to demand cost and quality transparency. Through the introduction of market forces, HIP has been able to yield superior results compared to traditional Medicaid.

This report includes an evaluation of the most recent demonstration year, DY 6 (calendar year 2013). Also included are the results of the entire demonstration to date showing achievement of the original program goals as listed in the original 1115 waiver. The State of Indiana respectfully submits this combined Sixth Annual Healthy Indiana Plan Section 1115 Demonstration Report and Interim Evaluation Report to the Centers for Medicare & Medicaid Services (CMS).

Key Findings

The HIP program has experienced a variety of successes. These successes lend strong evidence to the effectiveness of using a consumer-driven health plan model to insure a low-income population. Evaluation results demonstrate that this model can effectively promote appropriate healthcare utilization while staying within budget neutrality limits and providing an affordable health insurance program to protect some of the most vulnerable citizens from unmanageable medical costs. The following report demonstrates that HIP has been able to effectively adapt to a changing healthcare market and regulatory landscape while continuing to achieve its foundational goals and objectives. Some key findings, discussed in greater detail throughout this report are:

- **HIP has been a popular program within the State, offering coverage to many previously uninsured individuals.**

As of December 31, 2013, the State had received 483,561 valid HIP applications since the program began; of those, 71,993 (15 percent) were submitted in 2013. During the first six years of program operations, 114,241 unique individuals have been enrolled in HIP. As of the enrollment at the end of 2013, approximately seventy percent (70%) of enrollees (totaling 24,544) were caretakers and approximately thirty percent (30%) of enrollees (totaling 10,390) were non-caretakers.[1] The HIP population mix of caretakers and non-caretakers has shifted since 2009 when the non-caretaker cap was imposed. At the end of 2009, just over forty-seven percent (47.8%) of those enrolled in HIP were caretakers and fifty-two percent (52.2%) were non-caretakers.

- **A number of indicators suggest that HIP is valued by its members, and is affordable for them.**

In 2013, 94 percent of individuals that were determined eligible for HIP made their first required monthly contribution to their POWER account and became full members, and 89 percent made subsequent contributions to remain enrolled. This indicates that contributions are affordable for members. The majority of HIP beneficiaries indicate a willingness and ability to contribute to the cost of their health care coverage, and report that they value having the coverage. Analysis of the 2013 Mathematica Policy Research HIP member survey indicates that the majority of HIP beneficiaries believe that the amount of their monthly POWER account contributions is the right amount or, in fact, too low and that they would be willing to pay more to remain enrolled in the program.

The required POWER account contributions do not appear to impose an undue financial burden on beneficiaries. Only 14 percent of former HIP members reported that cost-sharing was their reason for leaving the program—they were much more likely to report other reasons, such as gaining other insurance coverage, an increase in income, or not returning enrollment paperwork. Most HIP members (83 percent) prefer making up-front monthly payments with the opportunity to have unspent funds returned as opposed to making a co-payment each time they visited a health professional, pharmacy, or hospital. The survey also found that 96 percent of HIP members were either somewhat or very satisfied with their overall experience with the program.

[1] HIP Dashboard December 2013.

- **HIP incentives are successful in promoting appropriate healthcare utilization.**

In 2013, 60 percent of members received at least one recommended preventive service for their age and gender. To discourage inappropriate ER usage, the program charges co-payments for non-emergent visits. In 2013, only 30 percent of HIP members visited the ER, compared to 38 percent of adult Hoosier Healthwise members (traditional managed care Medicaid). Additionally, 5 percent of members reported deciding to seek care at an urgent care facility or their primary care doctor because of the co-payment.

- **HIP is cost-effective and continues to meet budget neutrality requirements.**

All Section 1115 Medicaid research and demonstration waivers are required to be budget neutral, meaning that the demonstration may not cost more to the federal government than it would have cost had it not been implemented. HIP has met its federal budget neutrality targets for the first six years of the demonstration. The estimated total cumulative cost for the first six years of the demonstration (through December 31, 2013) was just under $1.2 billion with an administrative cost of just over $650,000. The cumulative waiver margin for demonstration years 1 through 6 is $1.2 billion—meaning the program has cost the state and federal government $1.2 billion less than what it would have cost had the same population been covered under traditional Medicaid. The HIP model has been proven to reduce cost for the state and federal government versus traditional Medicaid.

SECTION 2: INTRODUCTION

HIP was designed to provide health insurance coverage to low-income Hoosiers who do not have access to health insurance and are not eligible for Traditional Medicaid. On December 14, 2007, HIP was approved as an Indiana Section 1115 Medicaid Demonstration Project (11-W-00237/5) for a five-year period – January 1, 2008, through December 31, 2012 – in accordance with section 1115(a) of the Social Security Act. Since the original waiver's approval, Indiana has been granted two 1-year waiver extensions and the demonstration is currently set to end on December 31, 2014.

HIP originally targeted uninsured working-age non-disabled adults between the ages of 19 and 64 with a household income less than 200 percent FPL who were not otherwise eligible for Medicaid and did not have access to employer-sponsored health insurance. However, following the implementation of the Affordable Care Act (ACA), HIP eligibility thresholds were revised to align with new Marketplace coverage options. Therefore, beginning in 2014, HIP now targets non-disabled adults with household income less than 100 percent FPL. In addition, the program no longer restricts eligibility to individuals who have been uninsured for at least six months and who do not otherwise have access to employer-sponsored insurance. In order to maintain budget neutrality, the Special Terms and Conditions (STCs) that govern the demonstration continue to impose a firm enrollment cap of 36,500 on the number of otherwise eligible non-caretakers allowed to participate in HIP, although there is not a similar enrollment limit for eligible parents and caretaker relatives. Non-caretakers consist of childless adults while parents and caretaker relatives are individuals who have individuals under the age of 18 in their household.

This demonstration is the first of its kind in the United States and uniquely empowers members to be cost-and value-conscious health care consumers. It also has a uniquely strong emphasis on personal responsibility and consumer value-based purchasing. HIP aims to promote personal responsibility by providing a high-deductible health plan for enrollees and incorporating the concept of health savings accounts in the form of Personal Wellness and Responsibility (POWER) accounts. Members must make regular, income-based monthly contributions to their POWER accounts (approximately 2 percent of gross family income). The State also funds a portion of the POWER account, which is utilized to pay the program's required eleven-hundred dollar ($1,100) deductible. Members are provided a debit card to access their POWER account funds to pay their required plan deductible, and manage their POWER accounts through receipt of monthly statements documenting account activity. Members are subject to program disenrollment and a 12 month lock-out from the program for failing to submit their monthly contribution within sixty (60) days of the due date or failing to submit information required for their annual eligibility redetermination process in a timely manner.

The program also includes financial incentives for members to manage their POWER account as well as obtain recommended preventive health services (which are predetermined for each individual based on age, gender and personal disease history). Members who prudently manage their POWER account and have balances remaining at the end of the benefit year are eligible to roll over their pro-rata share of the balance to offset required contributions in the following year. However, members who also complete their recommended preventive services are eligible to roll over the entire balance remaining in the POWER account at the end of the benefit period.

All Section 1115 Medicaid research and demonstration waivers are required to be budget neutral—the demonstration may not cost more to the federal government than it would have cost had it not been

implemented. The estimated total computable budget neutrality limit for the six years of the demonstration is $12.3 billion. Over the past six years of the demonstration, the HIP program has cost just under $1.2 billion (almost $572 million for caretakers and about $615 million for non-caretakers). When this figure is added to the six years of expenditures for the Title XIX Mandatory Populations (just under $10.5 billion), the cumulative waiver margin is $1.2 billion[2]. The Special Terms and Conditions (STCs) that govern the demonstration allow Indiana to use a portion of its Disproportionate Share Hospital (DSH) funds and managed care savings in the program's budget neutrality calculations. HIP is also funded by a portion of a cigarette tax which was implemented July 1, 2007.[3]

Historical Narrative

On January 1, 2008, HIP began enrolling working-age, uninsured adults in HIP coverage. The original HIP program targeted uninsured adults between ages 19 and 64 that have income under 200 percent of the federal poverty level (FPL). In order to discourage crowd-out of private insurance, the original legislation also required that eligible individuals have been uninsured for at least six months prior to applying for the program, and not otherwise have access to employer-sponsored health coverage.

The HIP program was not intended to cover all of the eligible population, but, per the legislation, only the number of individuals that revenue sources (cigarette taxes and Disproportionate Share Hospital payments) could support. While HIP does not limit enrollment for parents and caretaker relatives with income below 100 percent FPL, the waiver imposes a firm enrollment cap of 36,500 on the number of non-caretakers allowed to participate in HIP.

In 2011, following the passage of the ACA, the Indiana General Assembly reinforced its support for HIP by calling for HIP to be the coverage vehicle for Medicaid expansion. The legislature passed Senate Enrolled Act 461 (codified at Indiana Code §12-15-44.2), which made several conforming changes related to the ACA, including revising program eligibility thresholds to align with the Marketplace coverage options available to individuals beginning in 2014. In addition, the legislation included a provision authorizing the Secretary of the Family and Social Services Administration (FSSA) to "amend [HIP] in a manner that would allow Indiana to use the plan to cover individuals eligible for Medicaid resulting from the passage of the [ACA]."

The State sought approval to expand and extend HIP coverage. In December 2011, after four successful years of administering HIP and entering the fifth and final year of its original demonstration period, the State submitted a three year waiver extension request. Although CMS did not accept all of the requested modifications to the program, in September 2012, CMS granted a one year extension for 2013 (DY 5). In April 2013, the State once again requested a three year extension to the program and, in September, this request was also granted as a modified one year extension (DY 6) to run through December 31, 2014.

In the most recent waiver request, CMS granted the State several modifications to HIP eligibility. The waiver contained specific language that allows the State to adjust eligibility levels to control enrollment. Beginning in 2014, HIP eligibility was reduced to cover individuals with household income up to 100 percent FPL, recognizing that individuals above 100 percent FPL who were previously eligible for HIP

[2]Source: Milliman Budget Neutrality Waiver Renewal Report to the Family and Social Services Administration, July 2014.

[3] At that time, the cigarette tax rose 81 percent, from $0.550 to $0.995 per pack.

would have new coverage options and access to premium tax credits and cost-sharing reductions via the federal Marketplace. Further, consistent with the changes in the HIP legislation, requirements that an individual be uninsured for at least six months and lack access to employer-sponsored insurance were removed from the HIP eligibility criteria effective January 1, 2014. The State also eliminated the HIP wait list and moved high-cost HIP enrollees back into the HIP program from the state's high-risk pool program, which was eliminated to coincide with the start of the marketplace coverage.

The more recent series of one-year, temporary extensions of the HIP program have resulted in a substantial amount of uncertainty and concern for current enrollees lacking alternative coverage options. During this time, the State has consistently sought guidance from CMS regarding the long-term future of HIP and its potential expansion. The State remains committed to expanding the HIP coverage model to engage more consumers in their health care decisions, reduce cost and improve the quality of healthcare services.

Goals for the Interim Evaluation and 2013 Annual Report

HIP's public-private model promotes making enrollees active participants in purchasing their health care services and improving their health. Policymakers at the state and national levels have a strong interest in understanding the progress HIP has made towards its program goals. Various models attempting to reform health insurance coverage are being developed and implemented across the country. At a time of significant economic challenges and pressure to assess program results, Indiana conducted a comprehensive evaluation of HIP to analyze successes, identify potential efficiencies and determine the future path of the program. In this report, the State of Indiana presents data gathered during the first six years of the demonstration, through December 2013 (DY 6). This data reflects the achievement of the goals put forward in Section 6 of this report. A final demonstration report will be submitted on cumulative data analyses over the course of the seven year demonstration and will present final program evaluation findings upon completion of the demonstration.

Data Sources and Methods

Information about HIP's first six years was gathered through a variety of methods, including interviews, program monitoring data obtained from the Indiana Office of Medicaid Policy and Planning (OMPP) and Milliman (the firm providing actuarial services for HIP), and such national data resources as the U.S. Census Bureau. For this report, data analysis and compilation was performed on various aggregate data reports such as the HIP dashboard, CMS quarterly reports, MCE reports and national reports (e.g. HEDIS, CAHPS, etc.). These reports, covering January 2008 through December 2013, provided a plethora of statistics about the HIP program, including the number of applications received, the number of complete and conditional enrollments in each health plan, and basic demographic information about enrollees. In addition, Milliman produces quarterly reports containing enrollment and expenditure information on HIP and Hoosier Healthwise (HHW) enrollees as well as annual budget-neutrality agreements and assessment.

SECTION 3: ACCOMPLISHMENTS

Throughout the HIP demonstration, the program has shown success and accomplishments in all areas.

Enrollment and Program Take-Up Rates - Impact on Uninsured

- By December 2013 - the close of the sixth demonstration year - the HIP program had served a total of 114,241 Hoosiers. The highest level of enrollment peaked in September 2009 at 50,339 members.
- The uninsured rate for Hoosiers with incomes under 50 percent of FPL has *decreased* from about 47 percent in 2005-2007 (prior to HIP implementation) and held steady at approximately 43 percent between 2008 and 2012. Uninsured rates for other income groups HIP covers above 50 percent of FPL (up to 200 percent of FPL) have increased since before HIP was implemented. The increase in the uninsured rate among other income groups is likely due to external factors such as the national economic recession and high unemployment rates during the HIP implementation period. It likely would have been higher without HIP. (See Table 5.7).

Fiscal Conditions

- As in previous years, the State took steps in 2013 to ensure that HIP meets federal budget neutrality and legislative requirements dictating that funding would be adequate to support enrollment. One step included keeping the program closed to new non-caretakers (also known as childless adults) through 2012 and 2013.
- By the end of 2013, the HIP program had cost approximately $1.2 billion over the course of its six years, staying below the six-year waiver margin.

Operational Accomplishments

- The HIP program continued with no operational changes in 2013.

POWER Accounts

- In 2013, 72 percent of HIP members were required to contribute to their POWER accounts.
- Through the end of 2013, about 35 percent of member POWER accounts contained funds after 18 months of member enrollment. Thirty-five percent of these accounts received full rollovers (member and State-contributed funds), while 65 percent of these accounts received partial rollovers (member-contributed funds only).

Evaluation/Program Design Accomplishments

- HIP has demonstrated success in using the model of a consumer-driven health plan for a low-income population. In addition, HIP has effectively promoted preventive care utilization and discouraged inappropriate emergency room use.
- The majority of HIP members report that they prefer to make a fixed monthly payment to the POWER account with the opportunity to receive unspent funds back versus making copayments each time they seek medical care. In Mathematica's 2013 survey of HIP enrollees, 83 percent of survey respondents said they preferred to pay up front each month

over paying each time they visited a health professional, pharmacy, or hospital. This finding lends support to the HIP contribution approach (funding POWER accounts based on income) as opposed to co-payments.

- Most HIP members feel that their POWER account contributions were reasonable. According to Mathematica's 2013 survey, among those who made a monthly contribution to their HIP POWER accounts, approximately three quarters of current HIP members felt that their monthly contributions were "the right amount," and nearly 85 percent believed the amount was either right or less than the right amount. Overwhelmingly, members reported that they would be willing to pay more to remain in HIP. In 2013, 94 percent of members made the first required contribution to the POWER account and 89 percent made subsequent contributions.
- HIP is effective at promoting greater use of of preventive care. In 2013, 69 percent of female HIP beneficiaries and 40 percent of male HIP beneficiaries (60 percent of the overall HIP population) received at least one age-appropriate recommended preventive service, according to a claims analysis. Members who were required to contribute to their POWER accounts used preventive care at higher rates than non-contributors, perhaps because of the incentive to receive a full rollover and reduce required contributions in the next year if services were obtained.
- HIP is effective at reducing inappropriate emergency room usage among beneficiaries. Only 30 percent of HIP enrollees visited the ER in 2013, as compared to 38 percent of adult Hoosier Healthwise (Indiana Medicaid managed care) enrollees. In the 2013 Mathematica survey, 5 percent of HIP beneficiaries used an urgent care center or their regular doctor to seek care rather than an emergency room. The co-pay required for non-emergency use of the emergency room is intended to encourage more appropriate use of healthcare services.

SECTION 4: POLICY AND ADMINISTRATIVE DIFFICULTIES AND SOLUTIONS

The effect of the Affordable Care Act on HIP continued to be a significant policy and operational challenge in 2013. Since the passage of the ACA, Indiana has sought Federal guidance regarding the future of HIP. In September 2012, the State received notice of a one-year extension of the waiver, which served as a short-term reprieve but maintained the long-term uncertainty about the program's existence. In 2013, Indiana received approval of a second one-year extension of the waiver for demonstration year seven (2014). The continued uncertainty of the future of the program has impacted enrollment and, although a multi-disciplinary workgroup identified several efficiencies that could be implemented into HIP, operational improvements, system maintenance and modification projects were put on hold due to the uncertainty of the program's future.

A second administrative difficulty has been the uniform monitoring of the three Managed Care Entities (MCE's). The three MCE's maintain different management information systems resulting in challenges while responding to data requests from the State. Continued collaboration between the State and the MCE's, however, have allowed continued progress in aligning the reporting needs of the State with what the MCE's are able to provide. An additional difficulty in the State is reaching those members of the HIP program who live in more rural settings. Potential issues regarding access to care can arise for these individuals and the State has worked with the MCE's in order to ensure provider network adequacy for the rural parts of the State. Providing continued outreach and information to these rural individuals is crucial to ensure that they do not suffer from a lack of provider options.

An additional difficulty surrounding the program is the failure of individuals to cooperate in providing information when it is necessary to determine their eligibility, causing the individual to lose coverage. Increased education of the members is a necessary step in informing a member that they will no longer be eligible for coverage if they do not turn in the requisite information to maintain eligibility. In addition, although the State has put forth significant efforts toward lowering inappropriate emergency room (ER) usage and increasing preventive service usage, there is always more work that can be done to improve these outcomes. The State has seen great improvements in both categories since the inception of the HIP program, and the State will continue to strive to achieve better results for both outcomes.

SECTION 5: PROJECT STATUS

5.1 OUTREACH AND PLAN ACTIVITIES

A. OUTREACH

The three Managed Care Entities (MCEs) that contract with the state for HIP (Anthem, MDwise, and Managed Health Services) continue to conduct outreach and marketing activities for the program. All three MCEs have active marketing programs and regularly organize and participate in community events to raise awareness of HIP.

Anthem

In 2013, Anthem's outreach staff participated in more than 375 events to provide information on HIP and HHW (Hoosier Healthwise - Indiana's Medicaid risk-based managed care program for pregnant women, very low-income parents, and children). Outreach activities seek to promote the HIP program by educating members on HIP benefits and the POWER account, and by promoting cost-conscious health care decision-making and preventive care among members. Further, Anthem utilizes HHW outreach events as an opportunity to promote HIP. During Anthem's 60 Clinic Days, held throughout the state to promote preventive health services for children enrolled in HHW, applications for HIP were distributed to parents and caretakers.

Anthem utilizes partnerships with faith-based organizations, minority health organizations, government agencies, public libraries, retail stores, pharmacies, and community health organizations such as Work Force One, and Covering Kids and Families to reach its target populations. Outreach Specialists have traveled to food pantries to educate members about HIP transportation benefits and emergency room (ER) usage; participated in Men's Health Week at Federally Qualified Health Centers (FQHC) to raise awareness of preventable health issues and encourage early detection and treatment for diabetes, HIV, and other conditions; and presented at college health fairs. Outreach Specialists have built relationships with local FSSA Division of Family Resources (DFR) offices throughout the state, allowing them to present during monthly IMPACT classes (job training and education for TANF and SNAP recipients). During these presentations, the Outreach Specialists provide an overview of the HIP program, including the application process, POWER account requirements, and the availability of transportation (an Anthem offered enhanced service for HIP members). Anthem also works with medical providers to offer individualized member outreach. Providers can refer members who miss appointments or who might benefit from health education classes, connection to community resources, or an explanation of member benefits.

Anthem staff made efforts to specifically reach out to Allen County's Burmese community. Recognizing the cultural and language barriers faced by this population, Anthem developed alternate processes for access to customer services and provided specialized assistance in accessing preventive health services and education for this population. Anthem has collaborated with the other MCEs to conduct open houses for members from Burma/Myanmar. These open houses offered education on how to schedule doctor's appointments, secure transportation, manage their health care, and understand their HIP plan benefits.

Each new HIP member who enrolls in Anthem receives a welcome call from a Customer Service Representative to inform them about plan benefits, including access to preventive care, coverage for doctor's visits and hospitalizations, and the POWER account. During the call, the member is given the opportunity to select a primary medical provider (PMP) and to complete a health risk assessment. HIP members also receive customized MyHealth Notes, which remind members to get regular preventive care, encourage the correct use of prescription drugs, and promote overall wellness.

MDWise

In 2013, MDwise conducted outreach, education and marketing to HIP members and community members throughout Indiana. This outreach was done through 1,177 events and presentations and reached 196,371 people. Specific efforts to promote HIP through these events included general program awareness, enrollment awareness, MDwise educational material distribution, presentations to community members and organizations, redetermination awareness, provider education, HIP Power account awareness and MDwiseREWARDS.

A key to general program awareness is reaching caregivers. As a result, MDwise targets school events that focus on parents and caregivers including parent nights, back to school nights, family nights, after school programs, presentations to staff, registration days, parent teacher conferences and Title One parent meetings. In 2013, MDwise conducted 216 of these types of school related events. The caregiver audience can also be reached at DFR offices, health departments, FQHCs and other agencies and programs providing services to low income families. MDwise held 249 Q&A Chats at these locations in 2013. The outreach team also promoted HIP at over 70 Everyone Needs Check-up events targeting children who haven't had checkups, 32 IMPACT presentations, 7 Human Resource departments, 20 support groups for women including Women Care Centers, and 15 community baby showers. Topics such as continuous coverage after pregnancy, how to apply for HIP after pregnancy, common misconceptions, and eligibility questions are covered. MDwise outreach also distributed HIP applications at these events and presentations, and more than 871 applications were distributed in 2013.

Working with enrollment partners to provide enrollment assistance at community events is another key approach utilized by MDwise. MDwise partnered with enrollment partners at 27 events in 2013. Through these events, 109 HIP applications were completed by DFR and community enrollment center staff. Nine hundred forty-eight HIP applications were completed by Covering Kids & Families through these events and other referrals.

General program education is achieved by distributing MDwise brochures, FSSA materials, and redetermination efforts and materials at outreach events. Redetermination efforts include both field outreach and customer service outreach using items such as the "How to Stay Enrolled on Hoosier Healthwise and HIP" flyer and "Got Insurance" brochure. The MDwise brochure covers all Indiana Health Coverage Programs and summarizes MDwise's special programs such as SMOKEfree INcontrol, etc. The brochure also discusses the HIP POWER account and MDwiseREWARDS program. Once a HIP member is enrolled, more specific mailings and other communications are sent to discuss specifics about the HIP program such as the new member letter with ID card, handbook, quarterly newsletters, POWER account statements and preventive health postcards.

Managed Health Services (MHS)
MHS attended more than fifty health fairs in 2013. At many of these events, MHS was a named sponsor. At each health fair, MHS had a booth with banners and health plan staff to greet and talk with attendees. Staff distributed small giveaways and information on how to apply for HIP. Staff also distributed HIP application forms. Some of these health fair events include:

- Monroe County Indiana Health and Safety Fun Fair
- Spring Sickle Cell Health Fair in Marion County
- Cinco de Mayo celebration in Lake County
- Pentecostal Church Health Fair in Lake County
- 10th Annual Northern Indiana Hispanic Health Coalition Health Fair and Back to School Event in Elkhart County
- HealthLinc Fun Fest in Mishawaka

At some health fairs MHS provides "Ask the Expert" hours where its booth staff included a licensed clinician – a doctor, nurse, registered dietician, or diabetes educator. MHS provided booth visitors with a chance to play a "plinko" game with health questions and prizes such as pens or water bottles. At faith-based events, MHS has also sponsored healthy shopping and cooking demonstrations with tastings included.

MHS makes a point to sponsor and/or attend certain health fairs every year, such as:

- American Lung Association Lung Expo and TB Symposium in Marion County
- Indiana Black Expo Summer Celebration and ISDH Health Fair in Indianapolis

MHS Healthy Celebrations are special events that MHS coordinates with its network's primary care providers across the State. The purpose of these events is to get MHS Members assigned to the particular FQHC or primary care group to come in to see their PMP for needed check-ups and screenings while MHS and the practitioners and staff provide health and benefit education. In advance of the events, MHS and the provider group identify a date or dates, then MHS identifies members assigned to that group and any care gaps they may have. MHS then calls these members and works to schedule them to come in during the day of the event.

After the member receives services, they are invited to stay for a "celebration," including health-related games, coloring activities for their children and healthy snacks for everyone. MHS conducted 17 such events in 2013 that were aimed at reaching adults in all parts of the State, including in Kokomo, Howard County, South Bend, and at the HealthLinc FQHC in Porter County, Indiana.

MHS also takes the opportunity to sponsor a booth and present information to the public and HIP members at many public events that are not strictly Health Fairs. The MHS approach is very much the same as described at Health Fairs above. MHS helped sponsor and had a booth at a number of these all over the State. Examples for 2013 included the Indiana Latino Expo in Marion County, Indiana on June 15 and the Healthy Start of Northwest Indiana Stroll in the Park Event in Lake County on August 9, 2013. Every year, MHS sponsors an exhibit or activity at the Indiana State Fair in August and presents its booth there for the duration of the Fair. For example, MHS has sponsored the "Flippenout," Trampoline show with former Olympic athletes, which is very popular. In 2013, MHS was at the State Fair every day, with a rotating booth staff from all levels and departments of the organization.

MHS has helped to sponsor many events held by important community organizations that work for health access and improvement around the State. Some of the events are fundraisers and others are geared toward networking, recognition and learning. Examples of community organized events include:

- Susan G. Komen for the Cure Foundations 10th annual Pink Tie Ball
- *Scavenge the Avenue* with Indy Reads
- Fathers and Families Annual Luncheon
- Little Red Door Big Bash in Marion County
- Indianapolis Public School system Alumni Foundation luncheon
- Indy Reads Annual Spelling Bee
- Mental Health America Gala: Removing the Mask
- Fathers and Families 20th Anniversary Celebration Inaugural Symposium

MHS also looks for opportunities to sponsor and attend community events that promote fitness and other aspects of a healthy lifestyle. MHS has sponsored and had a booth at many of these events in 2013 across the State, and sent employees to participate:

- "Drumstick Dash" in Marion County
- "Sunburst Races," in South Bend
- Indy 500 Mini Marathon
- March of Dimes walk
- American Diabetes Association Step Out and Walk in Marion County

Finally, MHS looks for opportunities to attend and provide information to members, the community and providers at events aimed at education and knowledge-sharing across the State. In 2013, MHS sent management and other staff to the Ivy Tech Corporate College Healthcare Summit, to hear the speakers, provide feedback to Ivy Tech about hiring and training needs, and to interact with other attendees from the health care industry. MHS also attended the Indiana State Medical Association Convention and had its booth there to reach out to the provider community with information about MHS, about HIP and other Indiana Health Coverage Programs and resources available to MHS members.

Enhanced Services Plan (ESP)

The ESP program is for high-risk, high-cost HIP members and does not have a formal marketing requirement, but it does have a program to promote preventive care and utilization of lower cost services. The program includes bi-monthly mailings and an annual newsletter that outlines all the preventive care benefits covered by the program, as well as the health consequences of not receiving preventive care. The 2013 mailings focused on depression, situations when urgent care or discussions with a regular doctor are more appropriate than a trip to the ER, and the importance of getting a flu shot. The ESP program was terminated at the end of 2013 and these high-cost members under 100% FPL were moved to the HIP managed care plans.

Maximus

Maximus, the State's enrollment broker, provides general information on all three MCEs. As the enrollment broker, Maximus' function is to outreach to newly enrolled members regarding their options with plan selection, and when necessary, plan changes. Maximus also assisted the state with transitioning ESP members to HIP health plans in late 2013 as the ESP program ended.

B. HEALTH PLAN INCENTIVE PROGRAMS FOR MEMBER AND PROVIDERS

Member Incentives

Anthem

During 2013, Anthem continued its member incentive program designed to encourage members to schedule and obtain preventive services. For this program, Anthem identifies members who are approaching the end of their benefit period without having received recommended preventive care services, and offers these members a $50 gift card if they secure these services. Mailers were sent to qualifying members encouraging diabetes, breast cancer, and cervical cancer screenings.

Breast cancer screening mailers were sent to 2,190 HIP members, about 11 percent of whom returned the form to claim the gift card. Diabetes screening mailers were sent to 1,224 members with 11 percent claiming the reward. Cervical cancer screening mailers were sent to 5,187 members, with about 4.5 percent receiving the incentive.

During Anthem's welcome calls, new members are encouraged to complete a Health Risk Assessment (HRA) and are offered incentives to do so. Those who complete an HRA online receive a $20 CVS gift card, while those who complete it over the phone receive a $10 card (with a limit of one per household).

MDWise

The MDwiseREWARDS program, launched in 2011, uses incentives to encourage members to seek preventive care. Members earn points for activities such as completion of a health risk assessment, visiting the doctor for an annual exam, receiving screenings such as mammogram or cervical cancer screen, or registering to receive monthly statements online. These points can then be redeemed for a gift. Members can choose from gift card options like CVS, Subway or Kroger. MDwise promotes the incentive program in its main brochure, member handbook, on its website, and through postcards mailed to all members. Providers may also promote the program with their MDwise patients, to encourage preventive care appointments. Several of these promotion efforts proved successful in increasing the program's reach. In October of 2013, a targeted mailing was sent to all HIP households, after which the REWARDS website saw a 641 percent increase in unique page views compared to September. There was a 368 percent increase in HIP member gift card redemption. Overall, the total number of members redeeming their points for a gift card in 2013 was 110 percent more than the previous year (2012). Also, the number of activities or events that earn reward points have increased every year since the program's inception.

MHS

MHS continued their CENT-Account Rewards Program that provides incentives for various healthy activities where the incentive money is loaded directly onto the member's HIP debit card and can be used to purchase health supplies or co-pays, and now can also be used to pay utility bills. Members can receive $10 for visiting their assigned PMP within their first 90 days with MHS, and $30 for completing their Health Risk Assessment within that same time period. Of MHS HIP members who maintained at least 90 days of membership, and could be reached during that period, 59 percent completed a new member health screening, a 10 percent increase over 2012.

Table 5.1: HIP 2013 HEDIS results for Preventive Care Services

	Anthem	MDwise	MHS
Breast Cancer Screening	69.74%	70.70%	69.74%
Cervical Cancer Screening	74.89%	67.03%	74.89%
Diabetes HbA1c	88.27%	89.60%	88.27%

Source: 2013 HEDIS certified results for CY 2012

Table 5.1 illustrates the HEDIS results for each of the plans reflecting the usage rates for preventive care services. All three MCE's have an average score higher than what was received in 2012 and 2011, showing that the incentives provided by the MCE's to the members are working as more and more members continue to utilize preventive care services.

Provider Incentives

The Indiana Office of Medical Policy and Planning (OMPP) has instituted a Pay for Outcomes program that utilizes a selection of Healthcare Effectiveness Data and Information Set (HEDIS) measures to track the performance of HIP health plans. HIP health plans have a contract requirement to pass along at least 50% of their performance-based awards to their contracted health care providers. Through this contract requirement, health care providers have a stake in the results and are provided incentives to improve targeted measures. For that reason, the health plans develop incentives along with recognizing providers that go above and beyond in order to assist members by providing efficient and quality care. The incentives offered to the providers are designed to encourage system-wide improved performance for members and providers. These incentives are based on priorities set by the OMPP and the State Quality Strategy Committee, as well as through partnering with the Indiana Health Information Exchange (IHIE) to produce community-wide physician or practice level standards.

In 2012, (the most recent data available at the time of this report) the two HEDIS pay-for performance bonus measures pertaining to HIP members were: ER admissions per 1000 member months and percentage of members that obtain a preventive examination. A third pay-for-outcome measure was chosen from the CAHPS (Consumer Assessment of Healthcare Providers and Systems) Survey: the number of smokers advised to quit.

Anthem and MDwise earned pay-for-outcome bonuses for the 2012 CAHPS measure of advising smokers to quit. MHS did not meet pay-for outcomes bonus rates for any of the HEDIS or CAHPS measures pertaining to HIP in 2012. None of the three MCEs achieved the 2012 bonus rate results for the HEDIS measures of ER admissions per 100 member months and percentage of members obtaining a preventive examination.

5.2 OPERATIONAL AND POLICY DEVELOPMENTS

A. CONTRACTING

No substantial changes occurred during 2013 MCE contract negotiations. In the initial years of the demonstration, the management of plan risk was adjusted to account for unforeseen demand for services, as well as multiple co-morbidities that had been previously untreated. As a result, the State amended the

risk-sharing arrangements to include higher monthly capitation rates and a stop-loss provision for non-caretakers (effective retroactively to January 2009), as well as new criteria for the high risk pool. CMS approved the amended contracts in mid-December 2009, January 2010, and May 2011. As of 2011, the plans began reporting declines in utilization and more predictable costs, and the stop loss provision ended with the conclusion of CY2011, though reconciliation with the plans for the prior year continued.

The early high costs of care seen in HIP caused the State to identify ways to broaden access to the HIP Enhanced Services Plan (ESP), the high risk plan for a HIP member with particularly costly conditions. The State expanded the list of qualifying conditions and modified the application process. When HIP applicants checked one of the qualifying conditions on the application, they were automatically enrolled in HIP ESP and remained enrolled until their eligibility was redetermined. If their claims history at redetermination confirmed the information reported on the application, they stayed with HIP ESP. Otherwise, the member would be transitioned to one of the health plans. In addition, the plans had six months to refer a member to HIP ESP. Those members found to have a HIP ESP qualifying condition and scored at or above 150 points, using underwriting guidelines and a scoring methodology provided by the program's actuary (Milliman) were transferred to HIP ESP. Referrals by the plans were halted during the fourth quarter of 2013 in preparation for the implementation of the ACA. While the health plans reported that the HIP ESP process ran smoothly in most cases, they noted that challenges sometimes emerged when a member did not wish to transfer plans and when lags occured in the State's payments to the plans to reconcile costs for members transferred to HIP ESP. Collective effort between the plans, the program's actuary, and FSSA Operations decreased the time lag for reconcilement and payment for members transferred to HIP ESP.

The Indiana Comprehensive Health Insurance Association's (ICHIA) contract that operated the HIP ESP terminated 12/31/13. The State of Indiana extended coverage for HIP members above 105 percent until 4/30/14 to allow members to apply and get a coverage determination through the federal marketplace. The subcontractor of ICHIA, Xerox, continued to serve these members through 4/30/14. All members at or below 105 percent FPL chose a new plan with one of the existing MCE's that serve the rest of the HIP population.

Calendar year 2013 marked the third year for the HIP and Hoosier Healthwise (HHW) integrated contracts. All three of the health plans reported that the combined HIP and HHW contracts allowed for increased administrative ease and for improved care coordination, particularly for families with members enrolled in the two different programs. The plans noted that joint HIP/HHW call centers in particular have improved their ability to serve entire families more effectively. For example, while a call center worker is discussing an issue with a HIP member, the worker now has the ability to view the entire family's record, and can remind the adult if an HHW-enrolled child in the family needs a certain visit or service. In addition, the existence of a single call center enables workers to help families find ways to streamline care. For example, during a call, a member can select a PMP that serves both HHW and HIP members, so that the member and the child can see the same medical provider. Improved outreach was also cited by the plans as a benefit. If a HIP member places a call to the call center, staff will inquire whether the member has a child in the household in need of coverage.

The State has also realized important efficiencies from the integrated contracts, as it has been able to streamline HIP and HHW oversight and monitoring processes. The State has maintained distinct quality review and contract compliance teams. Individual teams result in a more in depth analysis of contract

compliance, plan reporting, quality and accessibility of health care services, utilization of services, and progress of stated plan goals. The two teams work jointly in preparation of the monthly onsite visits. While each team brings a different perspective to the onsite visits, there is joint analysis of the plans' policies and procedures to ensure contract compliance and delivery of quality care to the members. This method results in a strong oversight of healthcare quality and contract compliance.

Additionally, integrated contracts allow both the State and MCEs to increase their focus on quality issues and member behaviors, such as smoking and weight management. Further, the integrated contracts have allowed discussions between the State and MCEs to focus on populations (children and families versus adults), whereas earlier discussions were focused on the differences between the HHW program and the HIP project. From the State's perspective, communication between the State and MCEs has improved as a result.

Calendar year 2013 also marked the third year of the HIP debit swipe cards. The cards are intended to be used at the point-of-service to verify eligibility, whether the service is covered, and whether the provider is participating in the HIP. The card is also meant to be linked to members' POWER accounts. MHS, Anthem and MDwise issue a single-swipe card that functions as the ID and debit card.

B. MONITORING

Monthly on-site meetings are held between the State and each MCE. These visits follow a uniform protocol. This allows the contract and quality analysts to review each MCEs operations and quality efforts. For the most part during 2013, each monthly onsite visit addressed the same topic area. Topics were selected based on analysis of reports, member/provider inquiries, routine topics, quality strategy initiatives, contract incentives, identified non-compliance by an MCE, and various other methods. The Onsite Tool was prepared in a manner that covered the topic from distinct contract compliance and quality perspectives. Various questions related to the monthly onsite topic were submitted by the contract analysts and quality analysts to the MCEs through use of the Monthly Onsite Tool. Each of the three MCEs received the same Onsite Tool. By asking the same questions and requesting the same material from each MCE, the analysts can review MCE specific information and make comparisons across MCEs. MCE responses were submitted to the State with the MCE Completed Onsite Tool. The completed tools included policies and procedures along with specific examples, data, program updates and case studies. The contract compliance and quality analysts completed a review of the responses and documents submitted by the MCEs. This assessment led to the development of an Onsite Agenda including questions and topics for in depth discussions during the scheduled onsite visit to ensure compliance by the MCEs. This process is vital to identify gaps and/or issues in program administration. For example, if two of the three MCEs do something a way that proves to be efficient or a best practice and the third MCE's method is less effective, the analysts can identify the discrepancy and ensure compliance and quality measures equally amongst the MCEs.

C. ELIGIBILITY AND ENROLLMENT

Indiana made several modifications to HIP eligibility and enrollment in the later part of 2013 to align with the federal marketplace and to comply with the requirements contained in the HIP waiver renewal for 2014.

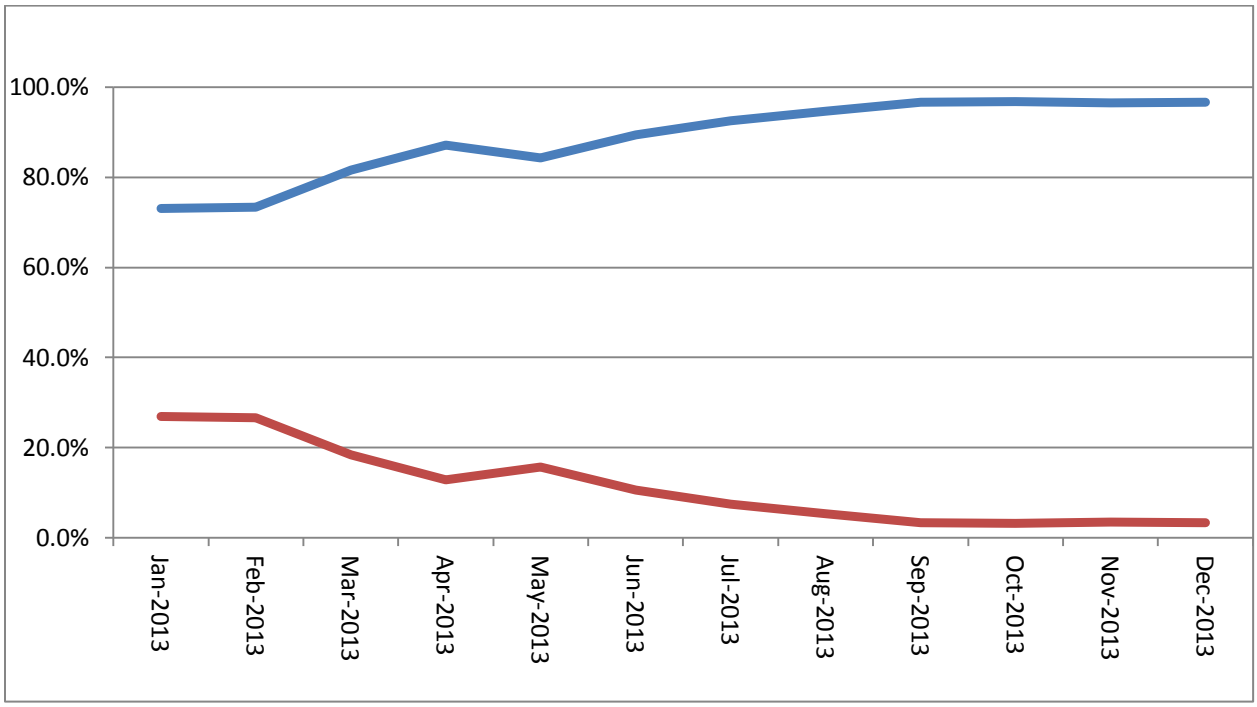
During the last quarter of the 2013 calendar year, Indiana sent multiple communications to current HIP clients as well as HIP applicants that were on the wait list to advise them of forthcoming changes in the new 2014 HIP waiver program. The communications included Indiana's Interactive Voice Response (IVR) phone system calling approximately 34,000 active HIP clients in September to alert them to a letter they would be receiving describing HIP Program changes for 2014. At the end of September, Indiana sent letters to these same active HIP participants identifying program changes and presenting different expectations if the participant was over or under 100 percent FPL. In parallel, Indiana's Outbound Dialer, operated by the Division of Family Resources (DFR), was also used to contact approximately 54,000 individuals on the HIP wait list with a similar message. Those individuals were then notified by letter that due to the program changes they would either need to reapply by November 30, 2013 to retain a slot on the HIP wait list or they could apply to the Federally Facilitated Marketplace (FFM), depending on which subsidized program they would qualify for in 2014. The HIP wait list was only for those individuals who were considered non-caretakers. In October 2013, a letter was sent to all members on the waitlist telling them that the eligibility standards were changing and that if they wished to be considered for enrollment they would need to reapply. These individuals were given until late November to reapply, and those found eligible were placed into the HIP program.

In October, additional notices were sent to active HIP participants with incomes less than 105 percent FPL—approximately 22,000 individuals—informing them that a new twelve month HIP benefit period and a new POWER Account would be established at their next scheduled redetermination when it came due between October 2013 through March 2014 and that no participant action was required to continue in HIP. For participants with incomes greater than 105 percent FPL, approximately 10,600 individuals, notices were also sent indicating that due to program changes, their HIP benefits would end as of December 31, 2013. These individuals were advised to re-apply by November 30, 2013, if their income had changed since their last redetermination or the individual could choose to apply to the FFM. The State of Indiana subsequently extended coverage for HIP members above 105 percent until April 30, 2014, to allow members to apply and get coverage through the federal marketplace.

D. APPLICATION PROCESSING

Throughout the first six months of 2013 the timely processing of applications was below 90 percent, which is unusual for the State. The timeliness of application processing became a noted concern for the State during this time period. The timeliness of application processing also suffered during the end of calendar year 2012, demonstrating a lower level of efficiency leading into 2013. Subsequently, new leadership was put into place within the Division of Family Resources, the division in charge of application processing. Once the new management team was in place, application processing quickly improved and over the last four months of 2013 averaged 96.7 percent timely processing of HIP applications. (Figure 5.1). HIP application processing timeliness continues to be an important benchmark for the agency. The HIP application processing timeliness standard is 45 days.

Figure 5.1: Percentage of HIP Applications Processed in a Timely Manner, January – December 2013



Blue = Percent Timely Red = Percent Untimely
Source: ICES Eligibility System, January 2013 – December 2013

E. HIP AMENDMENTS APPROVED BY CMS

The State did not submit any amendments for the HIP program in 2013. However, the State has submitted multiple waiver extensions in the past two years. In September 2012, CMS granted a one-year extension of HIP, in response to a waiver extension submitted in December 2011. In February 2013 the State submitted a request to extend the program beyond 2013 for the maximum waiver renewal period of three years. In response, CMS granted another one year extension which permits the program to operate through December 31, 2014.

5.3 FINANCIAL AND BUDGET NEUTRALITY

The State maintained waiver margins well below the CMS-approved limit from DY1 through DY4 by negotiating sound rate increases. This allowed the state to request the restoration of the Disproportionate Share Hospital funding. DY5 was the only year where the waiver margin was negative due to increased hospital reimbursement rates authorized by Public Law 229-2011, Section 281 (described in more detail in Section 6.7). These increased rates led to higher Per Member Per Month (PMPM) expenditures for HHW caretakers, children and pregnant women in 2012.

The cumulative cost of the HIP program from 2008-2013 (DY1-DY6) was just under $1.2 billion. The cumulative waiver margin for years DY1-DY6 is approximately $1.2 billion. The HIP program remained budget-neutral over the first six years of the demonstration.

5.4 CONSUMER ISSUES

The State maintains a consumer issue management system known as the "Internet Quorum" or "IQ," which permits the State to monitor and manage formal and informal inquiries. Overall, the number of consumer inquires posed through the IQ has declined over the six years of the program. Most questions posed in 2013 were classified as requesting "general information" on the program; other questions most commonly asked were regarding the HIP buy-in option, a program that was discontinued at the end of 2013.

Table 5.2 Total Internet Quorum Inquiries, 2008-2013

Quarter	Total Number of Inquiries						Change
	2008	2009	2010	2011	2012	2013	
Year Total	**1,695**	**1,205**	**693**	**575**	**364**	**338**	-80%
First	628	425	270	152	133	35	-94.5%
Second	486	289	206	123	100	36	-92.6%
Third	278	261	128	164	95	60	-78.5%
Fourth	303	230	89	136	36	207	-38.8%

Source: HIP Quarterly Reports to CMS, 2008-2013

Table 5.3: Types of Inquiries, 2013

Issue	Total	Percentage of Inquiries
Buy-In	34	10%
General Questions	256	76%
Waiting List	16	4.7%
Anthem	19	5.6%
ESP	1	0.2%
MDWise	6	1.8%
MHS	6	1.8%
Total Inquiries	**338**	

Source: Compiled HIP Quarterly Reports to CMS, 2013

The State also tracks the number of eligibility appeal hearings each year. These appeals involve issues such as benefit terminations. Member appeals may also involve the required amount of POWER account contributions. The annual number of member appeals first peaked in 2010, when total HIP enrollment also peaked and receded in the following two years. However, 2013 saw the highest number of member appeals over the first six years of the demonstration. The increase can be attributed to an increase in incomplete verification requests.

Table 5.4 Formal Appeal Hearings, 2008-2013

Quarter	Total Number of Formal Appeal Hearings					
	2008	2009	2010	2011	2012	2013
Year Total	1,003	2,223	6,118	5,391	5,783	7,188
First	181	263	1,422	1,182	1,503	829
Second	336	1,249	1,584	1,083	1,529	2,041
Third	286	586	1,721	1,690	1,394	2,294
Fourth	200	125	1,391	1,436	1,357	2,024

Source: FSSA Hearing and Appeals, 2008-2013

Table 5.5 Adjudication of Appeals and Hearings, 2009-2013

Findings	Percentage of Hearings and Appeals				
	2009	2010	2011	2012	2013
Other Insurance	60%	44%	46%	30.47%	27.7%
Did Not Complete Verifications Request	21%	26%	43%	59.7%	64.8%
Other	10%	25%	0.2%	0.2%	0.16%
Financial Eligibility	8%	5%	10%	9.4%	7.26%

Source: FSSA Hearings and Appeals, 2009-2013

5.5 ELIGIBILITY AND ENROLLMENT INFORMATION

A. DY6 HIP ENROLLMENT DEMOGRAPHICS

The HIP program served a total of 49,390 unique individuals during 2013. The majority of 2013 members were female and consisted of more than 68 percent of the program enrollment. The most represented age group enrolled in the HIP program were individuals between 30-39 years of age. These demographics—majority female and ages 30-39—were consistent with previous years enrollment demographics. The least represented age group were those less than 20 years of age. The over 60 population is the second smallest enrollment age group. Due to the program's cap and wait list for non-caretakers, more than two-thirds of members in 2013 were caretakers. More than 82 percent of members were white while African Americans comprised approximately 10 percent of the HIP membership. These figures align closely with state demographic data. Approximately 72 percent of 2013 HIP members had incomes at or below the federal poverty level (FPL). Approximately 26 percent were below 22 percent of the FPL and 32 percent were between 51 percent-100 percent FPL.

The DY 6 membership demographics are consistent with the cumulative demographic data for all members over the course of the HIP program (2008-2012). Between 2008 and 2012, women made up 65 percent of the membership, and those in the 30-39 age range comprised the greatest share of beneficiaries. The second largest age range consisted of the 40-49 age group which also remains consistent with DY 6 data. The 2008-2012 cumulative racial and ethnic breakdown is similar to that of 2013 with African-Americans comprising approximately 12 percent of the total membership during this

timeframe and over 80 percent of members being white. Between 2008 and 2012, 70 percent of members had incomes at or below 100 percent of the FPL. The amount of members in DY 6 that were below 100 percent of the FPL has risen slightly.

Table 5.6 Enrollment Demographics, DY 6 (2013)

Characteristic	Number of Members in 2013	Percentage of Total
Total Number	49,390	100.00%
Gender		
Male	15,471	31.4%
Female	33,919	68.6%
Age		
<20	18	0.0%
20-29	6,189	12.5%
30-39	15,444	31.3%
40-49	14,639	29.6%
50-59	9,803	19.8%
>60	3,297	6.7%
Caretaker Status		
Caretaker	35,491	71.9%
Non-Caretaker	13,899	28.1%
Race/Ethnicity		
Asian	1,059	2.1%
Black	4,930	10.0%
Hispanic	1,605	3.2%
American Indian	48	0.1%
Other	930	1.9%
White	40,818	82.6%
Income as % of FPL		
< = 22%	12,909	26.1%
23%-50%	6,654	13.5%
51%-100%	15,938	32.3%
101% - 150%	9,165	18.6%
> 150%	4,724	9.6%

Source: OMPP Data Management & Analysis

B. IMPACT ON THE STATE'S UNINSURED RATE

HIP was designed to serve a limited number of Hoosiers, as the Indiana General Assembly cigarette tax does not generate sufficient revenue to cover all uninsured adult Hoosiers under 200 percent of FPL. Crowd-out provisions, such as the requirements to be uninsured for six months and not have access to employer-sponsored health insurance, also limit the number of individuals who are eligible. These requirements were repealed and are not included in the demonstration after DY6. According to Current Population Survey (CPS) estimates, individuals with income under 100 percent of the FPL had the

highest uninsurance rate in the years before HIP was implemented, ranging from 47 percent among the most low-income group to 41 percent for those with incomes just below the poverty level (Table 5.7).[4]

Using data from the American Community Survey (ACS) from 2008-2012, Milliman estimates that the number of uninsured adult Hoosiers with incomes below 200 percent of FPL (Table 5.7) grew from the pre-HIP period and continued to increase over the four-year period, likely due in part to the national recession occurring during this time period. However, beginning in 2011 the number of uninsured adult Hoosiers began to decline and continued to do so through 2012 to below 31 percent of individuals in the FPL range. The uninsured rate for Hoosiers with incomes under 50 percent of FPL has *decreased* from about 47 percent in 2005-2007 and held steady at approximately 43 percent between 2008 and 2012.

Uninsured rates for other income groups increased since prior to HIP implementation. The increase in the uninsured rate among income groups above 50 percent of the FPL, as shown in Table 5.7, is likely due to external factors such as the national economic recession and high unemployment rates during the HIP implementation period. Beginning in 2011, however, the uninsured rate among adult Hoosiers has declined in every FPL range represented in the chart below indicating a general improvement in the insured rate of adult Hoosiers.

Table 5.7. Uninsured Rates, Adults 19-64 by FPL before and after HIP

	Uninsured before HIP (CPS 2005-07)		Uninsured (ACS 2008)		Uninsured (ACS 2009)		Uninsured (ACS 2010)		Uninsured (ACS 2011)		Uninsured (ACS 2012)		HIP Members 2013
FPL	#	%	#	%	#	%	#	%	#	%	#	%	#
Under 50%	85,977	47.2%	88,974	43.3%	95,878	40.1%	115,308	43.1%	121,959	43.1%	118,029	42.8%	19,432
51% - 100%	80,063	40.8%	103,102	42.3%	111,258	40.7%	124,712	44.2%	121,812	43.5%	126,733	41.7%	15,520
101% - 150%	89,426	34.8%	113,782	41.7%	115,394	39.1%	127,031	37.8%	133,837	41.0%	132,038	39.7%	9,566
151% - 200%	79,497	26.5%	86,535	28.4%	108,586	33.2%	115,320	32.9%	108,075	31.9%	103,965	30.9%	4,880
Total	**334,963**	**35.8%**	**392,393**	**38.2%**	**431,116**	**37.9%**	**482,371**	**39.0%**	**485,683**	**39.3%**	**480,765**	**38%**	**49,398**

Source: Milliman, Inc. "Uninsured rates by FPL and year." Baseline uninsured numbers and percents are from the U.S. Census Bureau, CPS, Annual Social and Economic Supplement, 2006-2008, CPS three-year average data collected 2006-2008 reporting on the prior year (2005-2007).
http://www.census.gov/hhes/www/cpstc/_cps_table_creator.htm

Note: 2013 ACS data were unavailable at the time this report was written.

The data for individuals with incomes less than 51 percent of poverty were aggregated because the CPS does not separate estimates for incomes less than 22 percent of poverty or between 23 and 50 percent of poverty

There is also some variation in the uninsured trends with respect to gender and age. During the time of HIP implementation, uninsured rates among men increased more than those among women. At the same time, the Medicaid coverage rate among women increased 3.0 percent from 2008 to 2011, as compared to 2.3 percent for men. Uninsured rates also varied by age. While those in the 19-29 age group saw a drop in uninsured rates, older groups saw an increase. The 50-64 age group experienced a 5.1 percentage point increase in the uninsured rate from 2008 to 2011. The uninsured rate among caretakers dropped one percentage point during this time period, while the Medicaid coverage rate among the same group rose 6.3 percentage points.

Nevertheless, the uninsured rate among non-caretakers is most likely to be affected by the HIP program, because these individuals can only access Medicaid if they are disabled. Statewide non-caretaker uninsured rates rose by 1.8 percentage points, while Medicaid coverage among non-caretakers increased by 1.7 percent during this time. Presumably, the uninsured rates for these groups would have been higher had Medicaid, and possibly HIP, not been available. The ACS data does not allow for a more detailed analysis of whether these non-caretakers were obtaining coverage through HIP or Medicaid's provision for people with disabilities because it is not split into caretaker and non-caretaker. Some proportion, however, would have been uninsured during this period had the HIP program not been available to them.

Table 5.8: Proportion of Indiana's Low-Income Working-Age Adults (19 through 64) Who Are Uninsured, 2008-2011

Subgroup	Statewide Uninsured Rates					Statewide Medicaid Coverage Rates				
Year	2008	2009	2010	2011	% Change	2008	2009	2010	2011	% Change
Total	38.2%	38.2%	39.2%	39.5%	1.3	18.0%	20.7%	19.6%	20.6%	2.6
Males	41.3%	42.9%	43.8%	43.5%	2.2	13.8%	15.6%	15.4%	16.1%	2.3
Females	35.6%	34.3%	35.3%	36.0%	0.4	21.6%	25.2%	23.3%	24.6%	3.0
Ages 19-29	42.5%	41.9%	43.4%	40.6%	-2.0	15.6%	18.6%	16.7%	17.1%	1.5
Ages 30-49	40.0%	39.3%	39.9%	42.2%	2.2	17.5%	20.6%	19.9%	21.2%	3.7
Ages 50-64	28.4%	30.3%	31.8%	33.5%	5.1	22.5%	24.5%	23.2%	24.6%	2.1
Caretakers	34.3%	30.3%	33.1%	33.3%	-1.0	22.1%	29.2%	25.7%	28.4%	6.3
Non-Caretakers	39.5%	40.9%	41.1%	41.3%	1.8	16.7%	17.9%	17.7%	18.4%	1.7

Source: Mathematica analysis of 2008-2011 ACS data.

C. AUTO-ASSIGNMENTS AND REASSIGNMENTS

Over 79 percent of individuals enrolling in HIP for the first time in 2013 selected their plan of choice at the time of application. This is approximately a 5 percent increase from 2012. Conversely, 17 percent of individuals were auto-assigned to a plan. Only 1.3 percent of the HIP members were enrolled in the ESP program. In addition, 2.2 percent received assistance from an enrollment broker. A majority of new members for Anthem and MDwise selected their plans at enrollment, while most of MHS' new members were auto-assigned to their plan.

There were 8,936 new members enrolled in plans in 2013. Anthem gained approximately 50 percent of the new members while MDwise received 28.2 percent of new members. MHS had the least amount of new members with 20.9 percent. Compared to 2012, Anthem's new enrollment numbers decreased by

roughly 16 percent because MDwise saw a substantial uptick to the number of new members that were enrolled in their plan.

The number of individuals assisted by an enrollment broker dropped between 2012 and 2013, for the second year in a row. 734 new members selected a plan with the assistance of a broker in 2011 and 428 received the same type of assistance in 2012 which is a 42 percent decrease. For 2013, new members who received enrollment broker assistance further declined to 229 new members.

Table 5.9. Health Plan Assignment Methods, Initial Assignments for Those Enrolling in HIP for the First Time in 2013

Form of Plan Selection	Anthem	ESP	MDwise	MHS	Total Number
Total	4,455	93	2,522	1,866	8,936
	49.9%	1.0%	28.2%	20.9%	100.0%
Assigned to ESP	-	91	1	-	92
		97.8%	0%		1.3%
Auto-Assigned	462	2	359	1,095	1,918
	10.3%	2.2%	14.3%	58.8%	17.3%
Enrollment Broker Assisted	173	-	36	20	229
	3.9%		1.4%	1.0%	2.2%
Member Selection on Application	3,820	-	2,126	749	6,695
	85.8%		84.3%	40.2%	79.2%

Source: OMPP Data Management & Analysis

D. HEALTH PLAN CHANGES

Upon enrollment in the HIP program, members select or are assigned to one of the three health plans that are a part of HIP. In 2013 and prior to the expiration of the ESP program, positive answers to the Health Screening Questionnaire portion of the HIP application indicated that assignment to ESP is appropriate. Once conditionally enrolled, members may change their plan selection before making their first POWER account contribution (or afterwards, for just cause, as discussed below). After receiving notice of a new member's conditional eligibility, the health plan sends a "welcome letter" notifying the member that the first POWER account contribution will be due within 60 days of the conditional eligibility date. Members not in the ESP may change health plans without cause within this initial 60-day window and before they make their initial POWER account contribution. After the first POWER account contribution is made, members may change plans when their program eligibility is redetermined at the annual renewal date. For requests after the initial 60-day period, members cannot change plans midyear without OMPP allowing a transfer for just cause, unless they move out of the MCE's service area.

During the first three years of the program, 2008-2010, a total of 2,475 plan changes occurred out of almost 60,000 enrolled members. In 2008, 520 changes occurred, 837 changes occurred in 2009, and 1,118 changes occurred in 2010. The number of plan changes spiked to 2,988 in 2011 as an additional MCE was added and enrollment grew. 2012 saw the number of plan changes drop to 1,941. Most recently, plan changes dropped again to 1,574 in 2013.

Table 5.10 Health Plan Changes in the HIP by Year, 2008-2013

Type of Change	2008		2009		2010		2011		2012		2013	
	Number Changes	%	Number Changes	%	Number Changes	%	Number Changes	%	Number Changes	%	Number Changes	%
Total Number Changes	520	100%	837	100%	1,118	100%	2,988	100%	1,941	100%	1,574	100%
Anthem →MDwise	9	2%	225	27%	137	12%	274	9%	231	12%	56	4%
Anthem → MHS	-	-	-	-	-	-	97	3%	83	4%	32	2%
Anthem → ESP	40	8%	67	8%	268	24%	552	18%	482	25%	238	15%
MDwise →Anthem	12	2%	236	28%	128	11%	913	31%	254	13%	82	5%
MDwise → MHS	-	-	-	-	-	-	459	15%	53	3%	13	1%
MDwise →ESP	18	3%	73	9%	478	43%	275	9%	249	13%	108	7%
MHS → Anthem	-	-	-	-	-	-	211	7%	293	15%	56	4%
MHS → MDWise	-	-	-	-	-	-	80	3%	108	6%	24	1%
MHS → ESP	-	-	-	-	-	-	4	0.1%	19	1%	19	1%
ESP → Anthem	301	58%	125	15%	70	6%	54	2%	82	4%	644	41%
ESP → MDwise	140	27%	111	13%	37	3%	67	2%	66	3%	250	16%
ESP → MHS	-	-	-	-	-	-	2	0.1%	21	1%	52	3%

Source: OMPP Data Management & Analysis, via HP and Maximus

Table 5.11 Month of Enrollment when Health Plan Change occurred, for those who changed health plans, by year, 2011 - 2013

	2011	2012	2013
Percent who switch in month 1	8.5%	11.2%	4.4%
Percent who switch in month 2	3.3%	4.4%	3.0%
Percent who switch in months 3	3.1%	3.8%	4.6%
Percent who switch in month 4-12	27.2%	41.2%	35.2%
Percent who switch in month 13 +	57.9%	39.4%	52.8%

Source: OMPP Data Management & Analysis

5.6 POWER ACCOUNTS

A. POWER ACCOUNT CONTRIBUTIONS

The POWER account is a key feature of the Healthy Indiana Plan. Instead of traditional cost-sharing through the use of premiums and copayments, HIP participants make up front contributions for their health care through required POWER account contributions. The funds contributed to the POWER account are used to pay for deductible expenses ($1,100 annually). Contributions are based on a sliding scale tied to income so that individuals can afford to make the monthly payments and still be financially invested. The program ensures that no participant pays more than 5 percent of his or her income to the POWER account, consistent with CMS cost-sharing rules. The State then subsidizes the POWER account to ensure that it is fully funded, up to the amount of the deductible ($1,100). Employers are also allowed to make up to 50 percent of the member's required contribution while non-profit organizations are allowed to make up to 75 percent of the required contribution.

Participants have control over how POWER account dollars are spent and receive monthly statements on POWER account expenditures and account balances. Unlike traditional premiums or copayments, HIP members own their contributions and are entitled to any unused contributions if they leave the program. Additionally, HIP members who receive required preventive services are rewarded by the program allowing any remaining POWER account balance after 18 months of enrollment — including the portion that is the State's contribution—to roll over and offset required contributions in the next year. If individuals do not complete the required preventive services, only the pro-rated balance of their individual contribution rolls over. The incentive is designed to increase the use of preventive care. Because the health plans wait six months after the member's benefit period ends for claims to run out, they do not calculate rollovers until members have been enrolled for 18 months to assure that all services have been reimbursed.

While every HIP member has a POWER account, members make different monthly contributions based on a sliding scale tied to income. In 2013, contributions varied from 2 to 5 percent of household income. There are also individuals who do not have any POWER account contributions due to their income levels and payments into other Indiana Health Coverage Program options. In 2012, 77 percent of HIP members were required to make some contribution to their POWER accounts. This number decreased in 2013 to 72 percent of the HIP population. Those in the lowest income bracket (22 percent of the FPL or below) make the lowest average monthly contributions at $9.05 each month. Individuals that are below 22 percent of FPL and have no POWER account contribution are not included in this average figure. The amount of the required payment rises as income increases, with individuals making more than 150 percent of the FPL paying on average $62.82 on a monthly basis.

Table 5.12 Average POWER Account Monthly Payment in 2013, by FPL

FPL	Member Count with Monthly Contribution	Average Monthly Contribution of Member
< = 22%	3,964	$9.05
23%- 50%	6,249	$10.96
51%- 100%	15,062	$19.38
101%- 150%	8,794	$44.02
> 150%	4,516	$62.82
Total Members with Contribution:	38,585	
Total Members without Contribution:	10,805	
Total Members:	**49,390**	

Source: OMPP Data Management & Analysis

Approximately 28 percent of HIP members were *not* required to make monthly contributions to their POWER accounts in 2013. (Table 5.13). These individuals do not make contributions either because they have no income, or because the family is already spending five percent of its income on premiums and cost-sharing requirements for family members covered by Medicaid or the State Children's Health Insurance Program. Those in the non-contributor group tend to report much lower incomes than the HIP population as a whole.

Table 5.13 Demographic Characteristics of HIP Members Not Required to Make Monthly POWER Account Contributions, 2013

	All HIP Members in 2013		HIP Members with No Monthly Contributions	
Characteristics	Number	Percentage of Total	Number	Percentage of Total
Total number	49,390	100.0%	10,805	100.00%
Gender				
Female	33,919	67.6%	6,622	61.3%
Male	15,471	32.4%	4,183	38.7%
Caretaker Status				
Caretaker	35,491	68.9%	5,573	51.6%
Non-caretaker	13,899	31.1%	5,232	48.4%
FPL				
<22%	12,909	26.7%	8,945	82.8%
23%-50%	6,654	12.2%	405	3.7%
51%-100%	15,938	31.1%	876	8.1%
100%-150%	9,165	19.8%	371	3.4%
>150%	4,724	10.2%	208	1.9%

Source: OMPP Data Management & Analysis

Each year, the majority of HIP members who were involved in the POWER account rollover process did not have an account balance left after 18 months of enrollment. This is a reflection of the high prevalence of chronic disease among the HIP population, as discussed further in Section 6.5. A Milliman analysis of 2013 claims showed that among those enrolled in HIP for at least six months during 2013,

32.8 percent of members had cardiovascular disease, 24.5 percent had a psychiatric diagnosis, 21.4 percent had a skeletal and connective tissue disease, 20.2 percent had a gastrointestinal ailment, and 13.2 percent had diabetes. Multiple diagnoses were common as well— 31.7 percent of HIP members had been diagnosed with three or more chronic conditions in 2013. These members incur higher healthcare costs to manage and treat their chronic disease(s), and therefore tend to quickly meet the deductible and exhaust the POWER account. By the end of 2013, just under one-third of POWER accounts eligible for a rollover over the course of the demonstration contained any funds to carry forward. The rates discussed here reflect updated data sets from the MCE's in which all member account reconciliations have been included. This data is cumulative, reported on a rolling basis as of the end of each calendar year.

Table 5.14 POWER Account Rollover Reconciliation

Status	2009	2010	2011	2012	2013
Percent of accounts with a balance after 18 months of member enrollment	36.1%	35.2%	34.7%	34.6%	32.82 *
Of those accounts, percent that received a partial rollover (did not receive recommended care)	44.7%	58.9%	64.9%	65.2%	69.73%
Of those accounts, percent that received a full rollover (received recommended preventive care)	55.3%	41.1%	35.1%	34.8%	30.26%

Source: MCE POWER Account Reconciliation Files
*Total number of active Members minus Members with a balance excluding $0 contributors

Of those accounts that did have a balance, the majority received a partial rollover, meaning just member contributions were rolled over. Members who do not spend down their POWER accounts and retain a balance at the end of 18 months are likely to be healthier, have a lower rate of chronic disease, and use fewer healthcare services (totaling less than $1,100 annually) than those who do exhaust their funds. Since overall preventive care utilization rates are much higher in the general HIP population, the observed lower rate among those with funds remaining in the POWER account might be due to a perception of lower need for routine physicals and screenings and lower health service utilization in general. The MCEs continue to work to promote the preventive care incentive and develop member awareness and understanding of how the POWER account works.

B. COST-SHARING LIMIT MONITORING

Per CMS rules for HIP Caretakers and Non-caretaker, the total aggregate amount of (1) POWER account contributions, (2) HIP Emergency Room copayments, (3) Medicaid cost sharing requirements, and (4) CHIP cost sharing requirements may not exceed five percent of family income. The health plan verifies the member's cost-sharing documentation, and then notifies the HIP program manager that the member has reached the five percent maximum contribution amount and the date it occurred. The member is not required to pay any further POWER account contributions or ER co-payments for the rest of the 12-month benefit period. Member handbooks were modified in 2009 to clarify that members must maintain their receipts and document their out-of-pocket costs.

C. COST-SHARING: POWER ACCOUNT CONTRIBUTION RATES

After completing an application and meeting the financial and other eligibility criteria, members are "conditionally eligible" for the HIP program. They do not become fully eligible until they make their first POWER account contribution. Individuals with no required POWER account contribution, however, become eligible immediately after they meet the financial and other criteria. Individuals with no required contributions either have no income, or are exempt due to CMS cost-sharing rules. Once fully enrolled, members must continue to make monthly contributions to maintain their HIP eligibility. If they fail to do so within the grace period, they are disenrolled, and must wait 12 months to re-apply. The State has collected annual data on the rates at which HIP members make required contributions to the POWER account. The rate of members who make their initial contributions to complete the enrollment process has increased consistently each year of the demonstration. The rate of members who make their subsequent required monthly contributions has decreased slightly, but continues to stay at approximately 10 percent.

The State has refined both the quality of the data as well as the methods assessing rates of member contribution over the course of the demonstration. In the past, if members were missing data in any fields of their eligibility file, they were excluded from analysis. The State has developed mechanisms to correct this, leading to inclusion of more members in the analysis and more robust reporting. The new methodology has been applied retroactively and the data below represents an updated annual review of contribution rates.

The HIP program has historically had low non-contribution rates, suggesting that the disenrollment penalty could be a strong motivating factor to make regular payments. Data from the 2013 Mathematica survey also supports that the required financial contributions are affordable and HIP participants prefer making upfront contributions rather than making copays. According to the survey, 85 percent of HIP enrollees believed that their required contributions were either the right amount or below the right amount. In 2013, 94.3 percent (47,030) of HIP members made the initial POWER account contribution if required and only 5.7 percent or 2,827 individuals did not. Although there is some variation between income brackets, the majority of individuals at all levels made the first required POWER account contribution.

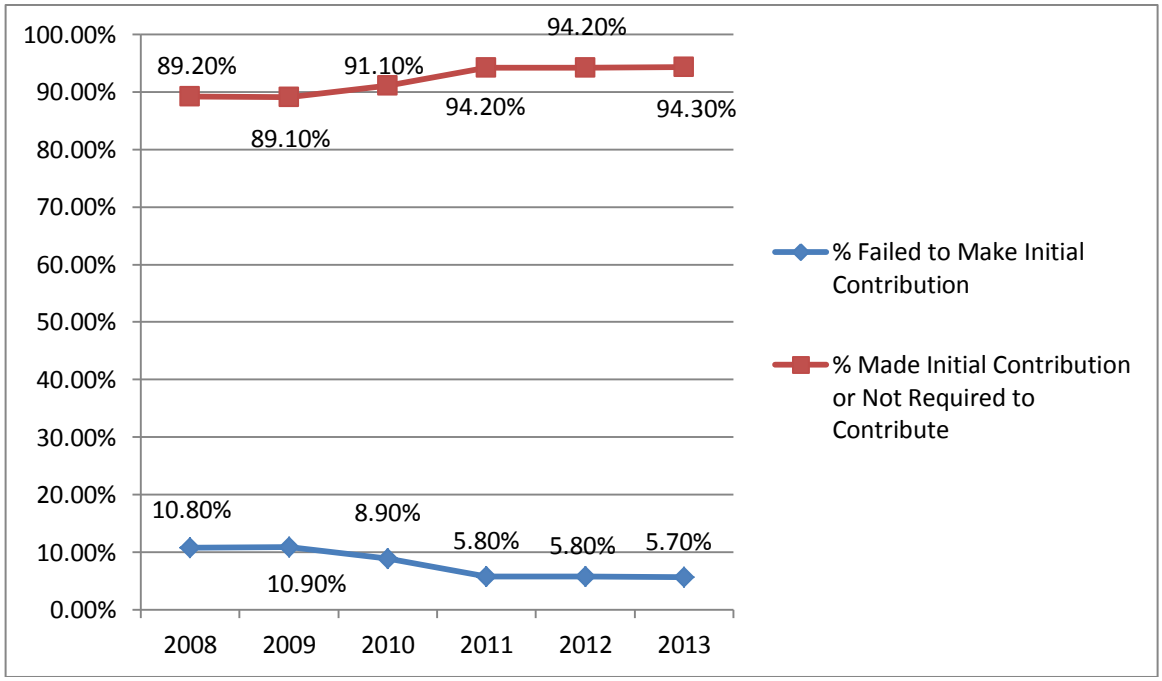
Table 5.15. Calendar Year 2013 Initial Non-Contribution Rates (Did Not Make First POWER Account Contribution

Income as % of FPL	Members not making first payment	Members within FPL range	Initial Non-Contribution Rate
< = 22%	619	12,976	4.8%
23%- 50%	449	6,726	6.7%
51% - 100%	1,152	16,095	7.2%
101% - 150%	315	9,281	3.4%
> 150%	292	4,779	6.1%
Total	**2,827**	**49,390**	**5.7%**

Source: OMPP Data Management & Analysis

Initial contribution rates have increased consistently over the course of the HIP demonstration. In DY 1 (CY 2008), the initial non-contribution rate among HIP enrollees was about 10.8 percent. This rate dropped over five years, reaching 5.8 percent in 2011 and 2012 with an additional drop in 2013 to 5.7 percent. These percentages include individuals not required to make contributions.

Figure 5.2 Initial POWER Account Contribution and Non-Contribution Rates, CY 2008-2013



Source: OMPP Data Management & Analysis

In 2013, more than 89 percent of HIP members continued to make their required monthly contributions to remain enrolled in the program. The 5,324 members who did not make subsequent POWER account payments were disenrolled. Subsequent non-contribution rates were the highest in the greater than 150 percent FPL income bracket and lowest in the below 22 percent FPL income bracket. These figures include members not required to make contributions.

Table 5.16 Calendar Year 2013 Subsequent Non-Contribution Rates

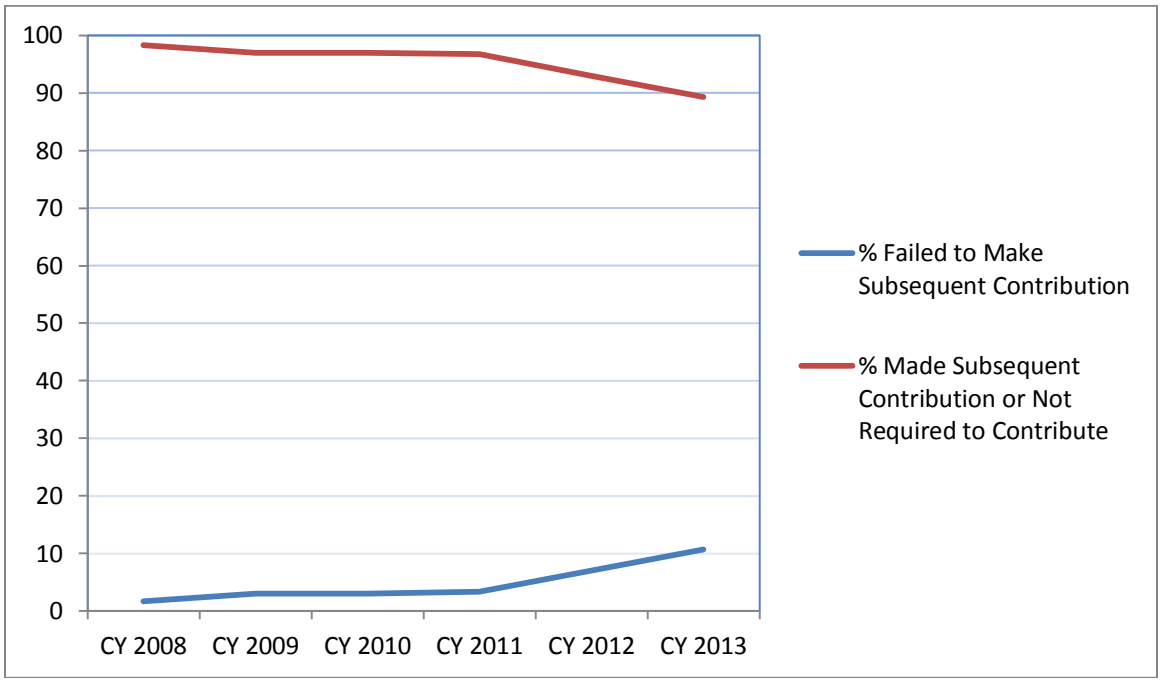
Income as % of FPL	Members not Making Subsequent Payment	Member Count	Subsequent Non-Contribution Rate
< = 22%	267	12,976	2.1%
23%- 50%	1,464	6,726	21.8%
51% - 100%	1,998	16,095	12.4%
101% - 150%	302	9,281	3.3%
> 150%	1,293	4,779	27.1%
Total	**5,324**	**49,390**	**10.7%**

Source: OMPP Data Management & Analysis

Annual subsequent non-contribution rates rose slightly during the demonstration. In DY 1 (CY 2008), the subsequent non-contribution rate was very low at 1.7 percent. It rose slightly to 3 percent in 2009

and hovered around the same rate for three years. In CY 2012, the subsequent non-contribution rate rose again, and the trend continued in 2013. The reasons may be related to uncertainty surrounding the program with the implementation of the Affordable Care Act occurring nationally and individuals gaining other insurance.

FIGURE 5.3 Subsequent POWER Account Contribution and Non-Contribution Rates, CY 2008-2013



Source: OMPP Data Management & Analysis

Failure to make an initial POWER account contribution was not one of the top five reasons for HIP enrollment denials in 2013, which is consistent with earlier years.

Table 5.17 Top Five Types of HIP Denials in Calendar Year 2013

Member Count	Denial Reason
27406	Non- Caretaker Cap Reached
12649	Failure to Cooperate in Verifying Income
10787	Program Capacity Reached
8651	Failure to Provide Insurance Information
8551	Failure to Provide all Required Information

Source: OMPP Data Management & Analysis

Table 5.18 Top Five Types of HIP Denials in Calendar Years 2008-2013

Member Count	Denial Reason
133381	Non-Caretaker Cap Reached
58240	Failure to Cooperate in Verifying Income
37367	Failure to Provide Insurance Information
32427	Failure to Provide Proof of Citizenship
14546	Has Access to Health Insurance Through Employer

Source: OMPP Data Management & Analysis

Failure to make a subsequent POWER account payment was the second most common reason for dis-enrollment in 2013. Other top reasons included a failure to return the HIP member packet, closure due to the ruling of an Appeals judge, failure to cooperate in verifying income and a failure to complete redetermination process. These reasons are mostly consistent with previous years with the exception of other health insurance causing HIP members' accounts to be closed.

Table 5.19 Top Five Types of HIP Member Accounts Closed in Calendar Year 2013

Member Count	Denial Reason
4,839	HIP Packet not Received
3,832	Failure to Make Payment to POWER Account
3,440	HIP Closure Due to Ruling of Appeals Judge
1,842	Failure to Cooperate in Verifying Income
1,565	Individual Fails to Complete Redetermination

Source: OMPP Data Management & Analysis

Table 5.20 Top Five Types of HIP Member Accounts Closed in Calendar Years 2008-2013

Member Count	Denial Reason
35,580	HIP Packet not Received
16,676	Failure to Make Payment to POWER Account
9,459	Failure to Cooperate in Verifying Income
9,195	Currently Has Other Health Insurance
9,169	HIP Closure Due to Ruling of Appeals Judge

Source: OMPP Data Management & Analysis

Coverage and Benefits Limits

HIP benefits are limited to $300,000 annually and $1 million lifetime. The health plans and the State identify members when they reach $200,000 in annual benefits in order to ensure a member doesn't hit the limits without advance knowledge. The health plans and the State then closely monitor these members, and work to refer them appropriately to other programs, including Medicaid disability and M.E.D. Works (Indiana's Medicaid Buy-In program for those with disabilities). For the calendar year 2013, one HIP member reached the lifetime maximum. That individual was referred to and enrolled in Medicaid.

5.21 Number of HIP Members Who Reached $200,000 in Annual Benefits During 2013

	Anthem	MDWise	MHS	Total
Total Number	0	0	0	0

Source: MCE Reporting Data, 2013

5.22 Number of HIP Members Who Reached $300,000/Annual or $1,000,000 /Lifetime in Benefits During 2013

	Anthem	MDWise	MHS	Total
Total Number	1	0	0	1

Source: MCE Reporting Data, 2013

SECTION 6: EVALUATION FINDINGS TO DATE

Due to the ground-breaking nature of the program, a variety of analyses and reports have been produced for the HIP program over the first six years of the demonstration. This section represents the analyses completed for the sixth year of the demonstration program (CY 2013), including telephone interviews, program monitoring data obtained from various systems, and an actuarial review completed by Milliman. Data results include analyses of a telephone survey of HIP members completed in 2013. This survey, completed in the spring of 2013, included a sample of 847 current HIP enrollees, along with 620 individuals who had been previously enrolled in HIP within 12 months of the survey.

6.1 GOAL I – REDUCE THE NUMBER OF UNINSURED LOW-INCOME HOOSIERS

HIP seeks to reduce the number of uninsured low-income Hoosiers by providing an insurance option for those who do not have access to employer-based coverage and do not currently qualify for other public insurance. While complete 2013 data analyses on uninsured rates are unavailable at the time of writing, trends show that uninsured rates for individuals aged 19 to 64 and below 200 percent of the FPL have remained relatively constant since the last report of the demonstration. Overall, the uninsured rate for Hoosiers with incomes under 50 percent of FPL has *decreased* from about 47 percent in 2005-2007 (prior to HIP implementation) and held steady at approximately 43 percent. Two factors may have impeded the program's ability to further reduce the number of uninsured low-income Hoosiers. First, the program was implemented during a significant economic downturn when the uninsured rate was increasing. It is fair to assume that uninsured rates in Indiana would have been higher without the HIP program. Second, the program limits enrollment of non-caretaker adults by design to meet its budget neutrality requirements and, therefore, limits the breadth of impact the program can make in this group that would otherwise be ineligible for Medicaid.

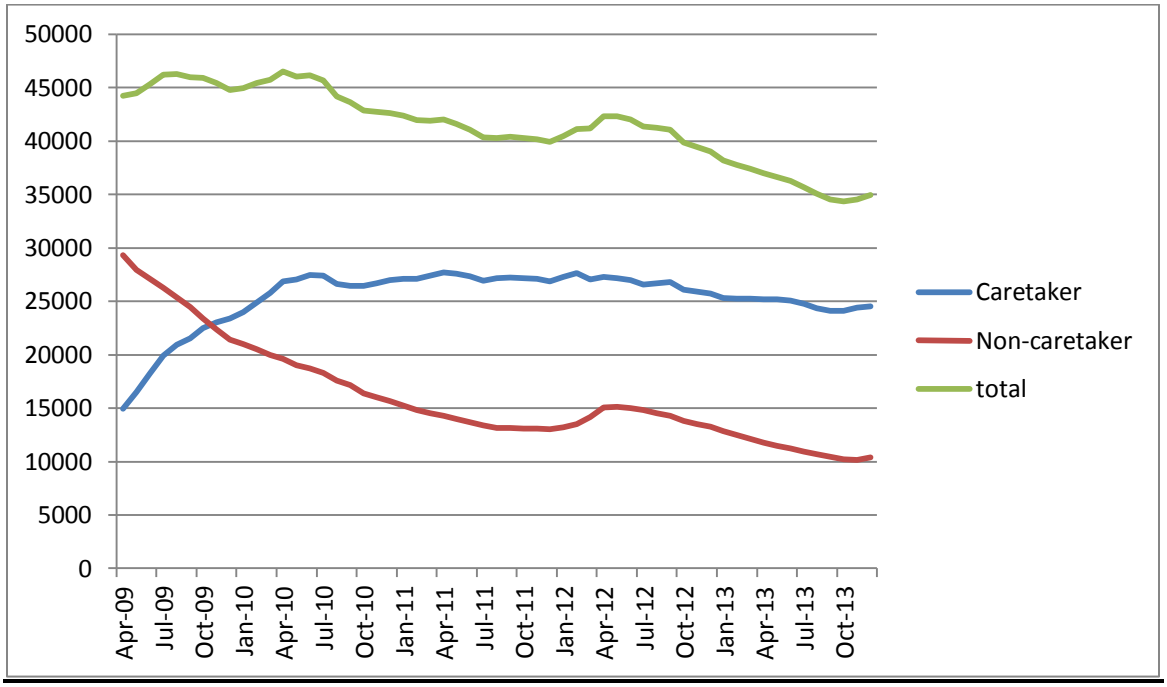
After six years HIP has enrolled 114,241 Hoosiers. Major findings on HIP enrollment include:

- As reported in previous demonstration years, monthly enrollment grew steadily from the program's inception until April 2009, when it began to level off with about 46,000 to 47,000 enrollees per month. Enrollment figures approached the non-caretaker adult cap in early 2009 and the State closed enrollment to non-caretakers at that time. Monthly enrollment remained relatively stable until September 2010, when it fell to the 43,000-44,000 range. The State opened the non-caretaker waiting list in 2010 and again in 2011. As of December 2012, 39,005 individuals were enrolled in the program. By December 31, 2013, there were 49,390 individuals enrolled into the HIP program at the end of the year.
- The program continues to enroll more women than men (33,919 women vs. 15,471 men enrolled in 2013), and more caretakers than non-caretakers (35,491 caretakers vs. 13,899 non-caretakers during 2013). However, non-caretakers comprised a greater proportion of the total HIP population until September 2009, about six months after the non-caretaker cap was reached and the waitlist was implemented.

A. ENROLLMENT TRENDS IN HIP

Overall monthly enrollment in HIP increased steadily from the program's inception in January 2008 through mid-2009. Non-caretakers enrolled at a much higher rate than caretakers through April of 2009, when non-caretaker adults found to be eligible were placed on a waiting list. The chart below shows the impact of the waiting list. Enrollment steadily decreased through October 2011. In February of 2012, the number of non-caretaker enrollees began to increase and continued to rise until June 2012, when numbers began to decrease again. Non-caretaker enrollment was not reopened in 2013 and can be seen as the cause for decline in total enrollment in the HIP program. Caretaker enrollment however, remained relatively steady through 2013 and ended with a slight uptick at the end of the year.

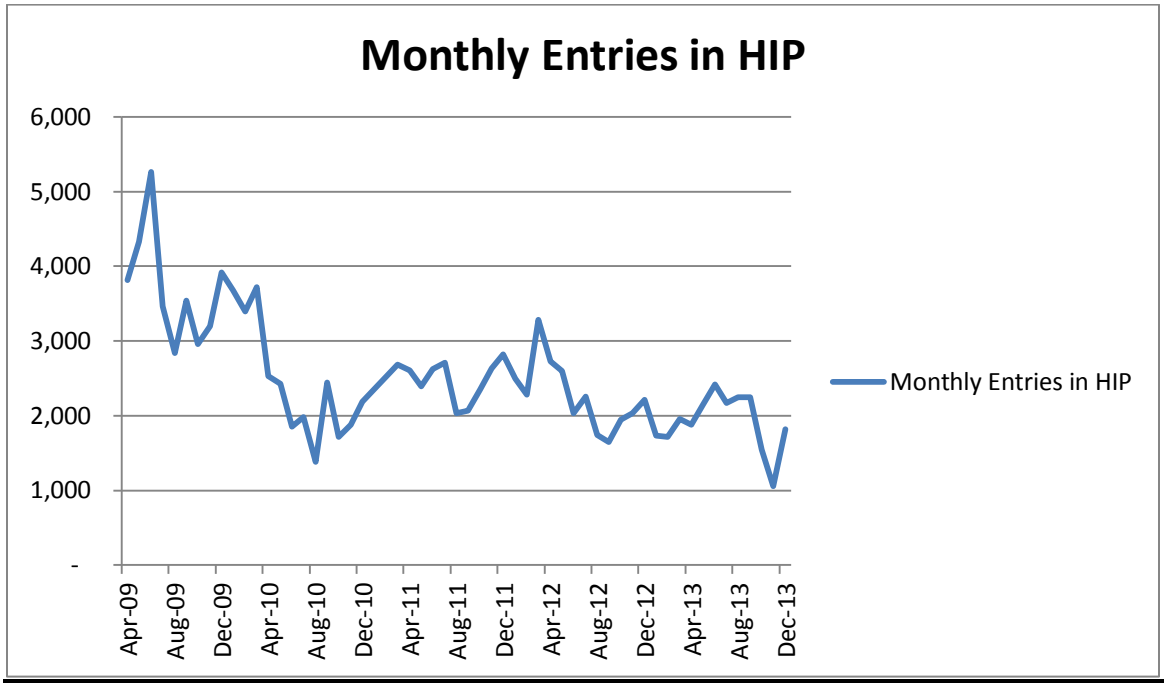
Figure 6.1 Monthly HIP Enrollment, Overall and by Caretaker Status, 2009-2013



Source: ICES Data, 2009-2013

Monthly enrollment figures are affected by the number of people entering and leaving the program each month. Figure 6.2 shows the number of people that entered the program each month from January 2009 – December 2013.

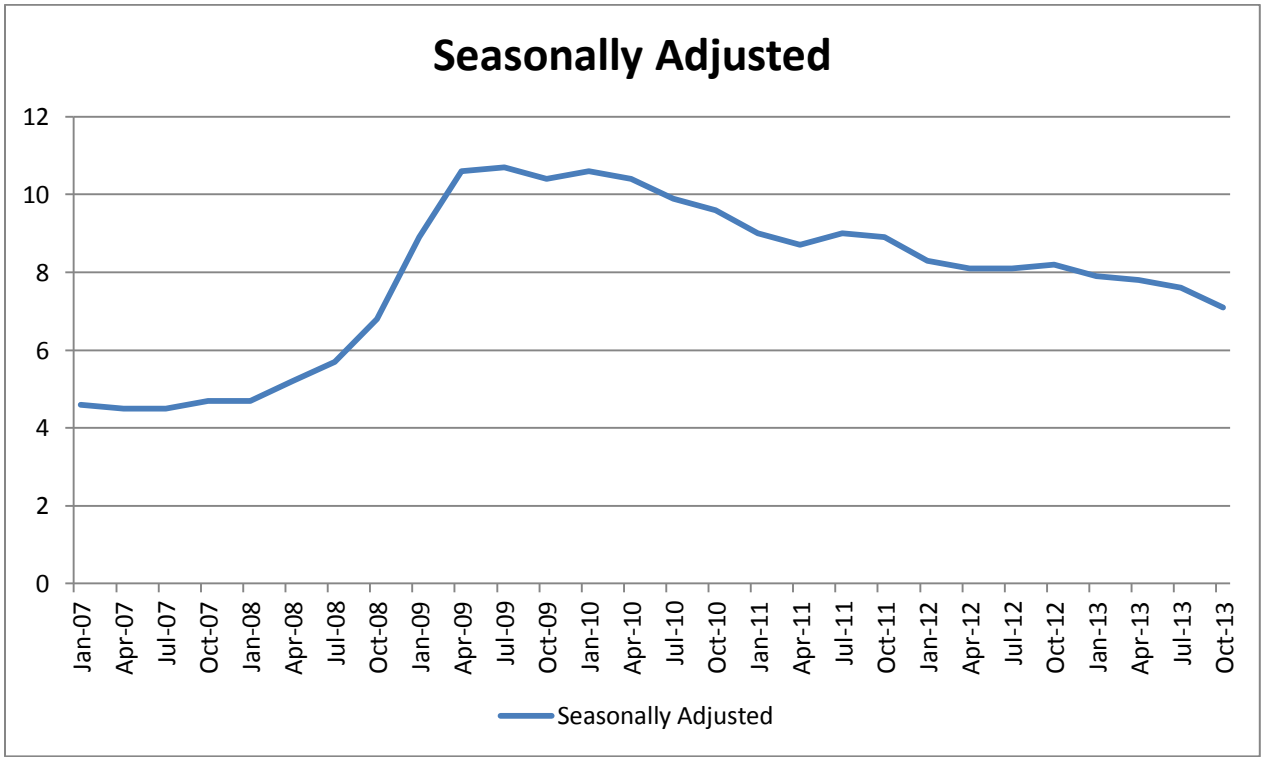
Figure 6.2 Monthly Entries into HIP, 2009-2013



Source: ICES data, July 2014.

In the past, Hoosiers were required to be uninsured for at least six months before becoming eligible for HIP. Consequently, trends in unemployment rates have always been of interest to the State. Hoosiers that otherwise fit the eligibility criteria for HIP who previously had employer-sponsored insurance may lose it due to becoming unemployed, or allow any privately-purchased coverage to lapse due to a loss of income. Those individuals are then required to wait six months before applying for the program.

Figure 6.3 Monthly Unemployment Rates in Indiana, 2007-2013



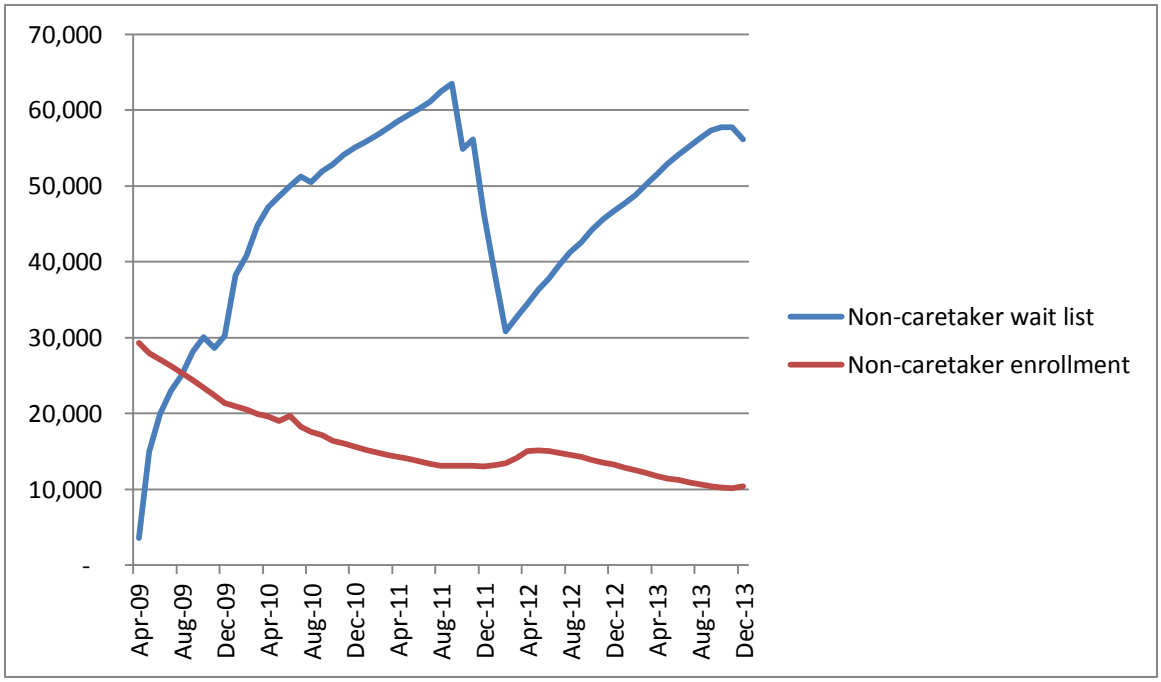
Source: U.S. Bureau of Labor Statistics, Local Area Unemployment Statistics. Available at: http://www.bls.gov/data/#unemployment

After non-caretaker enrollment was capped in March 2009, the waitlist continued to grow and non-caretaker enrollment declined through January 2012. The program was opened to those on the waitlist three times after its inception and before its elimination. In November 2009, 5,000 letters were sent to individuals on the waiting list inviting them to re-apply for HIP. A few hundred reapplied and were enrolled if found eligible. In August 2011, another 19,500 letters were sent to those on the waitlist and 2,157 individuals on the waiting list enrolled in the program (11 percent response rate). Due to the length of time many applicants had spent on the waiting list, some individuals who received letters may have experienced a life change, such as moving out of state or no longer meeting eligibility criteria for the program.

During the first quarter of the 2012 calendar year, 18,800 letters were sent to non-caretakers on the waitlist, inviting them to reapply for the program. In response to these letters, 1,587 individuals were able to enroll, an 8.4 percent response rate (see Figure 6.4). During this time, 7,113 additional individuals were added to the waitlist. The waitlist was closed to new non-caretaker applicants in April 2012 as the State waited for guidance from CMS on whether HIP could be used as a framework for a potential Medicaid expansion under the Affordable Care Act of 2010.

In 2013, the non-caretaker waitlist continued to increase while the non-caretaker enrollment declined due to attrition of members enrolled in the program. The non-caretaker enrollment was not re-opened until December 2013.

Figure 6.4 Non-Caretaker Waitlist and Non-Caretaker Enrollment, April 2009- December 2013



Source: ICES Data, July 2014.

B. DEMOGRAPHIC CHARACTERISTICS OF THOSE EVER ENROLLED IN HIP

The State's analyses of HIP enrollment records indicate that HIP served 49,390 unique individuals during 2013 and 114,241 individuals over the six demonstration years. The demographics of HIP enrollees in 2013 compared to the enrollment composition over the life of the demonstration are somewhat similar. The proportion of females was slightly higher in 2013 compared to the life of the demonstration. Women have made up the majority of the HIP population throughout the course of the program. There was a drop in enrollment of individuals ages 20-29 years old with the older age groups all seeing an increase in enrollment. Enrollment of African-Americans was slightly lower in 2013; however, Hispanics, Asians and American Indians all saw increases in enrollment compared to their 2008-2012 enrollment data. Members enrolled with incomes between 23 percent to 100 percent FPL saw an increase with decreases in other income ranges compared to the first five demonstration years.

Table 6.1. Demographic Characteristics of Those Ever Enrolled in HIP in 2008-2012 vs. 2013

	2008-2012 Enrollment	2008-2012 % of Total	2013 Enrollment	2013 % of Total	Low-Income Uninsured Working-Age Indiana Adults, 2011	Low-Income Uninsured Working-Age Indiana Adults, 2011 % of Total
Gender						
Female	68,378	65%	33,919	68.6%	233,201	48.9%
Male	36,819	35%	15,471	31.4%	243,356	51.1%
Age Group						
<20	79	0%	18	0.0%	11,511	2.4%
20-29	19,394	18%	6,189	12.5%	151,246	31.7%
30-39	30,400	29%	15,444	31.3%	116,116	24.4%
40-49	28,391	27%	14,639	29.6%	98,753	20.7%
50-59	19,446	18%	9,803	19.8%	74,771	15.7%
60+	7,486	7%	3,297	6.7%	24,160	5.1%
Race/Ethnicity						
Asian	1,581	2%	1,059	2.1%	7,871	1.7%
Black	12,948	12%	4,930	10.0%	67,459	14.2%
Hispanic	3,591	3%	1,605	3.2%	69,404	14.6%
American Indian	74	0%	48	0.1%	6,171	1.3%
Other	1,695	2%	930	1.9%	35,922	7.5%
White	85,308	81%	40,818	82.6%	369,571	77.6%
Income as % of FPL						
<22%	30,265	28.7%	12,909	26.1%	65,297	13.7%
23%-50%	11,321	10.8%	6,654	13.5%	47,536	10.0%
51%-100%	31,330	29.9%	15,938	32.3%	121,812	25.6%
100%-150%	21,083	20%	9,165	18.6%	133,837	28.1%
>150%	11,197	10.6%	4,724	9.6%	108,075	22.7%

Source: OMPP Data Management & Analysis, Mathematica analysis of 2011 ACS data
Note: Most recent Mathematica analysis of 2011 ACS data.

6.2 Goal II – Reduce Barriers and Improve Statewide Access to Health Care Services for Low-Income Hoosiers

A key goal of HIP is to improve access to health care among low-income Hoosiers. To accomplish this goal, it is important not only to provide health insurance, but also to ensure that HIP members have access to both a primary medical provider (PMP) and needed specialists. Over the past five years, HIP has consistently achieved this goal by providing full access to PMPs and access to most specialists.

C. PROVIDER NETWORKS

Primary Care Providers

In 2013, all HIP members were required to select a PMP. Those who did not select a PMP were auto-assigned to a provider. All three Managed Care Plans use Geo-Access software on a quarterly basis to evaluate whether their network meets the standard of access: a PMP within 30 miles of all members' homes and a specialist within 90 miles of their homes. In 2013, all plans continued to meet geo-access standards for PMPs. The health plans reported that HIP's higher payment rate has been a significant factor in their ability to recruit providers. More providers participate in HIP than HHW, in part due to HIP providing higher reimbursement rates. HIP reimburses services at Medicare rates or, when a Medicare rate is not available, 130% of Medicaid rates.

In addition to seeking primary care with PMPs, HIP members may also go to any Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC). All health plans reported contracting with most FQHCs, community mental health centers (CMHCs), and RHCs in the State.

Specialty Care

In the first year of HIP operations, development of specialist networks was a challenge for Anthem and MDwise, the initial HIP health plans. However, these plans have made significant strides in expanding their networks, and by the end of 2013 both reported that HIP members had access to most categories of specialists within 60 miles of their homes. During MHS's initial year as a HIP provider, 2011, the plan met geo-access standards for approximately half of its specialist categories, and has made significant improvements since.

All plans reported meeting geographic access standards in most categories during 2013, and provided transportation services to members when necessary due to not having a specialist in network within the required radius. The plans noted a few types of specialists that are difficult to locate within certain geographic areas, including pain management physicians, neurologists, psychiatrists, orthopedists and endocrinologists. However, all three plans reported that they had made efforts during 2013 to maintain their specialist networks.

In 2013, Anthem met the requirements for specialist access standards in all areas except for endocrinology and occupational therapy. Anthem was able to improve on and meet the requirements for specialist access standards for the specialty types of hematology and speech pathology which was not the case in 2012. Previous specialty types where there was not access information have now been improved and Anthem was able to meet the standards for clinical psychology. However, there is still not sufficient access information for diagnostic radiology, bringing the Anthem total to 23 out of 26 specialty types having met specialist access standards.

Between 2012 and 2013, Anthem expanded the number of specialists in its network in all categories except for clinical psychology, dermatology, infectious disease, neurology, ophthalmology, pathology, and pulmonary disease, though even these categories have been expanded since 2008. No information was available on the number of diagnostic radiology specialists available in 2011, 2012, or 2013. Anthem was able to raise the total number of specialists in its network from 20,875 to 21,428 between 2012 and 2013.

Table 6.2 Anthem Specialist Network, 2008-2013

Specialty Type	Providers 2008	2009	2010	2011	2012	2013	% Change 2008-2013	Total Provider Locations	Complete Coverage of IN with 60 mi Radius from Providers
Anesthesiology	88	170	199	219	219	233	164.77%	190	x
Cardiology	1276	2713	3261	2866	3124	3150	146.87%	387	x
Clinical Psychology (NOTE: Includes psychiatry beginning in 2012)	1726	2720	3321	*	5432	4922	N/A	706	x
Dermatology	32	87	127	181	213	205	540.63%	74	x
Diagnostic Radiology	159	201	247	*	*	*			
Endocrinology	48	129	159	159	168	190	295.83%	81	
Gastroenterology	210	332	351	376	556	746	255.24%	154	x
General Surgery	335	658	739	813	951	1108	230.75%	367	x
Hematology	129	221	216	225	228	236	82.95%	109	x
Infectious Disease	37	184	198	199	210	176	375.68%	57	x
Medical Oncology	696	829	863	917	913	1044	50.00%	172	x
Nephrology	208	462	683	1032	1194	1253	502.40%	223	x
Neurosurgery	103	135	240	261	252	271	163.11%	80	x
Neurology	257	1339	1460	1589	1617	1484	477.43%	209	x
OT	49	64	84	95	121	138	181.63%	118	
Ophthalmology	388	565	594	740	779	746	92.27%	267	x
Optometry	346	459	494	573	688	703	103.18%	275	x
Orthopedic Surgery	330	462	603	685	849	1220	269.70%	295	x
Otolaryngology	444	567	751	910	1012	1075	142.12%	284	x
Pathology	32	35	45	40	45	44	37.50%	38	x
Physical Therapy	99	133	177	180	211	234	136.36%	202	x
Pulmonary Disease	214	472	522	558	594	544	154.21%	207	x
Radiation Oncology	439	635	605	567	629	687	56.49%	129	x
Rheumatology	35	138	156	135	148	165	371.43%	78	x
Speech Pathology	11	18	20	21	22	23	109.09%	23	x
Urology	500	546	637	790	700	831	66.20%	199	x
Total	**8191**	**14274**	**16752**	**14131**	**20875**	**21428**	**161.6%**	**4924**	**23 out of 26**

Source: Anthem Specialists 2012 Summary

Note: * indicates information not available.

In 2013, MHS met geo-access standards except in eight categories, which is an improvement upon their data from 2012. The categories that did not meet geo-access standards included dermatology, neurosurgery, occupational therapy, pain medicine, pathology, radiation and speech pathology. MHS expanded its specialist networks in almost every category except otolaryngology in 2013. In addition, eleven of the reported specialty types saw a greater than 100 percent increase in network providers. MHS was not able to include percent changes in every category as they increased their reporting over previous years on specialty types that were not previously available or previously able to be reported on.

Table 6.3 MHS Specialist Network, 2012-2014

Specialty Type	Number of In-Network Providers 2013	Number of In-Network Providers 2014	Percent Change 2014 over 2013	Total Number of Provider Locations 2014	Complete Coverage of Indiana with 60 mi radius or less to Providers 2014
Anesthesiology	211	364	73%	69	✔
Cardiology	347	601	73%	169	✔
Cardiovascular Surgery	NR	77	--	30	✔
Clinical Psychology	394	577	46%	328	✔
Dermatology	53	74	40%	30	
Diagnostic Radiology	244	1171	380%	310	✔
Endocrinology	41	103	151%	45	✔
Gastroenterology	176	320	82%	75	✔
General Surgery	352	609	73%	171	✔
Gynecology	NR	647	--	196	✔
Hematology	86	267	210%	63	✔
Infectious Disease	30	77	157%	26	✔
Medical Oncology	86	267	210%	63	✔
Nephrology	100	236	218%	59	✔
Neurosurgery	72	93	29%	32	
Neurology	100	318	218%	110	✔
Occupational Therapy	33	78	136%	35	
Optometry	113	138	22%	67	✔
Ophthalmology	112	149	33%	58	✔
Orthopedic Surgery	275	496	80%	157	✔
Otolaryngology	139	133	-4%	63	✔
Pain Medicine (Anesthesiology Sub-specialty)	NR	76	--	26	
Pathology	117	149	27%	24	
Physical Therapy	77	150	95%	46	✔
Pulmonary Disease	113	292	158%	86	✔
Psychiatry	NR	360	--	130	✔
Radiation,	NR	15	--	6	

Interventional					
Radiation Oncology	58	152	162%	45	
Rheumatology	32	84	163%	38	✔
Speech Pathology	17	18	6%	11	
Urology	153	196	28%	67	✔
TOTAL	3,531	5,423	54%	1,699	23 of 31

Source: MHS Specialists Summary, 2013

Note: * indicates information not available. MHS provided information for 2013 and not for 2012.

In 2013, MDwise met geo-access standards for all specialist areas. This is an improvement over 2012 where standards were not met for dermatology and nephrology. Between 2008 and 2013 the only specialty area that has not expanded has been dermatology. Specialty areas that declined between 2012 and 2013 included clinical psychology, gastroenterology, home health, neurosurgery, psychiatry, and pulmonary disease. Even with these declines, there has still been more than a 100 percent increase in the vast majority of specialty types within the MDwise specialist network.

Table 6.4 MDwise Specialist Network 2008-2013

Specialty Type	Number of Locations 2008	Number of Locations 2012	Number of Locations 2013	% Change 2008-2013	Complete Coverage of IN with 60 mi Radius from Providers
Anesthesiology	91	237	286	214%	X
Cardiovascular	149	403	517	247%	X
Clinical Psychology	9	405	346	3,744%	X
Dermatology	369	50	88	-76%	X
DME and Prosthetic Suppliers	33	247	320	870%	X
Gastroenterology	37	164	147	297%	X
General Surgery	82	346	427	421%	X
Gynecology	99	515	566	472%	X
Home Health	13	103	84	546%	X
Nephrology	28	150	164	486%	X
Neuro Surgery	13	74	67	415%	X
Neurology	37	190	233	530%	X
Oncology	24	237	251	946%	X
Ophthalmology	23	194	203	783%	X
Optometry	11	158	192	1,645%	X
Orthopedic Surgery	56	247	301	438%	X
Otolaryngology	46	145	161	250%	X
Pathology	20	213	221	1,005%	X
Physical Therapy	15	272	292	1,847%	X
Psychiatry	7	265	217	3,000%	X
Pulmonary Disease	39	196	188	382%	X
Radiology	131	219	259	97%	X
Urology	22	158	185	741%	X
Total	**1,354**	**5,188**	**5,715**	**322%**	**23 out of 23**

Source: MDwise specialists summary 2013

D. MEMBER PERCEPTIONS OF COST SHARING REQUIREMENTS

To examine access to care among members and to evaluate whether HIP's cost sharing requirements serve as a barrier to coverage for low-income Hoosiers, Mathematica conducted a telephone survey in 2013 of 847 current HIP members who had been enrolled at least two years at the time of the survey. Another survey of 613 individuals who had been enrolled in HIP within the last 12 months but were not enrolled at the time of the survey was also conducted. Survey respondents shared their perceptions of cost-sharing requirements (including POWER account contributions and ER co-payments).

Monthly POWER Account Contributions

General Perception of the Method of Contributing to the Cost of Healthcare

The 2013 survey assessed currently enrolled HIP members' preferences for the method of contributing to their healthcare costs (up-front contributions versus making copayments at the time of service). A significant majority of HIP members, 83.1 percent, reported that when given the choice between paying a fixed monthly amount up front with the opportunity to receive funds back and making a payment each time they visited a health professional, pharmacy, or hospital, they preferred to pay up front by making a POWER account contribution. Members with incomes above 100 percent of the FPL were slightly more likely to report a preference for paying up front than those at or below 100 percent of the FPL (86.2 percent versus 81.6 percent, respectively).

Table 6.5. Preferred Method of Contributing to Healthcare Costs

	All Respondents	≤ 100% FPL	> 100% FPL
Prefer paying up front (POWER account)	83.1%	81.6%	86.2%
Prefer paying each doctor visit (copayments)	13%	15%	8.9%
Refused/Don't Know	3.9%	3.4%	4.9%

Source: Mathematica analysis of 2013 survey of current and former HIP members.

General Perception of the Size of the Monthly Contribution

In the survey samples, 84 percent of current HIP members and 82 percent of former HIP members contributed to their POWER accounts. Among those who made a monthly contribution to their HIP POWER accounts, approximately three quarters of current HIP members felt that their monthly contributions were "the right amount," and nearly 85 percent believed the amount was either right or below the right amount. Former HIP members had the same perception of the contributions they made while enrolled; 74 percent believed they were the right amount and 82 percent believed they were either the right amount or below the right amount. Members' perception of their contributions varied by income, but the variation was not consistent between current and former members. Current HIP members with incomes at or below 100 percent of FPL were the group most likely to report the monthly contribution was the right amount or too low (87 percent). Whereas former HIP members with income at or below 100 percent of FPL were the least likely to report the amount was right or too low (79 percent). Those with income above 100 percent of FPL fell in between, with former HIP members in this income range more likely to report the monthly contribution was right or too low (84 percent) compared to current HIP members in the same income group (82 percent).

Table 6.6. Perception of Monthly Contributions

	All Respondents Who Made Monthly Contributions		≤100% FPL		> 100% FPL	
Perception of Monthly Contribution	Current Members	Former Members	Current Members	Former Members	Current Members	Former Members
Too much	14.3%	16.8%	11.9%	19.9%	18.6%	15.4%
The right amount	76.3%	73.5%	78.6%	71.9%	72.1%	74.4%
Below the right amount	8.6%	8.8%	8.2%	7.4%	9.4%	9.4%
Don't know	0.4%	0.7%	0.7%	0.5%	0.0%	0.9%

Source: Mathematica analysis of 2013 survey of current and former HIP members.

Notes: Approximately 14.2 percent of respondents to the survey of former HIP members did not provide income information. These respondents are included in the "all respondents" column, but not in those containing income breakdowns. The source information for income varied by survey sample. For current HIP members, income information came from HIP administrative records and was therefore the income at the time of the member's last annual redetermination. Respondents to the survey of former HIP members were asked to report their income at the time of the survey, which may have been different than the time during which they were enrolled.

Worries about Ability to Pay the Monthly Contribution

Current and former HIP members reported similar rates of worrying about having enough money to pay their monthly contributions (Table 6.7). Approximately 81 percent reported that they sometimes, rarely or never were worried about having enough money to pay their monthly contribution. Conversely, 17 percent of current HIP members and 19 percent of former members reported that they "always" or "usually" worried about having enough money to pay their monthly contributions. Income appears to have an important association with this type of worry among former HIP members. The percentage of former HIP members who reported they sometimes, rarely, or never worried about their monthly contributions ranged from 75 percent among those with income at or below 100 percent of FPL to 85 percent among those with income above 100 percent of FPL.

Table 6.7. Worries About Paying Monthly Contributions Among Members Who Made Monthly Contributions

	All Respondents Who Made Monthly Contributions		≤100% FPL		> 100% FPL	
Frequency of Worrying About Paying Contribution	Current Members	Former Members	Current Members	Former Members	Current Members	Former Members
Always/Usually	17.3%	19.0%	16.8%	24.8%	18.2%	14.7%
Sometimes	32.9%	32.0%	31.1%	34.1%	36.1%	29.6%
Rarely	18.9%	22.0%	19.0%	18.3%	18.9%	25.8%
Never	29.5%	27.0%	32.3%	22.8%	26.3%	29.9%
Don't know	0.7%	0.0%	0.9%	0.0%	0.4%	0.0%

Source: Mathematica analysis of 2013 survey of current and former HIP members.

Notes: Approximately 14.2 percent of respondents to the survey of former HIP members did not provide income information. These respondents are included in the "all respondents" column, but not in those containing income breakdowns. The source information for income varied by survey sample. For current HIP members, income information came from HIP administrative records and was therefore the income at the time of the member's last annual redetermination. Respondents to the survey of former HIP members were asked to report their income at the time of the survey, may have been different than the time during which they were enrolled. The questions posed to current HIP members and former members varied slightly. Members were asked how often they were worried about having enough money to pay their monthly contributions over the last 12 months. Former members were asked how often they were worried about having enough money to pay their monthly contribution while they were enrolled in HIP.

Former members were also asked to report how often they had worried about their medical expenses at the time of the survey. Overall, 54 percent of former members reported "always" or "usually" worrying about their medical expenses, which was much higher than the 19 percent who reported that they had "always" or "usually" worried about their monthly payments (Table 6.8). While former members with incomes above 100 percent of FPL were more likely than those at or below the FPL to report "rarely" or "never" worrying about either monthly payments or medical expenses, both groups reported worrying about current medical expenses more frequently than they had worried about their monthly payments.

Table 6.8. Former Members' Frequency of Worrying about Monthly Contribution and Medical Expenses

Frequency of Worrying About Payment/Expenses	All Respondents Who Made Monthly Contributions		≤ 100% FPL		> 100% FPL	
	Monthly Payment	Medical Expenses	Monthly Payment	Medical Expenses	Monthly Payment	Medical Expenses
Always/usually	19%	51.1%	24.8%	54.6%	14.7%[b]	49.2%
Sometimes	32.0%	23.7%	34.1%	23.1%	29.6%	24.7%
Rarely/never	49.0%	22.6%	41.1%	19.1%	55.7%	24.7%
Don't Know	0.0%	0.4%	0.0%	0.5%	0.0%	0.0%

Source: Mathematica analysis of 2013 survey of former HIP members.

Note: 14.2 percent of former members did not provide income information. They are included in the "all respondents" category but not in the categories providing income breakdowns. 2.9 percent of respondents who made monthly contributions did not provide information on their frequency of worrying about medical expenses.

At the time of the survey, over half of former members said that they were currently uninsured, while 22 percent had gained public insurance through Medicare or Medicaid and 20 percent had gained private

insurance through an employer or by purchasing an individual policy (Table 6.11). Individuals reporting income at or below 100 percent FPL at the time of the survey were more likely to have public insurance than private (27 percent versus 12 percent). Of those reporting income greater than 100 percent FPL, 13 percent reported having public insurance coverage, while 31 percent had private coverage. Former HIP members who were uninsured at the time of the survey were more than twice as likely as those with public or private insurance to say that they "always" worried about medical expenses. Uninsured former members below the FPL were more likely than those above the FPL to say they were "always" or "usually" worried about their medical expenses (74 percent versus 67 percent). Though the uninsured worried about medical expenses at far higher rates than those with insurance, individuals with public insurance were more likely than those with private insurance to say that they "rarely" or "never" worried about their medical expenses. Though higher-income individuals appear to worry less often about medical expenses than those with income at or below 100 percent FPL, the number of individuals in each income group is too small to provide reliable data.

Table 6.9: Former Members' Frequency of Worrying about Medical Expenses by Insurance Status

	All Respondents			≤ 100% FPL			> 100% FPL		
Frequency of Worrying About Medical Expenses	Uninsured	Public	Private	Uninsured	Public	Private	Uninsured	Public	Private
Always/Usually	69.4%	32.5%	35.7%	74.0%	35.6%	34.8%	67.1%	27.8%	33.5%
Sometimes	15.5%	30.3%	34.0%	12.7%	29.6%	45.8%	18.0%	34.2%	30.8%
Rarely/never	10.5%	37.2%	30.3%	8.8%	34.9%	19.5%	12.8%	38.0%	35.7%
Don't know	0.7%[b]	0.0%	0.0%	0.8%	0.0%	0.0%	0.0%	0.0%	0.0%

Source: Mathematica analysis of 2013 survey of former HIP members.

Note: 14.2 percent of former members did not provide income information. They are included in the "all respondents" category but not in the categories providing income breakdowns.

Willingness to Pay a Higher Monthly Contribution:

Current HIP members were overwhelmingly willing to pay more each month to remain enrolled in HIP (Table 6.10). Among those currently making monthly contributions, nearly 94 percent are willing to pay $5 more each month and 88 percent are willing to pay $10 more to remain enrolled in HIP. Among those members who were not making monthly contributions, 82 percent reported that they would be willing to pay $5 each month for HIP coverage, while 75 percent said they would be willing to pay $10 each month. Willingness to pay more was fairly consistent between income groups.

Table 6.10. Current Members' Willingness to Contribute More

	All Respondents		≤100% FPL		> 100% FPL	
Willingness to Contribute More	Current Contributors	Current Non-Contributors	Current Contributors	Current Non-Contributors	Current Contributors	Current Non-Contributors
Would pay $5 more	93.5%	81.7%	93.0%	81.4%	94.5%	85.0%
Would pay $10 more	88.1%	75.0%	87.7%	74.8%	88.6%	77.2%

Source: Mathematica analysis of 2013 survey of current and former HIP members.
Notes: Former members were not asked whether they would have paid more to remain in the program.

Program Costs and Disenrollment

Among those surveyed members who disenrolled from HIP within the past year, program costs were only cited by 14 percent as the reasons for disenrolling (Table 6.11). More commonly, former members indicated they did not follow the requirements necessary to redetermine their eligibility (28 percent) or obtained other insurance (14 percent obtained other public insurance such as regular Medicaid or Medicare and 12 percent obtained private coverage). Twelve percent disenrolled because they forgot to pay their monthly contribution (data not shown and subsumed in the group that did not follow the requirements necessary to redetermine eligibility).

Some variation by income was observed, with 19 percent of former members at or under 100 percent FPL reporting that they left due to cost, compared with 9 percent among those above 100 percent of FPL (Table 6.11). In addition, former members at or under 100 percent FPL were disproportionately more likely to have left because they gained other public insurance (Medicare or Medicaid), while those above 100 percent FPL were disproportionately more likely to have gained private insurance.

Table 6.11. Former Members' Reasons for Disenrolling from HIP

Reason for Leaving HIP	All Respondents	≤ 100% FPL	> 100% FPL
Cost too much	14.2%	19.0%	8.8%
Didn't complete paperwork in time/ Forgot to re-enroll/Forgot payment	28.3%	30.7%	27.3%
Process issue	8.6%	9.3%	6.6%
Gained other public insurance	13.5%	16.5%	8.7%
Gained private insurance	12.3%	7.8%	18.8%
Reported other unspecified insurance	7.3%	8.1%	7.3%
Increase in income	10.1%	5.7%	16.1%
Other	10.9%	9.9%	9.9%

Source: Mathematica analysis of 2013 survey of former HIP members.

Note: Respondents had the option to select more than one reason for disenrolling in HIP. 14.2 percent of former members did not provide income information. They are included in the "all respondents" category but not in the categories providing income breakdowns. Former members were asked to report their income at the time of the survey, may have been different than the time during which they were enrolled.

Emergency Room Copayments

Current HIP ER co-payments range from $3 to $25, depending on caretaker status and income. Overall, 72 percent of members did not utilize the ER within the six months prior to the 2013 Mathematica survey (Table 6.12). Of the 28 percent of members who went to the ER at least once in this time frame, 60 percent reported that they were never asked to pay a copayment, while 28 percent said that they were asked to pay each time. Of the members who were asked to pay a copayment, 79 percent reporting being

able to pay it. While this ability appeared to vary by income (with more individuals at or below 100 percent FPL reporting an inability to pay the copay), the number of individuals asked to pay a copay was extremely small, and when this group was further broken down by income, the number of individuals in each category became too small to produce reliable estimates. Survey respondents were also asked whether the ER copayment policy ever caused them to decide not to go to the emergency room. Less than seven percent of members reported that they avoided the ER because of the copayment (data not shown).

Table 6.12. Emergency Room Copayments and Current Members' Use of the Emergency Room

ER Copayment and Usage	Respondents
Percent of members who went to ER in past 6 months	27.8%
Of members who decided not to go to ER because of the copayment	
Got care someplace else	39.7%
Did not get care	60.3%
Of members who went to ER in past 6 months	
Asked to pay a co-pay every time	27.9%
Sometimes asked to a pay a co-pay	5.0%
Never asked to pay a co-pay	59.5%
Admitted to hospital each time	5.0%
Don't know	2.6%
Of members asked to a make a co-pay	
Able to pay it	78.8%
Not able to pay it	21.2%
Don't know	0.0%

Source: Mathematica analysis of 2013 survey of current HIP members.

When asked their thoughts on paying a $25 co-payment to go to the emergency room, the majority of current non-caretaker members (68 percent) reported that it is the right amount or below the right amount, while approximately a third (31 percent) said that it is too much (Table 6.13). This perception varied by income, with 36 percent of members at or under 100 percent FPL saying this would be too much, compared to 22 percent of members above 100 percent FPL.

Table 6.13. Perception of $25 Copayment, By Income

Perception of a $25 ER Copayment	All Respondents	≤ 100% FPL	> 100% FPL
Too much	31.4%	35.7%	22.3%
The right amount	62.6%	58.3%	71.8%
Below the right amount	5.0%	4.9%	5.2%
Don't know	0.9%	1.0%	0.7%

Source: Mathematica analysis of 2013 survey of current HIP members.

6.3 GOAL III – PROMOTE VALUE-BASED DECISION-MAKING AND PERSONAL HEALTH RESPONSIBILITY

HIP employs a number of financial incentives in an effort to encourage members to become thoughtful health care purchasers and active participants in maintaining or improving their health. These incentives begin upon enrollment, when most HIP members are required to contribute to the cost of their care by making monthly contributions to their POWER accounts.

To assess the goal of value-based decision-making, the 2013 survey asked current and former HIP members about their knowledge of HIP program policies and incentives. The survey sought to assess whether members were knowledgeable about (1) the POWER account feature; (2) the status of their own POWER account; (3) incentives built into the program to encourage preventive care, such as rollovers; and (4) incentives built into the program to discourage non-emergent use of the ER. Key findings include:

- Most HIP members had heard of the POWER account, and many check the balance in their account at least monthly.
- More education is necessary to ensure that HIP members fully understand the link from securing preventive care to receiving a rollover to benefiting from reduced monthly contributions.
- Most respondents were aware of the required ER copayment. However, of the respondents who utilized the ER, the majority were not asked to make a copayment.

A. POWER ACCOUNT CONTRIBUTIONS

In 2013, about 72 percent of those eligible for HIP were required to make contributions to their POWER account. This rate has increased since 2008, when 65 percent of members were required to make a contribution.

Employers may pay for a portion of the employees' monthly contributions. Health plans provide information for members to give their employers about their ability to provide HIP subsidies for employees, however, few have taken up this option. In 2013, employers contributed $8,763 on behalf of 29 Anthem members, for an average employer contribution of $302. MDwise had employers contribute $4,158 to POWER accounts for 15 HIP members for an average employer contribution of $277. MHS received $1,108 from employers for four members, for an average employee contribution of $277.

Mathematica's 2013 survey of current members asked respondents about their experiences requesting employer assistance with the monthly contributions. Forty-one percent of currently employed members reported that they were aware that employers could help pay their monthly contributions (Table 6.14). Among those aware of the employer option, 83 percent of members with incomes at or below 100 percent FPL and 67 percent with incomes above 100 percent FPL reported that they had not asked their employers for assistance. Across income groups, the most popular reason for not asking was that members were confident that their employers would say no. Of the members who asked their employers for assistance, 92 percent reported that their employers had said no.

Table 6.14. Member Experiences Requesting Employer Assistance With Monthly Contributions

Member Experiences with Employer Assistance	Currently Employed Respondents	≤100% FPL	>100% FPL
Aware that employers could help pay monthly contribution			
Yes	41.0%	40.3%	42.0%
No	53.6%	53.6%	53.7%
Don't Know	1.5%	1.8%	0.9%
Of those aware, have asked employer to help pay monthly contribution			
Yes	23.1%	17.4%	30.9%
No	76.0%	82.6%	66.9%
Don't Know	0.0%	0.0%	0.0%
Of those who asked, employer response			
Agreed to pay all of contribution	8.0%	9.3%	7.1%
Agreed to pay part of contribution	0.0%	0.0%	0.0%
Did not agree to contribute	92.0%	90.8%	92.9%
Still deciding	0.0%	0.0%	0.0%
Other	0.0%	0.0%	0.0%
Don't Know	0.0%	0.0%	0.0%
Of those who did not ask, reason for not asking[a]			
Didn't know who to ask	2.4%	3.9%	0.0%
Afraid of losing my job/Asking may jeopardize my job	9.2%	9.2%	9.2%
Confident my employer would say no	40.0%	33.4%	50.9%
Didn't want employer to know I'm on HIP	3.4%	3.7%	3.0%
Felt like I was asking for a favor	4.7%	5.7%	3.0%
Other	2.3%	1.8%	3.3%
Don't know	7.2%	7.2%	0.0%

Source: Mathematica 2013 survey of current HIP members.

[a]Members were allowed to select more than one reason for not asking their employer.

B. HIP DISENROLLMENTS

HIP uses the POWER account to promote value-based decision making and personal health responsibility among its members. Of the 145,108 Hoosiers found eligible for HIP during the six-year demonstration, 114,241 individuals (79 percent) made their first POWER account payment and fully enrolled in the program, while the remaining 30,867 individuals who were otherwise found eligible did not. Nonpayment of the first POWER account contribution was much more common early on when the program was new; now that awareness of the HIP program is higher statewide, more understand and find value in making their first contribution (94% made their first contribution in 2013).

Over the six-year period, 16,064 HIP members (14 percent of those ever fully enrolled) left the program for failure to make a subsequent POWER account contribution.

Table 6.15: Summary of Denials and Disenrollments Associated with Monthly Contributions, 2008-2013

Types of Denials and Disenrollments	2008-2013
Number determined eligible for HIP	145,108
Number ever enrolled in HIP	114,241
Percent of those found eligible who enrolled	79%
Number who left HIP for failure to make a subsequent POWER account contribution	16,064
Percentage of those ever enrolled who left HIP for failure to make a subsequent POWER account contribution	14%

Source: OMPP Data Management & Analysis

In 2013, most HIP disenrollments occurred after a member did not return his or her HIP re-determination packet. Failure to make a required POWER account payment was the second leading reason for HIP members leaving the program in 2013. HIP accounts were closed for 3,382 members in 2013 when they failed to make a required payment.

Table 6.16 Top Five Types of HIP Member Accounts Closed CY 2013

Member Count	Denial Reason
4,839	HIP Redetermination Packet not Returned
3,832	Failure to Make Payment to POWER Account
3,440	HIP Closure Due to Ruling of Appeals Judge
1,842	Failure to Cooperate in Verifying Income
1,565	Individual Fails to Complete Redetermination

Source: OMPP Data Management & Analysis

C. POWER ACCOUNT ROLLOVERS

The majority of HIP members who were involved in the POWER account rollover process during calendar year 2013 did not have an account balance left after 12 months because they exhausted their POWER accounts over the course of the year, which is a reflection of high level of chronic disease burden in the HIP population. Of those who did have a balance, the majority received a partial rollover (their own contributions were rolled over, but not the State's). A full rollover (member contributions plus those of the state) is received if the members meet the preventive care receipt requirement. The members who do not exhaust their POWER accounts, meaning they have a balance left at the end of 12 months, may be healthier than those who do exhaust their POWER account, so the observed lower rate of preventive care receipt might be due to a perception of lack of need. The MCEs continue to work to promote the preventive care incentive and develop member awareness and understanding of how the POWER account works. By the end of 2013, about one-third of POWER accounts eligible for a rollover over the course of the demonstration contained any funds to carry forward after 18 months of enrollment. Of the accounts with a remaining balance, 69.7 percent received partial rollovers and 30.3 percent received full rollovers.

D. MEMBER KNOWLEDGE OF POWER ACCOUNTS

The POWER account is structured to incentivize the use of preventive services among HIP members by reducing their future monthly contributions if they obtain appropriate preventive services, available at no cost. Members who do not use their entire POWER accounts during the course of a year will have the remainder of the account "rolled over" to the next year. All members with money left in their accounts receive a rollover of any remaining portion of their individual contributions. State subsidies are also rolled over, as long as members have met their preventive services requirements. The amount rolled over is then used to reduce the member's future monthly contributions.

Consider the following example:

A member contributes $400 to the POWER Account over the course of a benefit period and the State contributes $700, for a combined contribution of $1,100 ($400 + $700 = $1,100). The member spends $450 of POWER Account funds to pay for covered services during the benefit period. At the end of the benefit period, $650 remains in the member's POWER Account ($1,100 -$450 = $650). One of the following outcomes applies:

- If the member obtained the preventive care services recommended by the State for his or her age, gender, and pre-existing conditions before the end of the benefit period, the entire $650 POWER Account balance will be available for rollover and used to reduce the member's required POWER Account contribution in the upcoming benefit period up to the amount of the next year's required contribution.

- If the member did not obtain the preventive care services recommended by the State for his or her age, gender, and pre-existing conditions before the end of the benefit period, only the member's *pro rata* share of the remaining POWER Account balance will be rolled over. In this case, the member's *pro rata* share would be $234 (because the member paid 4/11 or 0.36 of the POWER Account contribution, he or she would receive 0.36 of the remaining balance. So, 0.36 x $650 = $234). $234 is available to be rolled over and used to reduce the member's required POWER Account contribution in the upcoming benefit period up to the amount of the next year's required contribution. The MCE must credit the remaining balance of $416 ($650 – $234 = $416) to the State.

For the incentive structure to work as intended, members must understand the POWER account and the program's mechanisms for reducing their monthly contribution. Maximus, the state's enrollment broker, strives to explain the HIP program and POWER account to enrollees. However, the health plans noted that new members continue to have many questions after enrolling in HIP.

Mathematica's 2013 survey evaluated the extent to which current and former HIP members understood the POWER accounts and the HIP program incentives. Key findings include:

- More than three-quarters of current members had heard of the POWER account.
- Among current members, nearly 60 percent reported checking their POWER account at least monthly.
- More education is needed for members to fully understand program incentives. Most members believed that the cost of preventive screenings would be deducted from their POWER accounts,

and many appeared unaware of the connection between the receipt of preventive services and POWER account rollovers.

Familiarity with the POWER Account

Familiarity with the POWER account was high among survey respondents. Three-quarters (77 percent) of current HIP members reported that they had heard about the POWER account (Table 6.17). This rate was slightly lower among former members (67 percent). When asked how they had learned about the POWER account, current and former members offered similar answers. The most common methods for learning about the account included the member handbook and "the health plan," though smaller percentages said they had learned about it through the HIP Web site or because "someone from the plan had called them to explain."

Table 6.17. Knowledge of POWER Account

POWER Account knowledge	Current HIP Members	Former HIP Members
Had ever heard or learned about the POWER Account		
Yes	76.5%	67.0%
No	22.1%	27.2%
Don't Know	1.4%	5.8%
Of those who had heard of the POWER account, methods of learning about the POWER account[a]		
Member handbook	44.2%	44.0%
Someone from the plan called to explain	14.4%	16.5%
HIP Web site	12.4%	9.6%
Health plan	40.5%	40.2%
Medical provider	4.7%	4.8%
Family/Friends	6.6%	3.6%
None of these	7.0%	6.4%
Don't know	1.3%	1.6%

Source: Mathematica analysis of 2013 survey of current and former HIP members.

[a]Respondents were allowed to select more than one method they used to learn about the POWER Account.

Knowledge of POWER Account Balance

Three quarters of current HIP members had heard of the POWER account, while nearly 60 percent of these respondents checked their account balance at least monthly (Table 6.18). Forty-seven percent reported an account balance at or below $1,100, while the remainder said they either did not know their balance, or reported an amount above $1,100 (the maximum amount for a POWER account).

Table 6.18. Knowledge of POWER Account Balance Among Current Members

Knowledge of POWER Account Balance	All Respondents Who Had Heard of POWER Account	≤100% FPL	> 100% FPL
Frequency with which member checks POWER account balance			
Weekly	0.6%	0.9%	0.0%
A few times a month	2.8%	2.9%	2.4%
Monthly	54.9%	53.5%	57.9%
A few times a year, not every month	13.3%	12.3%	15.4%
Once a year	5.3%	5.3%	5.4%
Never	21.1%	23.0%	16.9%
Don't know	1.9%	1.8%	2.0%

Source: Mathematica analysis of 2013 survey of current HIP members.

Knowledge of POWER Account Rollovers

Forty eight percent of current members who had heard about the POWER accounts reported that they had funds left over in their POWER Account at their last HIP renewal date, which would have made them eligible for a rollover (data not shown). About 22 percent had exhausted their POWER account and did not have any funds to roll over and thirty percent of members did not know if they had funds left in their account at the last renewal date. Because so many of those who did not know may have only recently renewed their coverage at the time of survey, this section assesses respondents' history of POWER account rollovers over their entire membership in the program.

When members who had heard about the POWER accounts were asked specifically if they had ever received a rollover during their HIP membership, 39 percent reported that they had, one-third said they had not, and 28 percent did not know (Table 6.19). Current members were more likely to report receiving a rollover compared to former members (39 percent compared to 24 percent) and members in the higher income group were more likely to receive a rollover than those in the lower income group.

Table 6.19. Knowledge of Effect of Rollover on Monthly Contributions, Among Current and Former Members

	Current Members Who Had Heard of the POWER Account			Former Members Who Had Heard of the POWER Account		
Knowledge of Rollover Effect	All	≤100% FPL	> 100% FPL	All	≤100% FPL	> 100% FPL
Ever received a rollover						
Yes	39.2%	38.1%	41.4%	24.1%	22.8%	28.3%
No	32.1%	32.7%	31.4%	60.1%	59.6%	58.9%
Don't know	28.4%	29.2%	26.7%	15.0%	17.7%	12.0%
Of those reporting a rollover, knew rollover affected size of monthly contributions						
Yes	37.3%	30.6%	50.7%	34.8%	34.9%	38.5%
No	50.3%	55.6%	39.7%	58.9%	61.8%	57.6%
Don't Know	12.4%	13.8%	9.6%	6.3%	3.3%	3.9%
Of those who knew that rollover affected amount of required monthly contribution						
Reported their monthly contributions went down	41.5%	40.1%	43.2%	64.3%	93.0%	48.8%
Reported they no longer had to pay	45.0%	41.2%	50.0%	29.7%	7.0%	41.0%
Reported their monthly contributions went up/ Did not know	13.5%	18.7%	7.2%	5.9%	0.0%	10.2%

Source: Mathematica analysis of 2013 survey of current HIP members.

Understanding of Relationship between Rollovers and Monthly Contributions

Whether a current member remembered that his or her POWER account rollover affected the size of subsequent monthly contribution was closely related to their income. Overall, half of current members who reported receiving a rollover reported the rollover did not affect their monthly contribution, while 12 percent were not sure whether the rollover had affected their contribution (Table 6.19). However, members with income above 100 percent FPL were significantly more likely than those at or below poverty to report that their rollover had affected their monthly contribution (51 percent versus 31 percent, with a p value of .0018).

Of those current members who knew that their rollover had affected their monthly contribution, most (87 percent) reported that their contribution had been reduced or had been eliminated completely. The rest either did not know how their monthly contribution was affected or reported that their monthly contribution increased as a result of the rollover.

Knowledge of Preventive Services Incentive

The survey data suggests that most current members may not be aware of the HIP policy that would allow them to get no-cost preventive care. This policy, designed to provide a financial incentive for members to obtain preventive services, allows members to obtain preventive services without having the cost deducted from their POWER accounts. When members were asked if they thought "the cost of

preventive services like annual exams" would be deducted from their POWER account, 71 percent of members believed they would be deducted (Table 6.20). A similar proportion also thought that "the cost of preventive services like cancer screenings" would be deducted from the account.

Table 6.20. Current Member Knowledge of Preventive Services Policies

Knowledge of Preventive Services Policies	All Respondents Who Had Heard of POWER Account	≤100% FPL	> 100% FPL
Believe cost of preventive services like annual exams would be deducted from POWER account	71.3%	71.1%	71.6%
Believe cost of preventive services like cancer screening would be deducted from POWER account	72.6%	73.1%	71.3%

Source: Mathematica analysis of 2013 survey of current HIP members.

However, HIP allows the health plans to place a $500 cap on the amount of no-cost preventive services members can obtain. To date, only Anthem has imposed this cap, so members of this plan may be aware of this limit. A breakdown of results by health plans reveals that Anthem members were slightly more likely than MDwise members to believe that the cost of preventive services would be deducted from their accounts (Table 6.21). The number of MHS members in the sample was too small to draw conclusions, though they appeared to be the least likely to believe the cost of preventive exams would be deducted from their POWER accounts.

Table 6.21. Current Member Knowledge of Preventive Services Policies, By Plan

	Anthem			MDwise			MHS		
Knowledge of Preventive Services Policies, Among Those Who Had Heard of POWER Account	All	≤100% FPL	>100% FPL	All	≤100% FPL	>100% FPL	All	≤100% FPL	>100% FPL
Believe cost of preventive services like annual exams would be deducted from POWER account	72.4%	72.9%	71.2%	68.7%	67.3%	72.7%	56.9%	49.6%	100.0%
Believe cost of preventive services like cancer screening would be deducted from POWER account	75.0%	77.5%	70.0%	68.0%	66.3%	72.7%	63.9%	57.7%	100.0%

Source: Mathematica analysis of 2013 survey of current HIP members.

Knowledge of Connection between Preventive Care and Reduction of Monthly Contributions: The knowledge of current HIP members and their understanding of the link between preventive care receipt and POWER account rollovers and the reduction of their monthly contribution is mixed (Table 6.22). When those who had heard about the POWER account were asked how the receipt of preventive care services affected the POWER account rollover, if there was money to rollover to the next year, approximately one-quarter reported that getting preventive services would qualify them for a rollover.

More than half indicated that they were not sure how preventive services affected the rollover, while 14 percent thought that preventive services did not affect the rollover.

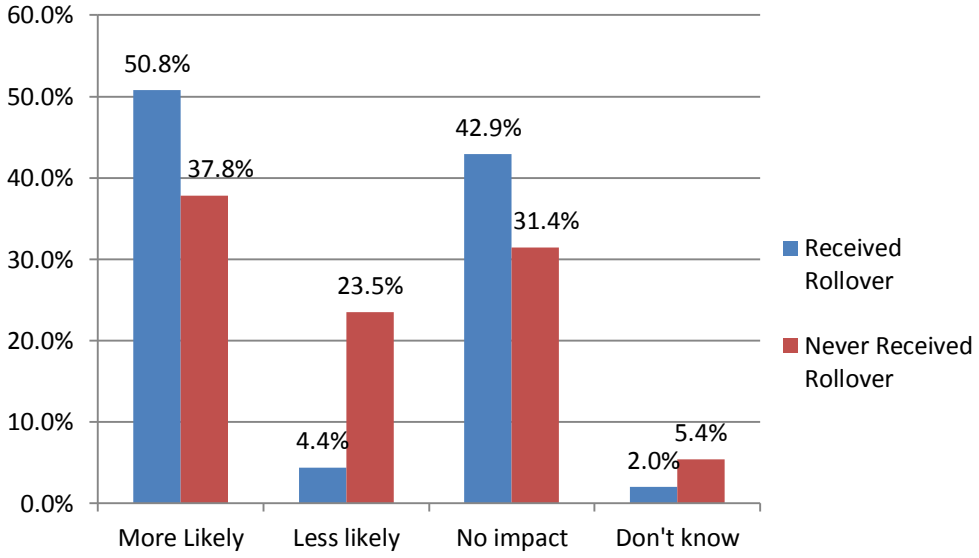
Table 6.22: Knowledge and Effects of Connection between Preventive Care and Rollover Receipt among Current Members Who Had Heard of POWER Account

Knowledge/Effects of Rollover Policies	Current Members Who Have Heard of the POWER Account	≤100% FPL	> 100% FPL
Understanding of relationship between preventive services and rollover			
Know that preventive services affect POWER account rollover	26.3%	24.4%	30.3%
Not sure how preventive services affect POWER account rollover	53.6%	53.8%	53.5%
Believe preventive services do not affect POWER account rollover	13.7%	14.1%	13.7%
Don't know	6.1%	7.5%	3.0%

Source: Mathematica analysis of 2013 survey of current HIP members.

Among the 39 percent of current members who had experienced a POWER account rollover, about half reported that the rollover had made them more likely to get preventive care and 43 percent reported that it had no effect on their decision to obtain preventive care. Notably, very few members reported that receiving a rollover would make them less likely to get preventive care in the future. Members who reported never having received a rollover were split on whether the experience of not receiving a rollover would incentivize them to get preventive care in the future. Approximately 38 percent reported that not receiving a rollover had made them more likely to get preventive care in the future (Figure 6.5). About one quarter of these individuals reported that the experience of not receiving a rollover would make them less likely to get care in the future, while nearly a third reported it would have no effect. Within this group of members who had never received a rollover, some differences by income were apparent, but the sample sizes are too small for reliable estimates.

Figure 6.5: Likelihood of Seeking Preventive Care by Receipt of a POWER Account Rollover



Source: Mathematica analysis of 2013 survey of current HIP members.

Note: The estimates for the group that received a rollover and reported that the rollover made them less likely to seek preventive care and those responding they did not know how the rollover affected their likelihood of seeking preventive care may be unreliable because the information is based on less than 30 respondents.

E. EMERGENCY ROOM USAGE

The HIP program requires members to make co-payments when they utilize the emergency room (ER) for non-emergent health issues. This policy is intended to encourage appropriate utilization of primary care and discourage inappropriate and costly ER use. In 2013, these co-payments varied from $3 to $25 depending on an individual's caretaker status and his or her federal poverty level (FPL). ER co-payments cannot be deducted from the member's POWER account and must be paid out-of-pocket. Additionally, HIP members are provided with explanations of benefits for all healthcare services, including ER visits, which increase member awareness of the cost of services.

Emergency Room Usage in 2013: Administrative Data

According to 2013 claims data, the top reasons for ER visits were fairly similar across the three MCE's, with abdominal pain, chest pain, and headaches emerging as some of the most common (Table 6.23).

Table 6.23. Top 5 Reasons for ER Visits, by Managed Care Entity

Anthem	MDwise	MHS
1. Abdominal Pain	1. Chest Pain	1. Chest Pain
2. Chest Pain	2. General Abdominal Pain	2. General Abdominal Pain
3. General Symptoms	3. Headache	3. Headache
4. Urethra and Urinary Tract Pain	4. Abdominal Pain with Specified Site	4. Abdominal Pain with Specified Site
5. Digestive System Symptoms	5. Lumbago	5. Lumbago

Source: Anthem, MDwise, and MHS

During 2013, 14,989 unique HIP beneficiaries made one or more trips to the emergency room (30 percent of total enrollees). This figure includes ESP (Enhanced Service Plan) HIP members. ESP is comprised of individuals with the highest risk in the HIP population and was designed to lower health plan risk and reduce capitation rates. Members have high-risk conditions (such as cancer, HIV/AIDS, and hemophilia), or have had an organ transplant or are on the waiting list, and tend to incur high healthcare costs. In contrast, 39 percent of adult Hoosier Healthwise (HHW) members (pregnant women and low-income parents) visited the ER at least once in 2013. HHW members are not required to make co-payments for inappropriate ER use, which may partially explain the overall lower rate of ER use among HIP members.

Table 6.24 illustrates the total number of HIP and HHW member visits to the ER. During CY 2013, HIP members had fewer emergency room visits per 1,000 members than HHW adult members, Additionally, HIP members who were required to make contributions to their POWER accounts visited the ER at a lower rate than those HIP ESP and HHW members who were not required to make contributions. HIP ESP members likely use the ER at higher rates compared to other HIP populations due to their high-risk conditions.

Table 6.24. Adult Emergency Room Visits, HIP and Hoosier Healthwise, 2013

	HIP ESP	HIP Contributors	HIP Non-Contributors	Hoosier Healthwise
Total Members in 2013	1,963	37,691	9,744	196,060
Total number of unique individuals who visited the ER in 2013	797	10,879	3,313	75,632
Percent of unique enrollees who visited the ER in 2013	41%	29%	34%	39%
Total Number of ER Visits, 2013	2,091	20,654	7,352	178,401
Average Visits per Unique Recipient*	2.6	1.9	2.2	2.4
Annual Emergency Room Visits per 1,000 members	1,320	746	1,020	1,509

Source: Milliman analysis of 2013 claims
*Of those who visited the ER in 2013

Emergency Room Usage, As Reported By Members

Among the respondents to the 2013 survey of current HIP members, twenty-eight percent reported that they had made at least one trip to the ER in the six months prior to the survey (Table 6.25). Of those who used the ER, eight percent reported that they had tried to make an appointment with a doctor or clinic, but had not been able to get one fast enough, and chose to go to the ER instead (data not shown). However, the majority of members using the ER were not high-frequency users. Of those who used the emergency room, the majority (64 percent) made only one trip, with 22 percent reporting two trips, and only 14 percent reporting three or more trips (Table 6.25).

Table 6.25. Use of Emergency Room In the Past Six Months, Among Current Members

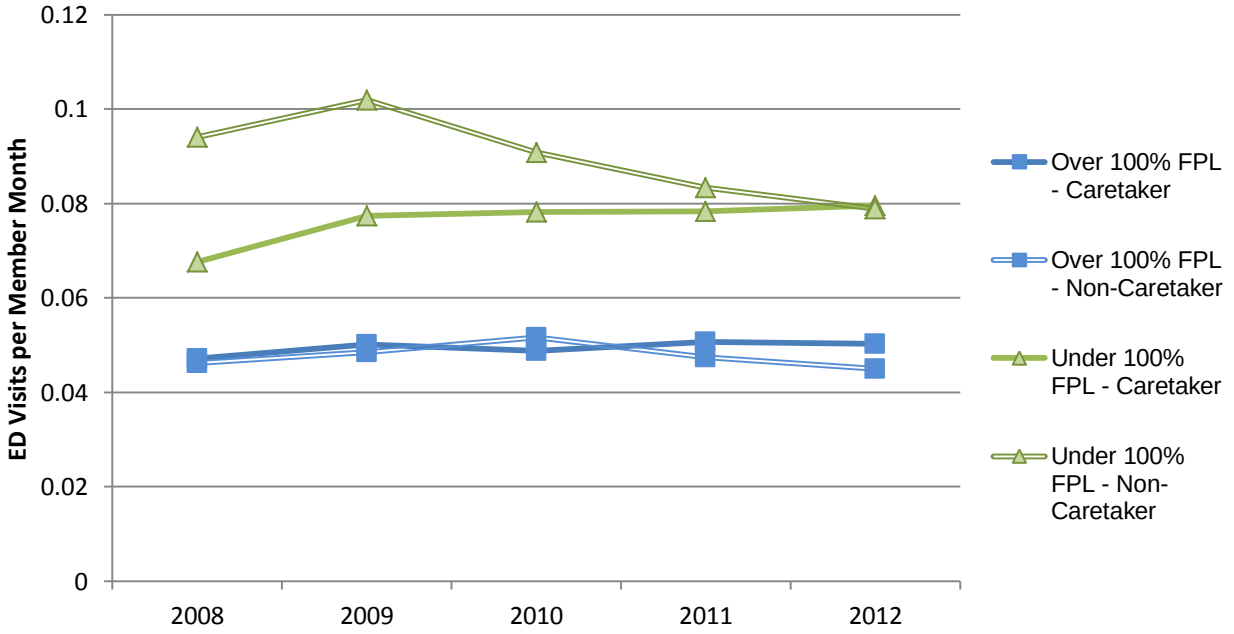
Access to ER Care	All Respondents	≤100% FPL	> 100% FPL
Percent of members who went to ER in past 6 months	27.8%	27.8%	27.8%
Of those who went to ER in past six months, number of trips made			
1 trip	64.4%	62.6%	69.5%
2 trips	21.7%	23.9%	16.2%
3 or more trips	13.7%	13.5%	14.3%
Don't know	0.8%	0.0%	1.1%
Number of times admitted to hospital after going to ER			
0 times	72.9%	74.7%	67.9%
1 time	22.1%	20.3%	27.4%
2 or more times	5.0%	5.0%	4.7%
Don't know	0.0%	0.0%	0.0%

Source: Mathematica analysis of 2013 survey of HIP members.

Self-Reported ER usage trends

Although trends in ER use have been relatively steady throughout the demonstration, several aspects of these trends are notable. As Figure 6.6 indicates, ER utilization rates are associated with income and those in the higher income group used the ER at a lower rate throughout the five years of the HIP program than those in the lower income group. It is also notable that during the first three years, from 2008 through 2010, the non-caretakers with income at or below 100 percent of FPL first increased and then decreased their use of the ER, eventually having a similar ER use rate as caretakers in the same income group. This data does not distinguish between emergent and non-emergent visits and it is unclear whether the changes are due to changes in non-emergent visits.

Figure 6.6 Rate of Emergency Room Visits per Member per Month, 2008 through 2012 (self-reported)



Source: Mathematica analysis of 2013 survey of HIP members.

Note: 2013 data not surveyed

HIP Strategies for Reducing ER Use for Non-Emergent Care: Copayments

In an effort to discourage non-emergent use of the ER and encourage members to seek care from a doctor or clinic, HIP asks members to make a copayment each time they seek care in the emergency room. This copayment is then refunded to caretaker adult HIP members if the visit was later determined to be a true emergency (non-caretakers must make the copay in any case). The majority of respondents (68 percent) reported that they had been informed about the copayment by their health plan, and 5 percent indicated that the copayment had caused them to wait to seek care from a doctor or clinic instead of using the ER (Table 6.26).[5]

[5] Respondents to the 2013 survey of current HIP members were asked the following question, "Has the emergency room co-payment ever caused you to wait to get care from a doctor's office or clinic instead of going to the emergency room?"

Table 6.26. Effect of ER Copayments on Care-Seeking Behavior

Effect of ER Copayments	Total	≤100% FPL	> 100% FPL
Reported being informed by health plan about ER copayment	67.7%	65.9%	71.6%
Of those informed about copayment, reported ER co-payment caused member to wait to get care from doctor or clinic instead of using ER			
Yes	5.4%	6.0%	4.0%
No	92.7%	92.4%	93.3%
Don't know	1.4%	1.2%	2.0%

Source: Mathematic analysis of 2013 survey of HIP members.

Although representatives from Anthem assumed that hospitals regularly collect HIP co-pays, MHS and MDwise staff expressed uncertainty about whether hospitals chose to collect them, due to the administrative burden of collecting small co-payments. Plans also noted the difficulty inherent in refunding copayments to members after ER visits were determined to be true emergencies. Overall, about one-third of current HIP members reported they were sometimes or always asked to pay the ER copayment and two-thirds were never asked (Table 6.27).

Table 6.27. Incidence of Requested ER Copayments, By Health Plan

Requested to Pay ER Copayment	Total	Anthem	MDwise	MHS
Sometimes or always asked to make ER copayment	32.9%	34.5%	26.9%	33.3%
Never asked to make ER copayment	64.5%	63.6%	67.2%	66.7%
Don't Know	2.6%	1.9%	5.9%	0.0%

Source: Mathematic analysis of 2013 survey of HIP members.

Table 6.28. Emergency Room Copayments, by Caretaker Status

Emergency Room Copayments	Caretaker	Non-Caretaker
Sometimes or always asked to make ER copayment	27.2%	38.8%
Never asked to make ER copayment	69.3%	59.5%
Don't Know	3.5%	1.7%

Source: Mathematic analysis of 2013 survey of HIP members.

Health Plan Strategies to Reduce ER Use for Non-Emergent Care
In addition to charging co-payments, each of the MCEs also engage in efforts to reduce non-emergent use of the ER.

Anthem
Anthem's efforts to reduce non-emergent use of the emergency room (ER) focused on providing education to its members about the appropriate use of emergency room services. Anthem developed and moved to a new system that allowed for less lag time between the plan and providers. Anthem completed 120 provider visits in the first two quarters of 2013 in order to review ER utilization with the providers and to distribute emergency room brochures that documented efficient uses. Anthem also utilized a call system and mass mailings in order to reach more members to teach proper ER usage. For example, about 2,800 calls were made in June of 2013.

Anthem also further developed a pilot program that focused on members who are repeat users of the ER within a 30 day period. The program targets the top ER diagnoses that are the highest risk of a bounce back visit and contacts the member in order to schedule an appointment with a provider and provide further education. Anthem also maintained their 24 hour nurse hotline that members are encouraged to use if they have any question regarding an ER visit and to be referred to services with a nearby primary care provider.

MDwise
MDwise had a stated goal of reducing ER utilization for members with frequent emergency room visits as well as discouraging ER visits for non-emergent reasons. Multiple objectives were outlined in order to meet this goal. By using targeted care management and case management for members that are frequent users of the emergency room, MDwise hoped to increase education amongst its members about alternatives to ER usage, such as going to the primary care physician instead. Correlated with this objective was receipt of feedback from the plan's contracted ERs as to the reasons members were utilizing these services and steps that could be taken to minimize inappropriate usage.

MDwise's ER initiative was based on information it gets from the Indiana Health Information Exchange (IHIE). The IHIE receives notifications of ER visits on a daily basis from five hospitals in Marion County. ER visits for MDwise members are forwarded to the plan for follow-up. A registered nurse at MDwise triages all notifications and identifies those with non-urgent symptoms. The nurse assigns a portion of these cases to care management for follow-up and the remaining are referred for follow-up by an automated call system. For the automated call system, MDwise contracted with a vendor that received a list of those members selected for a follow-up call. The vendor attempted to contact each member on the list at least three times, within two to four weeks of the ER visit. Once reached, the vendor followed an approved script. The script advised the member that MDwise was following up after an ER visit and identifies the date(s) of the visit. The call is interactive, requiring the member to answer a question about whether they called their doctor prior to going to the ER. It reminds the member of the plan's 24-hour nurse line and the importance of calling this line with questions about a perceived medical emergency. MDwise has been conducting these calls since 2010. This exchange has been used successfully since 2010 as a pilot and in 2013 was expanded to be used statewide. Along with the use of IHIE, MDwise seeks to create additional pilots with local hospital emergency rooms in order to redirect members to primary care instead of using the emergency room.

MHS

MHS specifically targeted Healthy Indiana Plan members that had three or more emergency room visits within a 6-month time period in order to further ascertain the cause for continued use of the emergency room. MHS case managers receive "ER Bounce Back Reports" detailing information for Healthy Indiana Plan members who utilize the ER more often than they should so that MHS staff can contact the individual and provide education. At this point, the case manager also attempts to enroll the member into the MHS' case management program. The case manager can then work with the member to further identify the root causes of the high rates of emergency room usage. MHS has found that contact via phone, home visits with members, and face to face encounters on site at the emergency room, are successful strategies to educate consumers about alternatives to inappropriate emergency room visits.

6.4 GOAL IV – PROMOTE PRIMARY PREVENTION

HIP encourages the use of preventive services by allowing members to obtain the first $500 worth of services without having to utilize their POWER account funds.[6] It also ties POWER account rollovers, and reductions in future monthly contributions, to the utilization of recommended preventive care.

To determine whether HIP has promoted the use of primary preventive services, the analyses below assess general patterns of preventive care use among different groups of HIP members. This is done by using the POWER account reconciliation process criteria for members who started eligibility periods in 2009 and in subsequent years. Completion of an annual wellness visit or any of the age-appropriate preventive services is recommended by the State.

In addition, Mathematica's 2013 survey of current members asked respondents about their receipt of preventive care and their overall knowledge of preventive care policies. Survey questions asked current members about the length of time since they had received a routine check-up, their knowledge of the preventive services that HIP wanted them to receive, and their plans to obtain these preventive services before the end of their benefit period.

Findings include:

- Women are far more likely than men to receive at least one preventive care service. Among both women and men, the likelihood of receiving at least one service increases with age.
- Members required to contribute to the POWER account receive preventive care at higher rates than those not required to contribute to the POWER account.
- Individuals at or below 100 percent of the FPL are slightly less likely to receive at least one preventive care service compared to those at higher income levels.
- Though 85 percent of survey respondents reported receiving a "routine check-up" in the past year, Milliman's assessment of HIP claims records indicate that only 36 percent of current members received a general physical exam in 2013. This discrepancy may be due to a difference in how members perceive a "routine check-up," versus how HIP or physicians may code for their services in a billing record.

[6] MDwise and MHS both allow their members to receive unlimited preventive care services, without any amount being deducted from their POWER accounts. Anthem, however, has a $500 limit allowed by the program.

- Forty-two percent of members knew that their health plan wanted them to get preventive services, though this number was higher among those above 100 percent FPL as compared to members at or below the FPL.

A. RECEIPT OF PREVENTIVE SERVICES

Beginning in 2009, the state required an annual wellness office visit or completion of any of the seven priority preventive services specified by the State for a POWER account rollover (Table 6.29).

Table 6.29. HIP Preventive Care Services, 2012

Preventive Care Service	Men			Women		
Age	19-34	35-49	50-64	19-34	35-49	50-64
Annual Physical	X	X	X	X	X	X
Cholesterol Testing		X	X		45+	X
Blood Glucose Screen	X	X	X	X	X	X
Tetanus-Diptheria Screen	X	X	X	X	X	X
Mammogram					X	X
Pap Smear				X	X	X
Flu shot			X			X

Source: Indiana OMPP. "Health Indiana Plan: Coverage for Preventive Services 2008-2009, Full POWER Account Rollover." Revised August 2009.

Note: Preventive care requirements have not changed since 2009

To assess receipt of preventive services among HIP members, encounter records submitted by the health plans were analyzed. A composite measure of preventive services receipt was constructed that utilized encounter records for inpatient, outpatient, and physician office services from February 2009 to December 2013. Table 6.30 lists the codes that were considered evidence of service receipt for each of the seven services considered. The analysis assessed whether each member had *any one* of the services appropriate for his or her age and gender and that were recommended from 2009 onwards.

Table 6.30. Designated Procedure/Diagnosis Codes for Receipt of Priority Preventive Services in 2013

Preventive Service	Designated Procedure Codes	Diagnosis Code Required to Accept Procedure Code
Preventive Care Visit	99385-99387 99395-99397 99401-99404 99201-99205 99211-99215	None V70.0, V70.3, V70.5, V70.6, V70.8, V70.9 Women only: V72.3, V72.31, V72.32, V76.2
Breast Cancer Screening	77057 77052 (with 77057) 77055 77056 77051 (with 77055 or 77056)	None
Pap Smear/Cervical Cancer Screening	88141-88155 88164-88167 88174-88175 88150-88154 88164-88167 88142-88143 G0101 G0123-G0124 G0141 G0143-G0145 G0147-G0148	None
Cholesterol Screening	83718 83719 83721 82465 84478	None
Blood Glucose Screening	V77.1 83036-83037 82945 82947 82950-82953 G8015-G8026	None
Tetanus-Diphtheria	90715 90714 90718	None

The receipt of preventive services was examined over four years of the demonstration: 2010, 2011, 2012, and 2013. Each year includes preventive services information for all benefit periods which ended during that year. For example, the year 2010 includes 12 benefits periods (February 2009-January 2010, March 2009-February 2010, etc).

Between 2010 and 2013, rates of preventive services receipt remained the same or rose slightly among all groups except for females age 19-34. That age group saw a 1 percent decline in 2011. Overall, the likelihood of receiving at least one preventive service increased with age, but women were far more likely than men to receive preventive care (69 percent versus 40 percent in 2013).

Table 6.31. Preventive Services Receipt Among HIP Enrollees, 2010-2012

Receipt of Preventive Services	2010	2011	2012	2013
Overall (across entire HIP population)	56%	57%	60%	60%
Contributors	57%	58%	61%	62%
Non-Contributors	51%	53%	53%	55%
Males				
All Ages	34%	35%	39%	40%
Ages 19-34	23%	23%	30%	29%
Ages 35-49	35%	36%	38%	38%
Ages 50-65	47%	51%	53%	53%
Female				
All Ages	68%	68%	69%	69%
Ages 19-34	64%	63%	63%	63%
Ages 35-49	68%	68%	70%	68%
Ages 50-65	73%	75%	78%	78%

Source: Milliman analysis of preventive care receipt.

Note: Rates above were developed using administrative data only. A chart review would likely show higher rates, as it would include individuals who received preventive care services that were not billed separately but provided as a part of an office visit. In addition, enrollees may have received preventive care as part of an outreach effort, such as a flu vaccination drive, that was not captured in the administrative data.

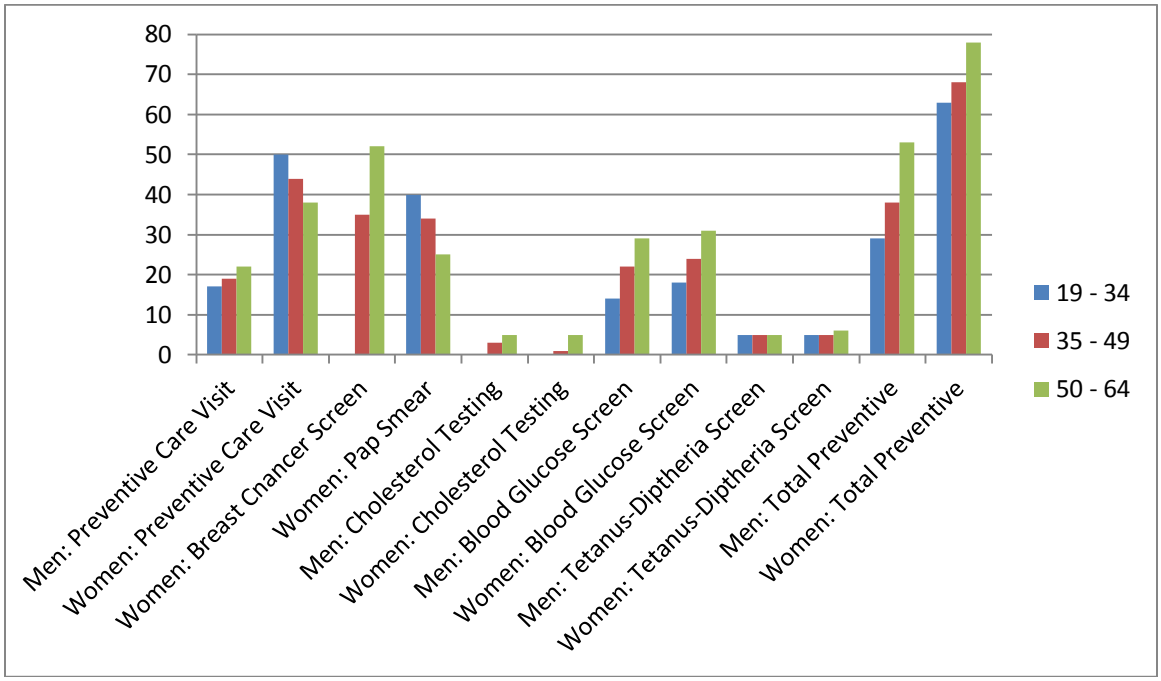
The HIP program's design creates a financial incentive for its members to receive preventive care. If any State-contributed funds remain in a member's POWER account at the end of the calendar year and he or she has received at least one recommended preventive service, the money carries over to help fund the next year's deductible. This effectively reduces the amount of the member's monthly contribution in the next year.

The majority of HIP members are required to make contributions to their POWER accounts, but some are exempt due to a lack of income or the federal cap on out-of-pocket expenditures. For these individuals, the State funds the entire $1,100 POWER account contribution. This circumstance creates a comparison group between the group that has a financial incentive to receive preventive services and reduce future monthly contributions and the group that makes no contributions. The HIP design appears to encourage use of preventive care among those who make contributions. Claims data show that HIP members required to make POWER account contributions received preventive care at higher rates than those who were not required to make POWER account contributions. In 2013, 62 percent of HIP members who were required to contribute to their POWER accounts received at least one recommended preventive service, while only 55 percent of those not required to make POWER account contributions received preventive care (Table 6.31).

Though the likelihood of receiving at least one preventive care service increased with age, variations were observed between men and women and across specific services (Figure 6.7). While older men

(ages 50-64) were slightly more likely than younger men (ages 19-34) to receive an annual physical, the reverse was true among women. Women ages 50-64 were more likely than younger women to receive a mammogram, but less likely to receive a pap smear/cervical cancer screening. Among both men and women, rates of cholesterol testing and blood glucose screening increased with age.

Figure 6.7: Type of Preventive Services HIP Members Received, 2013

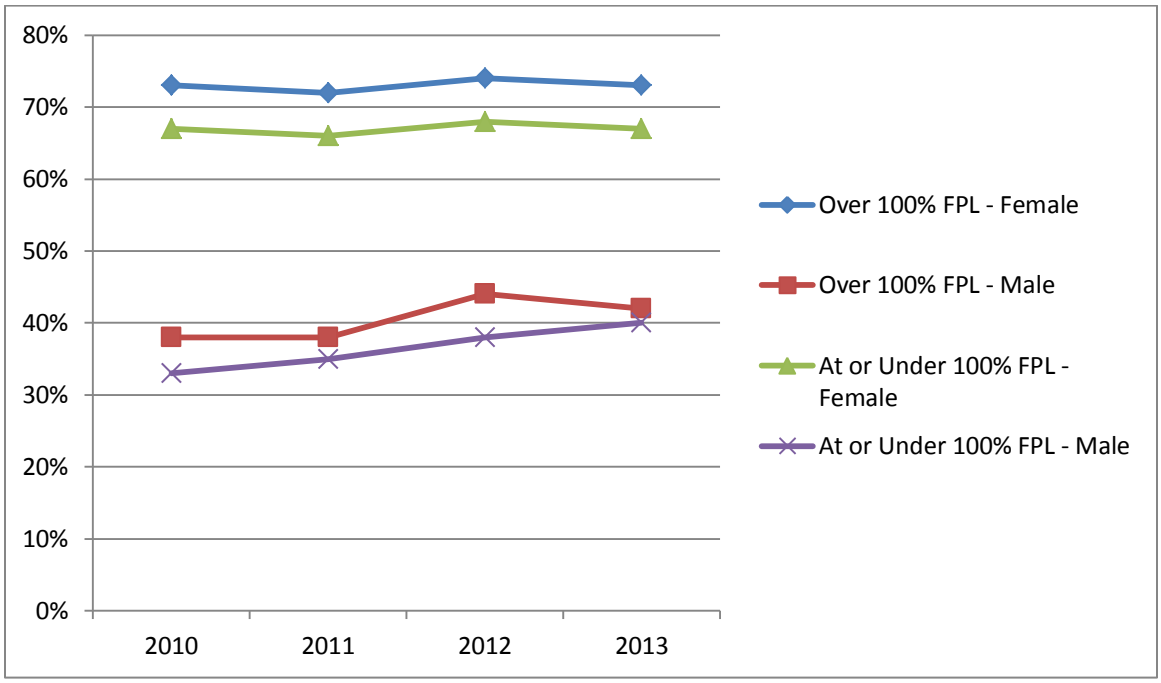


Source: Milliman analysis of preventive care receipt

Female non-caretakers between the ages of 50 and 64 utilized the highest level of preventive services, at a rate of over 78 percent. Alternatively, male non-caretakers between the ages of 19 and 34 were the lowest utilizers of preventative care.

Women who were above 100 percent FPL received preventive care services 73 percent of the time in 2013 while those at or below 100 percent FPL received services 67 percent of the time. Forty-two percent of men above 100 percent FPL received preventive services while only 40 percent of men at or below 100 percent received these services. In 2012 the gap between men over and under 100 percent FPL who received preventive care was larger than the women, however the inverse occurred in 2013 showing that the gap between women over and under 100 percent FPL was larger than men (Figure 6.8).

Figure 6.8: Trends in Preventive Services Receipt, 2010-2013



2.

Source: Milliman analysis of preventive care receipt

Note: Excludes ESP members

Self-Reported Use of Preventive Services

The majority of respondents to Mathematica's 2013 survey (85 percent) reported receiving a routine check-up within the year before the survey (Table 6.32).[7] Among those who reported not receiving a check-up in the past 12 months, nearly a quarter (23 percent) reported that the routine check-up was unnecessary (data not shown). Other prevalent reasons included not having time, not wanting to go, or feeling it was not needed because the respondent already received regular treatment for an ongoing medical condition. Notably, the analysis of claims records by Milliman suggests that 35 percent of current members received a general physical exam within 2012 (data not shown). The discrepancy between self-reported information and claims records may be due to a difference in how members perceive a "routine check-up," versus how HIP or physicians may report or code this type of care in a billing record.

[7] Respondents to the survey of current HIP members were asked how long it had been since they had visited a doctor for a routine check-up, defined as "a general physical exam, not an exam for a specific injury, illness, or condition."

Table 6.32. Routine Check-ups

Length of Time Since Routine Check-Up	All respondents	≤100% FPL	>100% FPL
Within past 3 months	37.9%	39.4%	34.7%
Within past year	46.7%	44.7%	51.0%
Within past 2 years	8.5%	9.4%	6.5%
2 or more years ago	6.5%	6.0%	7.5%
Don't know	0.4%	0.3%	0.4%

Source: Mathematica analysis of 2013 survey of HIP members.

Note: Response options were mutually exclusive groupings.

B. HEALTH PLAN STRATEGIES TO PROMOTE PREVENTIVE CARE

Anthem, MDwise, MHS, and the ESP administrator have promoted the use of preventive services through mailings, newsletters, telephone and other outreach, and a number of incentive programs.

Outreach through Telephone, Mailings, and Newsletters

Anthem

Each new HIP member who enrolls in Anthem receives a welcome call from a Health Needs Specialist to inform them about plan benefits, including preventive care. During the call, the member is given the opportunity to select a PMP. Anthem members also receive customized MyHealth Notes, which remind members to get regular preventive care, encourage the correct use of prescription drugs, and promote overall wellness.

MDwise

MDwise promotes preventive care through phone calls, mailings and newsletters. MDwise mails each member a new member letter and handbook which contains information about the rollover for POWER account funds and the MDwise REWARDS program as it relates to preventive care. The MDwise REWARDS program allows members to accumulate points towards a gift card. MDwise also conducts onboarding telephone outreach to members to encourage them to see a doctor within the first 90 days of becoming a HIP member and for them to do a Health Risk Screening. Members earn incentives through the plan's reward program for seeing their doctor and participating in the screening.

MDwise publishes a quarterly member newsletter, and uses it as a platform to promote and provide preventive care education. The newsletters are distributed via email and mail in March, June, September and December. Below are preventive articles that appeared in 2013.

- Spring 2013: Make the Most of Your Doctor's Visit and Women's Health: Covered Services
- Summer 2013: MDwise Member Benefits and Services and Check-Ups for Adults
- Fall 2013: Visit Your Doctor First

Every year, MDwise mails targeted direct mail postcards to every HIP household with the specific preventive care schedules for women and men. This practice has been commended by NCQA during the MDwise on site visit with NCQA staff. In addition, calls are made to all members who are identified as

having one of ten specific health conditions. The objective of the calls is to educate members with these conditions about the preventive care needed to avoid a health crisis.

MDwise mails monthly POWER Account invoices and statements that provide a listing of all health care services the member has used in the past year. Further, MDwise mails a letter to members that didn't qualify for a rollover and listing the services that they didn't get that they should have gotten to obtain rollover of their POWER account.

MHS

MHS distributes online publications to HIP members to encourage preventive care and educate members about plan benefits. All of these articles are made available on the MHS Website and the company's Facebook and Twitter pages. Topics included "Fluvention," the annual drive to educate members about and encourage them to get flu shots, and "Exercise Lowers Risk of Breast Cancer."

Further, MHS used mailings to PCPs listing their individual assigned members who MHS had identified through claims data analysis as missing a recommended preventive care service. As mentioned above, MHS also scheduled several "Healthy Celebration" days at primary care offices around the State for those members assigned to those practices who were identified as missing a preventative care service. MHS used telephonic outreach to the individual members to invite them to come in.

Incentive Programs

All three plans encourage members to receive preventive care and complete a Health Risk Assessment (HRA) through incentives described below.

Anthem

During Anthem's welcome calls, new members are encouraged to complete an HRA and are offered incentives to do so. Those who complete an HRA online receive a $20 CVS gift card, while those who complete it over the phone receive a $10 card (with a limit of one per household). In 2013, 1,546 Anthem HIP members completed an HRA.

MDwise

The MDwise REWARDS program, launched in 2011, uses incentives to encourage members to seek preventive care. Members earn points for activities such as: completion of a health risk screening with MDwise, a visit to the doctor for an annual exam, screenings such as a mammogram or a cervical cancer screen, or registering to receive monthly statements online. These points can then be redeemed for a gift card to businesses such as CVS, Subway or Kroger. MDwise promotes the incentive program in its brochure, member handbook, on its website, and through postcards mailed to all members. Providers may also promote the program with their MDwise patients to encourage preventive care appointments.

Several of these promotion efforts proved successful in increasing the program's reach. In October of 2013, a targeted mailing was sent to all HIP/HHW households, after which the REWARDS website saw a 641 percent increase in unique page views compared to September. There was a 368 percent increase in HIP member gift card redemption. Overall, the total number of members redeeming their points for a gift card in 2013 was 110 percent more than the previous year (2012). The number of activities or events that earn reward points have increased every year since the program's inception.

MHS

MHS continued the CENT-Account Rewards Program that provides incentives for various healthy activities where the incentive money is loaded directly onto the member's HIP debit card and can be used to purchase health supplies or co-pays, as well as pay utility bills. Members can receive $10 for visiting their assigned PMP within their first 90 days with MHS, and $30 for completing their Health Risk Assessment within that same time period. Of MHS HIP members who maintained at least 90 days of membership, and could be reached during that period, 59 percent completed a new member health screening, a 10 percent increase over 2012.

C. MEMBER KNOWLEDGE AND EFFECTS OF HIP PREVENTIVE CARE POLICIES AND OUTREACH

Many current HIP members knew their health plan wanted them to get preventive care and reported either getting the care or planning to obtain preventive care services before their next renewal period. When queried as part of Mathematica's 2013 survey, 42 percent of current HIP members knew that their health plan wanted them to get preventive services, though this number was higher among those above 100 percent FPL as compared to members at or below the FPL (48 percent vs. 39 percent) (data not shown).

Of those who knew their health plan wanted them to get preventive services, 80 percent reported that they had been encouraged by their health plan by letter, email, or phone call to receive preventive care (Table 6.33). Some variation was observed by health plan, with Anthem members more likely than MDWise members to report having been contacted by their plan about preventive care (83 percent versus 74 percent) (data not shown). Overall, 60 percent of these members said they had received at least one preventive service since their last renewal. Of those who had not, 78 percent said they planned to get them before their next renewal. Most of those individuals who did not plan to get these services reported that they felt it was unnecessary, did not have time to go, or did not want to go (data not shown).

Table 6.33. Preventive Care Knowledge and Self-Reported Receipt of Preventive Services

Preventive Care Knowledge and Receipt – Member Aware Plan Wanted Them to Get Preventive Services	Number of Members	≤100% FPL	>100% FPL
Knew that health plan wanted them to get:			
Blood Glucose Screen	60.2%	56.9%	65.8%
Cholesterol Screen	65.2%	61.4%	71.9%
Flu shot	61.4%	57.6%	67.9%
Mammogram[a]	58.4%	54.9%	64.6%
Pap Test/Pap Smear[a]	61.3%	58.3%	66.5%
Routine physical exam	84.4%	85.3%	83.0%
Tetanus shot	30.2%	29.0%	32.4%
Other service	6.6%	7.5%	5.2%
Don't know	1.5%	0.5%	3.2%
Have been encouraged by health plan via letter, email, or phone call to get preventive care			
Yes	79.7%	78.6%	81.7%
No	18.6%	20.1%	16.1%
Don't know	0.8%	0.4%	1.5%
Have gotten any of these services since last annual renewal			
Yes	59.5%	59.5%	59.4%
No	37.3%	38.2%	35.8%
Don't know	3.3%	2.3%	4.9%
Have not gotten services since last annual renewal, but plan to get services before next renewal			
Yes	78.3%	77.2%	80.4%
No	14.0%	13.3%	15.3%
Don't know	3.8%	5.9%	0.0%

Source: Mathematica analysis of 2013 survey of HIP members.

[a]All respondents were asked whether their health plan wanted them to get the services listed, including mammograms and pap test/pap smears. The percentages of people who accurately reported that their health plan wanted them to get these two services is therefore underreported, because the denominator includes men.

Sixty percent of individuals in both groups – those aware and those unaware that their plan wanted them to get preventive services – reported that they had received services since their last renewal. Of those who were unaware that their health plan wanted them to get services and had not already done so, 64 percent said they planned to get preventive care before their next renewal (Table 6.34). However, of those who were aware their health plan wanted them to get preventative services, 78 percent said they planned to get preventative care before their next renewal (Table 6.33). This indicates that health plan education about the benefits of utilizing preventative care services increases the likelihood that members will receive these services.

Table 6.34. Preventive Care Receipt Among Current Members Not Aware That Their Health Plan Wanted Them To Get Preventive Services

Preventive Care Receipt - Members Not Aware Health Plan Wanted Them to Get Preventive Services	Number of Members	≤100% FPL	>100%FPL
Have been encouraged by health plan via letter, email, or phone call to get preventive care			
Yes	29.4%	27.1%	35.1%
No	67.3%	70.0%	60.5%
Don't know	0.6%	0.6%	0.8%
Have gotten any of these services since last annual renewal			
Yes	60.4%	59.0%	63.1%
No	34.5%	37.7%	28.5%
Don't know	2.9%	3.3%	2.1%
Have not gotten services since last annual renewal, but plan to get services before next renewal			
Yes	63.7%	57.4%	79.7%
No	25.0%	32.1%	7.0%
Don't know	11.3%	10.5%	13.3%

Source: Mathematica analysis of 2013 survey of HIP members.

6.5 GOAL V - PREVENT CHRONIC DISEASE PROGRESSION WITH SECONDARY PREVENTION

By lowering cost and access barriers to care and encouraging members to be more engaged patients, HIP aims to slow disease progression among members with chronic conditions. Detecting the extent to which HIP is slowing the progression of chronic disease is extremely difficult and the data currently available does not provide a clear answer. The following analyses used diagnosis codes found on HIP service records to assess the occurrence of different categories of chronic conditions and used health plan reports to document ways in which the MCEs are helping members manage chronic conditions.

Analyses indicate that:

- Chronic disease is prevalent among members, and approximately 31 percent of HIP members had three or more chronic conditions (Table 6.36). The most common chronic conditions in 2013 were cardiovascular, psychiatric, skeletal and connective, and gastrointestinal disorders. This did not change from 2012. As in past years, non-caretakers were more likely than caretakers to be diagnosed with chronic disease.
- All three MCEs provide disease management programs to help members manage chronic conditions.

A. PREVALENCE OF CHRONIC CONDITIONS

To assess the prevalence of chronic conditions among HIP members, the Chronic Illness and Disability Payment System (CDPS) algorithm was applied to inpatient and outpatient encounter records of those enrollees with six or more months of enrollment in HIP during 2013. The CDPS is a diagnostic classification system developed to describe different burdens of illness among Medicaid beneficiaries. Using ICD-9 codes, the CDPS categorizes diagnoses into 20 major categories, which correspond to body

systems. Each of the major categories is subdivided according to the degree of increased expenditures associated with the diagnosis. The CDPS analysis was supplemented with the Medicaid Rx (MRx) algorithm, which was designed to identify chronic conditions among beneficiaries who receive pharmacotherapy but do not have a qualifying CDPS diagnosis in their encounter records.

Chronic disease was prevalent among HIP members, which may partly explain why the majority of members exhaust their POWER account funds and are not eligible for POWER account rollovers. Among those enrolled in HIP for at least six months during 2013, the most common chronic conditions classified by the CDPS algorithm were those associated with the cardiovascular (32.8 percent), psychiatric (24.5 percent), skeletal and connective (21.4 percent), and gastrointestinal systems (20.2 percent) (Table 6.35). Non-caretakers were much more likely than caretakers to have chronic conditions, which is consistent with the differences in demographic characteristics and that non-caretakers tend to be older than caretakers (see Table 6.1).

The MRx algorithm identifies an additional 6.7 percent of members who were treated with medications for cardiovascular conditions. The highest percent of members that the MRx algorithm identified were those HIP members that filled a prescription for psychotropic medicine for psychosis, bipolar disorder or depression. This measured at 16.6 percent of HIP members. In addition, seizure disorders registered a 3.8 percent rate for HIP members.

Table 6.35. Percent of HIP Enrollees with 6+ months of enrollment in 2013 with Chronic Conditions

	All HIP Members	HIP Caretakers	HIP Non-Caretakers
Category	N = 37,336	N = 25,550	N = 11,786
CPDS			
Cardiovascular	32.8%	25.5%	48.8%
Psychiatric	24.5%	23.6%	26.3%
Skeletal and Connective	21.4%	18.3%	28.1%
Gastrointestinal	20.2%	17.4%	26.3%
Pulmonary	16.7%	13.3%	24.0%
Diabetes	13.2%	10.0%	20.3%
Ear	11.5%	11.2%	12.0%
Nervous System	8.8%	7.0%	12.6%
Skin	6.6%	6.0%	7.9%
Metabolic	6.6%	5.3%	9.2%
Genital	5.7	6.1%	4.8%
Substance Abuse	4.6%	3.5%	7.1%
Renal	4.2%	3.2%	6.2%
Infectious Disease	2.9%	2.2%	4.6%
Eye	2.9%	1.5%	6.1%
Cancer	9.7%	8.4%	12.7%
Hematological	1.3%	1.1%	1.8%
Cerebrovascular	0.6%	0.4%	1.0%
Developmental Disability	0.0%	0.0%	0.1%
MRx			
Psychosis/Bipolar/ Depression	16.6%	15.7%	18.5%
Cardiac	6.7%	6.2%	7.8%
Seizure disorders	3.8%	3.8%	3.7%
Anti-coagulants	1.8%	1.5%	2.6%
Diabetes	1.3%	1.4%	1.1%
Malignancies	1.3%	1.1%	1.8%
Parkinsons / Tremor	0.7%	0.5%	1.1%
Inflammatory /Autoimmune	0.4%	0.5%	0.4%
Infections, high	0.3%	0.2%	0.3%
Hepatitis	0.1%	0.1%	0.2%
Tuberculosis	0.1%	0.1%	0.1%
HIV	0.0%	0.0%	0.0%
ESRD / Renal	0.0%	0.0%	0.0%
Multiple Sclerosis / Paralysis	0.0%	0.0%	0.0%
Hemophilia/von Willebrands	0.0%	0.0%	0.0%

Source: Milliman, Inc.

Multiple diagnoses were common. More than 31 percent of HIP members had three or more chronic conditions. However, most of these diagnoses reflected low-cost conditions. Considering only subcategories associated with medium or higher costs, only 1.85 percent had three or more CDPS diagnoses.

For all CDPS categories except genital conditions, prevalence among non-caretakers was higher than among caretakers and often by substantial margins. This reflects the same results that were seen in 2012. For example, almost 49 percent of non-caretakers had cardiovascular conditions compared to 25 percent of caretakers. Almost one-third of caretakers had no CDPS chronic conditions while only 17 percent of non-caretakers had no chronic conditions. The differences between groups persist when only medium- and high-cost conditions were considered. About 29 percent of non-caretakers were diagnosed with at least one higher-cost condition, as compared to 20 percent of caretakers. These patterns are summarized by each group's average CDPS risk score, which is a summary index of the relative expected medical costs for each member given their identified chronic conditions. The CDPS risk score for the population as a whole is 1.00. The average score among caretakers was 0.84, indicating that as a group they are expected to be 16 percent less costly than the HIP average. The average score among non-caretakers was 1.32, which rose from 1.27 in 2012, indicating that as a group they are expected to be 32 percent more costly than the HIP average (see Table 6.36).

Table 6.36. Chronic Illness and Disability Payment System (CDPS) Risk Score and Number of Conditions Identified, by Enrollee Group, HIP Members 2013

				All CDPS Identified Conditions, Percent with:			CDPS Identified Conditions with "Medium" or Greater Expected Cost Impact: Percent with:		
Characteristics	HIP Members	Scored HIP Members	Normalized CDPS Risk Score	No Conditions	1-2 Conditions	3 or More Conditions	No Conditions	1-2 Conditions	3 or More Conditions
All HIP Members	49,398	37,336	1.00	27.73%	40.53%	31.73%	75.22%	22.93%	1.85%
HIP Caretakers									
All	35,495	25,550	0.84	32.62%	42.07%	25.35%	78.69%	20.15	1.16%
19-34	11,749	7,764	0.69	39.37%	43.69%	16.94%	82.60%	16.81%	0.59
35-49	19,055	14,170	0.86	31.66%	41.68%	26.66%	78.23%	20.58%	1.19%
50-64	4,635	3,594	1.06	21.93%	40.07%	38.01%	72.01%	25.74%	2.25%
65+	56	22	0.96	13.64%	45.45%	40.91	86.36%	9.09%	4.55%
HIP Non-Caretakers									
All	13,903	11,786	1.32	17.15%	37.21%	45.64%	67.72%	28.96%	3.33%
19-34	1,603	1,239	0.91	32.45%	40.68%	26.88%	77.97%	21.15%	0.89%
35-49	3,670	3,126	1.36	17.34%	36.53%	46.13%	66.54%	29.78%	3.68%
50-64	8,216	7,204	1.37	14.48%	36.88%	48.64%	66.49%	29.94%	3.57%
65+	414	217	1.35	15.67%	38.25%	46.08%	66.82%	29.03%	4.15%

Source: Milliman, Inc.

Note: Scored members had at least six months of HIP eligibility. For Normalized CDPS Risk Score, Concurrent Risk scores were used, weighted by HIP Member Months. Table excludes "not well defined" and "super low" CDPS flags.

B. HEALTH PLAN MANAGEMENT OF CHRONIC CONDITIONS

The health plans provide support to their members with chronic conditions primarily through focused disease management programs, which use a telephone-based case management approach to help these members manage their health.

Disease Management

All three plans participate in the Right Choices Program (RCP), a care management program for members with unusually high service utilization, particularly of emergency room and prescription drug services. This program limits the pharmacies, providers, and hospitals where the member may receive care, while also providing outreach services from care managers at each plan. In addition, Anthem, MHS, and MDwise all offer disease management programs for members identified as having certain chronic conditions.

The MCEs reported that consolidating their HIP and HHW call centers increased their ability to provide disease management services. Plan representatives noted that if a person enrolled in either HHW or HIP placed a call to the call center, staff could view the records of the person's entire family. They could note if someone in the family was enrolled in a disease management program but had not recently received services, and immediately transfer the member to a case manager.

Anthem

Anthem's disease management program, known as 360 Condition Care, is available for members with medium- to high-risk asthma, coronary artery disease (CAD), heart failure, chronic obstructive pulmonary disease (COPD), diabetes, end stage renal disease (ESRD), and chronic kidney disease (CKD). The plan analyzes its service records to identify members with these conditions, rate their risk, and refer them to the disease management program when appropriate. Members with medium- and high-risk conditions are assigned to case managers, who provide clinical support by connecting patients to providers, goal setting, offering help keeping appointments, and offering strategies to help the member adhere to physician instructions. In 2013, Anthem continued offering disease management services to all members diagnosed with one of its identified conditions, but began targeting members who were diagnosed with a condition and were identified as experiencing a clinical gap in care (such as, members diagnosed with diabetes who had not received the recommended blood glucose test).

In 2013, Anthem's asthma and diabetes programs were the largest in terms of number of enrollees compared to other conditions.

Table 6.37. Anthems Disease Management Program

Primary Conditions	Total Enrolled in 2013
Asthma	1,617
Coronary Artery Disease (CAD)	42
Heart Failure	213
COPD	1,110
Diabetes	2,114
Total	**5,096**

Source: Anthem, 2013.

Note: More limited data were available for those in the ESRD and chronic kidney disease management programs.

MDwise

The disease management program at MDwise is called INControl. It uses a case management approach to help certain members at higher risk manage their chronic condition(s). The six managed diseases are: asthma, diabetes, congestive heart failure, coronary artery disease, chronic kidney disease, and chronic obstructive pulmonary disease.

Members are identified and referred to this program when they complete the Health Needs Assessment at enrollment and annually at re-enrollment. They may also be referred by a provider or through a call to the health plan. Those referred receive educational materials about their disease(s) and access to care management services. MDwise also offers information to members on its WEIGHTwise and SMOKEfree programs.

A large portion of the outreach process is the Network Improvement Team, a MDwise provider outreach team. The team meets with providers and discusses HEDIS quality measures and shares other pertinent information. Occasionally, the team will also hold meetings with groups of providers to discuss disease specific management topics.

Table 6.38. MDwise INControl Program Enrollment, 2013

INControl Program	Members Enrolled
Asthma	447
Diabetes	695
Congestive Heart Failure	37
CAD	25
Chronic Kidney Disease	0
COPD	1,122
Total	**2,326**

Source: MDwise

MHS

In 2013, MHS continued to offer complex case management, care management and disease management programs for members with asthma, diabetes, trauma, multiple co-morbidities, transplant care, coronary artery disease, chronic obstructive pulmonary disease, congestive heart failure, chronic kidney disease, depression, and bipolar disorder. To enroll members in its disease management programs, MHS examines encounter data to identify at-risk individuals with one or more of the selected conditions. In addition, the plan sends representatives to meet with HIP providers and encourage them to refer appropriate individuals to the disease management programs. MHS then contacts the members and works to assess and stratify them as to the appropriate type and level of intervention. Disease management intervention consists in some cases of telephonic coaching and in others of a coordinated program of member education.

MHS discontinued its obesity-only program, folding that program in to the other programs as those members had co-morbidities that required co-management.

MHS continued the higher-touch approach with their members with asthma and diabetes, increasing the number of home visits and outbound calls, improving member satisfaction, reducing ER usage and hospital readmissions among this population.

Table 6.39 MHS Disease Management Program Enrollment, 2013

DM Program	Members Enrolled
Asthma	41
Diabetes	50
CAD	3
COPD	2
Depression	95
Bipolar Disorder	41
Total:	**232**

Source: MHS

Incentive Programs for Disease Management

None of the plans offer incentives for participation in disease management programs.

6.6 GOAL VI – PROVIDE APPROPRIATE AND QUALITY-BASED HEALTH CARE SERVICES

A critical goal for HIP is to provide appropriate and quality-based health care services. Although the State is ultimately responsible for ensuring the quality of services delivered to HIP members, much of the day-to-day responsibility rests with the contracted MCEs. The analyses that follow use a number of data sources to evaluate the MCEs' ability to provide quality health care services, including (1) plan performance information abstracted from a March 2013 report completed by Burns & Associates, Inc., the program's external quality review organization (EQRO); (2) member experience with care data gathered from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) that the health plans submit to the State (these CAHPS surveys were of HIP members only, not the plans' other Medicaid, commercial, or Medicare populations); (3) satisfaction information Mathematica collected in 2013 through a survey of current HIP members; and (4) aggregate data on inquiries reported by the State.

A. OVERALL HEALTH PLAN PERFORMANCE: EXTERNAL QUALITY REVIEW

In 2013, Burns and Associates, Inc. (B&A) conducted an external quality review (EQR) of Anthem, MDwise, and MHS for calendar year 2012. The Centers for Medicare and Medicaid Services (CMS) require that EQRs consist of three mandatory activities:

1) A review to determine MCO compliance with federal Medicaid managed care regulations;
2) Validation of performance measures produced by an MCO; and
3) Validation of performance improvement projects undertaken by the MCOs.

In cooperation with the State, B&A developed focus studies in addition to the three mandatory activities. The 2012 focus study topics included the following:

1) Validation of Performance Measures
2) Validation of MCE Performance Improvement Projects (PIPs)
3) Optional EQR Activity: Calculation of Performance Measures (Selected CMS Child Core Measures)
4) Optional EQR Activity: Conduct a Focus Study on Access to Care
5) Optional EQR Activity: Conduct a Focus Study on Mental Health Utilization and Care Coordination

Validation of Performance Measures

For the first focus study topic, B&A used CMS's EQR Protocol #2, *Validation of Performance Measures*, as the basis for conducting the validation of six HEDIS®-like measures that the MCEs are required to report to the State on a quarterly basis. These measures are "HEDIS®-like" because the State requires that the MCE utilize most of the definitions of the actual HEDIS® measure but to change the anchor period with each quarterly submission so that the data is kept up on a rolling 12-month period

throughout the year. The other difference from HEDIS® is that the data submitted to the State throughout the year uses the administrative (claims-based) method only. The HIP measures included in this year's validation were:

1) Adults' Access to Preventive Ambulatory Services (the basis of which is HEDIS® measure AAP); and

2) Utilization of Imaging Studies for Low Back Pain (the basis of which is HEDIS® measure LBP).

B&A was able to verify the MCE performance measurements after identifying the probable limitations in the data that prevented closer alignment of results including different data sources and paid versus denied encounter claims.

It is noteworthy that the results from the Information Systems Capabilities Assessments (ISCA) completed by the HEDIS® auditors in regards to the 2012 measures achieved by the MCEs revealed the following:

1) Anthem- All standards were met.

2) MDwise- All standards were met.

3) MHS- All standards were met except one standard which was partially met because MHS was unable to generate information on one measure.

Validation of MCE Performance Improvement Projects (PIPs)

For the second focus topic, B&A also chose to validate three performance improvement projects (PIPs) from each MCE. The PIPs that were selected were among those that the MCEs selected from pre-set lists defined by the State that are tied to the State's overall quality strategy. The PIPs selected by B&A for review were chosen by all three MCEs (with some minor differences noted). All of them are HEDIS® measures. They include:

1) Diabetes Care (Anthem chose the Comprehensive Diabetes Care HEDIS® measure while MHS and MDwise selected LDL-C Screening component only). This PIP is for both HHW and HIP.

2) Follow-up Care after an Inpatient Mental Health Hospitalization (Anthem and MHS chose both the 7-day and 30-day follow-up; MDwise selected the 7-day follow-up only). This PIP is for both the HHW and HIP populations.

B&A developed recommendations on the administration of performance improvement projects in HIP. Specifically, B&A recommended that the State consider working with the MCEs to revise the PIP form so that it is most useful to the State, the EQRO and the MCEs themselves. The new format should be more concise but should contain most all of the requirements included in NCQA's tool. B&A recommended that the revised tool should provide less information about methodology for HEDIS®-based PIPs and more information about the interventions. In turn, B&A recommended that the MCEs build more data analytics into each of their interventions to assess their effectiveness. This recommendation stemmed from the fact that each MCE has conducted numerous and varied types of

interventions in these PIPs and in some cases have seen little improvement over multiple measurement periods.

Focus Study on Access to Care
The focus study on access to care completed by B&A included both a quantitative and qualitative component. B&A conducted a quantitative analysis on access to primary care among children and adults by MCE, age, race/ethnicity, and region of the state. B&A also reviewed access by measuring the rate of enrollees within each MCE who had received an office-based primary care service. This analysis limited the study to primary care office visits conducted in a physician's office, a federally qualified health clinic (FQHC), or at a rural health clinic (RHC). Analyses using these parameters were also examined by age, race/ethnicity and region of the state.

When examining adults' access to primary care, MHS had the greatest access among the three MCEs. Interestingly, access to primary care for African-American members in HIP was higher than other race/ethnicities. The access rates were generally similar across the MCEs within a region. The access rate among HIP adults was higher for every MCE in every region compared with the corresponding age/region cohort in HHW, likely due to higher reimbursement rates in HIP versus HHW.

Although progress has been made since the inception of HIP, the MCEs continue to experience difficulties in recruiting specialty providers in portions of the state. B&A found that the following gaps existed in the following regions:

1) Northwest: Pain management specialists
2) North Central: Orthopedists, psychiatrists
3) Northeast: Neurologists, orthopedists, endocrinologists, podiatrists
4) West Central: no specific specialty was noted as a gap, but long wait lists were noted
5) East Central: Neurologists, rheumatologists, endocrinologists, gynecologists, psychiatrists
6) Central: Pain management specialists, orthopedists, gastroenterologists, psychiatrists
7) Southwest: Behavioral health specialists, orthopedists, allergists, obstetricians accepting new HHW patients, gynecologists, ear/nose/throat physicians, neurologists, rheumatologists, pain management specialists
8) Southeast: Presumptive eligibility providers, psychiatrists, neurologists, nephrologists, orthopedists, pain management specialists, endocrinologists

B&A noted that while these specialists can often be found practicing in a community, they either refuse to accept Medicaid, will only accept traditional Medicaid rather than managed care, cap the number of Medicaid patients seen per month, or have long wait times.

Behavioral Health Utilization and Care Coordination:
B&A initially examined the prevalence of mental health diagnosis codes that appeared on professional service encounters (CMS-1500 claim form) for members in HIP in 2012. Of the 52,886 members ever enrolled in HIP during CY 2012 (all adults), 15,281 (28.9 percent) had a mental health diagnosis reported on an encounter. Next, B&A analyzed which provider specialties delivered services in the community to individuals with mental health diagnoses.

The encounter data showed that of the total number of HIP members who had a mental health diagnoses, 31.3 percent were Caucasian. In addition, 20.2 percent were African-American and 16.6 percent were Hispanic. HIP members were largely served at outpatient mental health clinics and community mental health clinics (CMHCs). These two provider types delivered more than 76 percent of all services rendered in relation to mental health. Three diagnoses comprised half of all mental health diagnoses among the HIP population. Those three were tobacco use disorder (19.6 percent), attention deficit disorder (15.5 percent), and major depressive or bipolar disorder (14.9 percent).

B&A reviewed the complex case management plans at each MCE for members that were enrolled in complex case management due to behavioral health diagnoses. The focus of this review was to verify coordination with and between the member's providers as this is critical for this population. B&A also wanted to verify that the development of the member's complex case management plan was completed in coordination with all providers. Coordination activities could range from physical attendance at case management plan meetings to providing input via telephone or fax. The EQRO report identified some areas for improvement in coordinating behavioral and physical health for members enrolled in complex case management due to behavioral health diagnoses. These findings were shared with the HIP health plans for their improvement and the state is working with each to improve behavioral health and physical health integration.

B. SELF-REPORTED SATISFACTION FROM HEALTH PLAN CAHPS DATA

MCE Ratings and Benchmarks

As part of the State's commitment to assuring that HIP is meeting the goal of providing appropriate and quality-based health care services, the plans are required to complete an annual Consumer Assessment of Healthcare Providers and Systems (CAHPS). Each MCE collects data from HIP members regarding their levels of satisfaction with several key health care components including: the plan overall, care provided by their physician and specialists, the ability to obtain care in a timely manner, and communication with the providers and plan. The health plans then submit their results to the State for review. The 2013 CAHPS results showcase the different strengths between the three plans. Anthem's strengths are identified as high satisfaction with the health plan overall, getting care quickly, and specialty providers. MDwise's strengths include high satisfaction in getting needed care, communication with doctors, and accessing care quickly. MHS had the identified strengths of customer service and members being able to obtain care quickly.

Table 6.6.1 CAHPS Ratings and Benchmarks

CAHPS Rating	Anthem		MDWise		MHS		Benchmark Rates[a]		
	2013 Plan Average	2012 Plan Average	2013 Plan Average	2012 Plan Average	2013 Plan Average	2012 Plan Average	Anthem		MDwise and MHS
							2013 DSS	2013 WP	
Rating of Plan Overall	**81.2**	**82.2***	**75.8**	**76.0**	**70.4**	**72.8**	*76.0*	*76.0*	***74.2***
Rating of Health Care	**77.6**	**77.2***	**71.1**	**70.6**	**73.0**	**72.7**	*72.5*	*71.9*	***71.0***
Rating of Personal Doctor	**79.8**	**81.0***	**78.2**	**76.3**	**80.3**	**79.9**	*79.8*	*77.6*	***78.3***
Rating of Specialist	**79.8**	**77.9**	**78.6**	**79.8**	**75.9**	**73.5**	*79.7*	*79.8*	***79.4***
Customer Service	**93.2**	**84.2**	**86.6**	**82.3**	**86.8**	**80.2**	*87.6*	*86.7*	***86.6***
Getting Needed Care	**87.4**	**85.1***	**84.7**	**83.4***	**83.2**	**79.5**	*81.1*	*81.3*	***81.1***
Getting Care Quickly	**87.0**	**86.6***	**84.9**	**83.0**	**86.6**	**83.7**	*81.9*	*81.6*	***81.6***
Doctor Communication	**92.6**	**91.6***	**90.0**	**88.4**	**89.4**	**90.0**	*89.7*	*89.1*	***89.2***
Shared Decision Making	**70.5**	**58.2**	**48.0**	**65.8***	**47.1**	**66.3**	*74.0*	*72.6*	*NA*
Health Education	**75.9**	**63.3***	**75.7**	**60.5**	**73.4**	**64.5***	*71.7*	*70.8*	*NA*
Coordination of Care	**79.4**	**77.0**	**76.2**	**77.2**	**78.7**	**75.6**	*78.9*	*76.9*	***78.9***

Source: Anthem data are from "2014 CAHPS 5.0H Member Survey prepared for Healthy Indiana Plan" 2014; DSS Research , MDwise data are from "2014 Medicaid Adult CAHPS 5.0H Final Report: MDwise Healthy Indiana Plan" 2014; The Myers Group, and MHS data are from "2014 Medicaid Adult CAHPS 5.0H Final Report: Managed Health Services Indiana, Inc" 2014; The Myers Group

[a] Anthem benchmark rates are 2013 WP (WellPoint) averages and 2013 DSS averages (from the 20123 DSS Adult Medical Book of Business averages. MDwise and MHS benchmark rate comes from 2013 Medicaid Adult Public Report.

* Indicates significant difference when compared to corresponding benchmark rates.

CAHPS = Consumer Assessment of Healthcare Providers and Systems; DSS = 2012 DSS Adult Medical Book of Business averages; WP = WellPoint average.

Characteristics of CAHPS Respondents

The MCEs identified a survey sample that was representative of the overall HIP membership, however, respondents to the CAHPS surveys were more likely to be white than the overall HIP population (Table. 6.6.2). Assessing the racial mix is challenging, because the administrative data does not allow for multiracial members, but CAHPS does. Women were slightly over-represented among the survey respondents.

Table 6.6.2 Demographic Characteristics of CAHPS Respondents, by Health Plan

Demographic Characteristics	HIP Members	Anthem Survey Respondents	MDwise Survey Respondents	MHS Survey Respondents
Number	49,390	666	**714**	605
Response Rate	n/a	53.5%	**55%**	46.8%
Race/Ethnicity				
White	82.6%	88.4%	**84.4%**	88.3%
Black	10.0%	7.4%	**12.4%**	10.0%
Hispanic	3.2%	4.3%	**4.7%**	4.3%
Asian	2.1%	2.0%	**2.3%**	1.6%
Native American / Alaskan Native	0.1%	2.0%	**6.7%**	4.4%
Other	1.9%	0.0%	**4.7%**	3.6%
Gender				
Female	68.6%	71.2%	**71.9%**	71.0%
Male	31.4%	28.8%	**28.1%**	29.0%

Source: Anthem data are from "2014 CAHPS 5.0H Member Survey prepared for Healthy Indiana Plan" 2014; DSS Research , MDwise data are from "2014 Medicaid Adult CAHPS 5.0H Final Report: MDwise Healthy Indiana Plan" 2014; The Myers Group, and MHS data are from "2014 Medicaid Adult CAHPS 5.0H Final Report: Managed Health Services Indiana, Inc" 2014; The Myers Group. Data on HIP members are from OMPP.

Note: Race and ethnicity were separate questions in CAHPS surveys, and respondents were able to choose more than one race. Therefore, responses will not equal 100 percent. HIP Member data produced by OMPP.

C. SELF-REPORTED SATISFACTION FROM MATHEMATICA'S 2013 SURVEY OF HIP MEMBERS

Mathematica's 2013 survey of current HIP members included questions about satisfaction with HIP. Overall, 76 percent of members reported that they were very satisfied with HIP, while an additional 19 percent said they were somewhat satisfied (Table 6.6.4). Further, 98 percent reported that they would choose to re-enroll in HIP if they left but then became eligible again. Of the small number of individuals who said they were somewhat or very dissatisfied, reasons included lack of coverage of certain benefits (such as dental, vision, or certain procedures), dissatisfaction with choice of doctors, and dissatisfaction with a payment or administrative issue (data not shown). However, the group of individuals asked about their reason for dissatisfaction was too small to provide reliable data.

Table 6.6.3 Satisfaction with HIP

Level of Satisfaction	Total	< 100% FPL	> 100% FPL
Overall level of satisfaction with HIP			
Very satisfied	76.2%	75.7%	77.1%
Somewhat satisfied	18.5%	18.9%	17.7%
Neither satisfied nor dissatisfied	2.1%	2.0%	2.2%
Somewhat dissatisfied	3.0%	3.3%	2.3%
Very dissatisfied	0.2%	0.2%	0.4%
Don't know	0.0%	0.0%	0.0%
Would try to re-enroll in HIP if they left but became eligible again			
Yes	98.2%	98.3%	98.2%
No	0.5%	0.4%	0.7%
Don't know	1.2%	1.2%	1.1%

Source: Mathematica analysis of 2013 survey of HIP members.

D. HEALTH PLAN INQUIRIES

The State maintains a consumer issue management system known as the "Internet Quorum" or "IQ," which permits the State to monitor and manage formal and informal inquiries. In each year, the total number of inquiries has been lower than in the previous years (see Table 5.2 in the Consumer Issues section). Overall, the number of inquiries has fallen by 80 percent between 2008 and 2013.

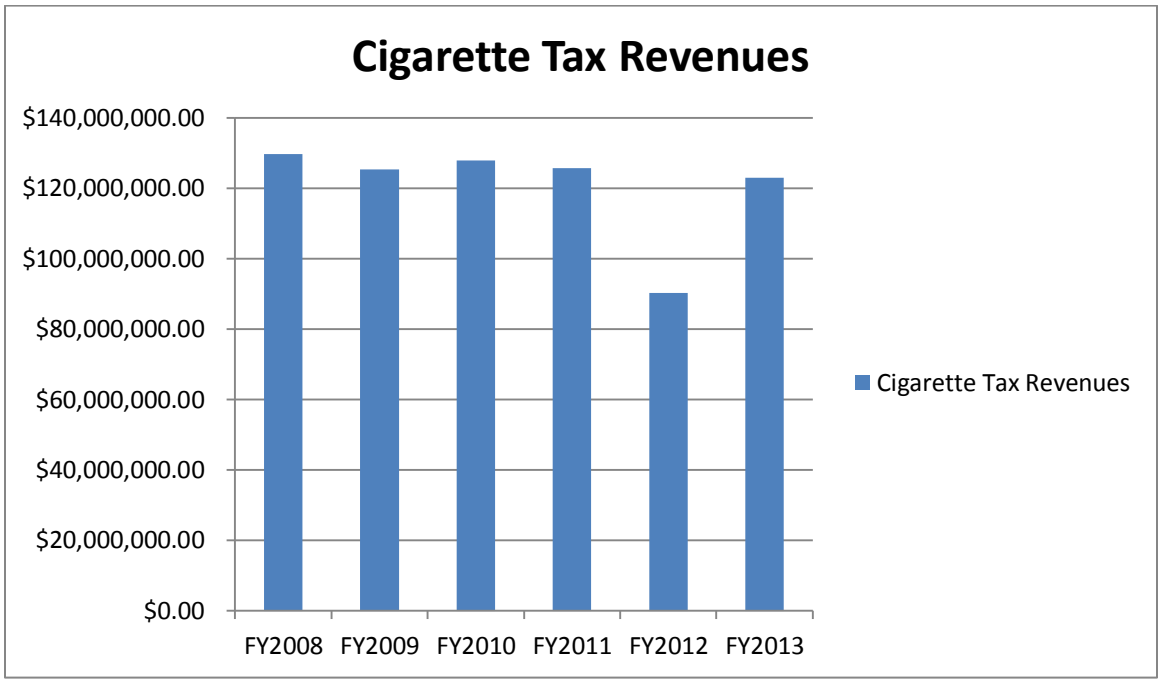
As in previous years, most inquiries in 2013 were questions of a general nature about HIP (See Table 5.3 in the Consumer Issues section). Ten percent of inquiries were about buying into HIP, approximately 5 percent related to the waiting list, and the remaining were questions regarding specific HIP plans, including the ESP. These percentages are similar to those seen in 2012 (data not shown).

6.7 GOAL VII – ASSURE STATE FISCAL RESPONSIBILITY AND EFFICIENT MANAGEMENT OF THE PROGRAM

1. Cigarette Tax Revenues

By design, cigarette tax revenues are the dominant financing mechanism for HIP. To date, HIP has collected nearly $722 million in revenues from the cigarette tax implemented in 2007. Cigarette taxes have fluctuated, but have hovered between $120 and $130 million each year. HIP is required to channel $11 million into an immunization fund each year. These payments were not made in FY2010 and FY2011, resulting in a lump sum of $31 million deposited into the fund in FY2012 and a lower level of tax revenues dedicated to HIP during this fiscal year. In 2013, the $11 million was once again channeled to the immunization fund with the remainder being dedicated to HIP.

Figure 6.9 Indiana Revenues from State Cigarette Taxes Allocated to HIP



2. Disproportionate Share Hospital Funds

In 2013, the State no longer reallocated the $50 million in Disproportionate Share Hospital (DSH) dollars to HIP. The waiver year starting January 1, 2013 was the first time that the DSH dollars were not reallocated to HIP.

3. Power Account Contributions

The monthly contributions that HIP members make to their POWER accounts are the third mechanism for funding HIP. POWER accounts are set at $1,100 per year. The monthly contributions are based on income and a sliding scale. Members may pay as much as five percent of their income toward POWER account contributions. The MCEs collect the POWER account contributions from members, and their capitation payments are lowered to offset the expected collection of these contributions. In 2012, about $7 million in POWER account contributions were collected, and in 2013 about $6 million in POWER account contributions were collected.

SECTION 7: CONCLUSIONS

The HIP program has proven to be a promising model for expanding access to health care for low-income populations. As demonstrated throughout this report, a consumer-driven health model promotes more conscious healthcare utilization and engagement in decision-making. HIP members overwhelmingly report that they value their health coverage, would be willing to make higher POWER account contributions to remain enrolled, and prefer paying "up front" (funding the POWER account) to making copayments each time they seek medical care. Eighty-five percent of members feel that their required contributions are either the right amount or below the right amount, and only a small proportion (14 percent) of former HIP members reported that cost-sharing had been their reason for leaving the program. Overall initial POWER account contribution rates have increased steadily over the course of the demonstration, indicating that contribution amounts are affordable and that members value having HIP coverage. HIP members continue to report high overall satisfaction with the program, and demand for HIP coverage continues to grow, as evidenced by the rate at which the non-caretaker waitlist continued to grow until it was closed in December of 2012.

Overall uninsured rates for the HIP-eligible population have increased slightly over the years of the demonstration, likely due to external factors such as the national economic downturn and higher rates of unemployment. However, the uninsured rates for those Hoosiers under 50 percent of the FPL have decreased by about four percent since the inception of the program. Had HIP not been available, the state uninsured rate would have increased more during the demonstration period.

HIP has accomplished or made substantial progress toward all of its stated goals while maintaining fiscal soundness. Over the course of the six years of the demonstration, HIP has cost just less than $1.2 billion. The cost has been $1.2 billion less than what the projected cost would have been to cover the same population in traditional Medicaid. With the exception of the cigarette tax revenue used to fund the program, HIP has no negative impact on Hoosier taxpayers.

Over the life of the program, challenges with MCE provider networks and administration have been addressed. Provider networks have improved significantly for both primary and specialty care in the six years of the demonstration. There are still areas where improvements can be made, including increased member awareness of how the POWER account works and understanding of the connection between the receipt of preventive care, account rollovers, and reduced contributions. The State continues to work with the MCE's to meet quality metrics and implement effective chronic disease management programs.

Overall, HIP has experienced marked success in making healthcare accessible to a vulnerable, low-income population that otherwise would have had limited access to affordable coverage over the past six years. The State anticipates continued accomplishments and improvements as it looks to use the HIP program as the model for coverage expansion to a substantial portion of the state's uninsured population.

Other Issues Unrelated to the Healthy Indiana Plan

In the Special Terms and Conditions for the waiver renewal, CMS asked Indiana to include an update in this report on managed care for the Aged, Blind, and Disabled population. In compliance with legislation passed by the Indiana General Assembly in 2013, FSSA studied this issue extensively in 2013 and issued a report to the legislature in December that outlined three approaches to better coordinating care for aged, blind and disabled members. Subsequently, the State decided to move forward with a risk-based managed care program for a portion of the ABD population. The program, called Hoosier Care Connect, will cover about 88,000 Medicaid enrollees with disabilities. Medicare-Medicaid Enrollees, institutionalized and nursing facility residents, and individuals in Home and Community Based Services waiver programs will be excluded from the program. The State will be submitting a waiver request to the federal government to implement the program and hopes to start enrollment into the program in Spring 2015. The State believes the program will improve the quality of care for people with disabilities on Medicaid and give them choices not available in FFS Medicaid.