HEALTHY INDIANA PLAN 2.0

PROJECT NUMBER: 11-W-00296/5

SECTION 1115 QUARTERLY REPORT

STATE OF INDIANA

REPORTING PERIOD:

Demonstration Year: 3 (02/01/17 – 12/31/17)

Demonstration Quarter: 4/2017 (11/2017-12/2017)

Date submitted to CMS: March 31, 2018

INTRODUCTION

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

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

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

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

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

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

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KEY EVENTS

During this quarter the HIP program offered the first annual Managed Care Entity (MCE) selection period from November 1, 2017-December 15, 2017. This allowed HIP members to pick their MCE for the next calener year. This practice aligns with commercial markets, where plan selection is done on an annual basis. Members were alerted that they could call the state's enrollment broker to change their MCE if desired. Any member who did not elect to change MCEs was re-enrolled with their current MCE for 2018. 3,769 members called to make a new plan selection.

During the month of November, on-site visits were conducted with each of the four MCEs to assess readiness for new operational policies. Many operational changes to the HIP program became effective in January and February of 2018. State staff attend meetings with each MCE to assure that operational changes are in place and cosistent with updated policy.

On December 28th a public hearing was held regarding the proposed changes to the HIP Rule found in Indiana Adminsitrative Code. The rule Amends 405 IAC 10 to align with the administrative simplifications and changes requested through the waiver extension.

This quarterly report reflects the last quarter of the demonstration period. In order to align reporting in the next demonstration period with the calender year, this report reflects only November-December 2017. The next quarterly reporting cycle will start with January 2018 and align with calender quarters.

OPERATIONAL CHALLENGS & ACHIEVEMENTS

Operational focus in this quarter remained on developing business and system design changes to incorporate new HIP program design elements requested in the HIP waiver extension application. While awaiting CMS approval, the State moved forward with system design in order to be prepared for implementation of changes in 2018. A series of change requests we implemented in the state eligibility system and the MMIS system to accomplish the major program changes.

ENROLLMENT BY INCOME LEVEL AND BENEFIT PLAN

Table 1 details HIP 2.0 enrollment by FPL and benefit plan. There were 400,577 fully enrolled members as of December 31, 2017, these numbers do not include those who are conditionally eligible and will move into HIP Plus if they make a POWER Account contribution or Basic if they do not. There were 261,873 individuals (65.4%) making their POWER Account contributions and receiving HIP Plus benefits. We continue to see most of the lowest income members (61%), under 23% FPL making POWER Account contributions. At the end of the quarter, 68,871 individuals (17% of total enrollees) had income over 100% FPL.

Table 1: Enrollment at the End of Quarter 4 (December 31, 2017)

	Basic				Plus				
	State	Regular	Basic Total	Percentage of Basic Enrollment	State	Regular	Plus Total	Percentage of Plus Enrollment	Total HIP Enrollment
<23%	41,247	33,115	74,362	39.0%	59,109	57,241	116,350	61.0%	**190,712**
23-50%	5,733	8,296	14,029	38.6%	7,631	14,665	22,296	61.4%	**36,325**
51-75%	6,172	12,407	18,579	37.7%	8,817	21,820	30,637	62.3%	**49,216**
76-100%	5,759	13,758	19,517	35.2%	9,293	26,643	35,936	64.8%	**55,453**
Total <101%	**58,911**	**67,576**	**126,487**	**38.1%**	**84,850**	**120,369**	**205,219**	**61.9%**	**331,706**
101 - 138%	4,762	5,306	10,068	15.8%	13,559	40,047	53,606	84.2%	**63,674**
>138 %	2,079	70	2,149	41.4%	2,704	344	3,048	58.6%	**5,197**
Grand Total	**65,752**	**72,952**	**138,704**	**34.6%**	**101,113**	**160,760**	**261,873**	**65.4%**	**400,577**

*Source: SSDW/EDW

POWER ACCOUNT CONTRIBUTION FROM THIRD PARTIES

Tables 2 and **3** outline the total number of members who received help paying PAC from either an employer or a participating non-profit organization during Q4 2017. The number of employers electing to make POWER Account contributions in the quarter was 259, these employers made contributions on behalf of 431 members. In this quarter, we saw an increase in the number of employers participating, growing from 201 employers to 259 and from 218 members to 431. Also, there were 144 non-profit organizations that made contributions on behalf of 2,258 members, we see that this number has increased from 65 to 144 since last quarter (Q3).

Third party contributions continue to represent a very small portion of the overall program. These numbers represent those groups that have made a formal arrangement with a MCE to pay on behalf of another individual. The State may not be aware of informal arrangements or payments on behalf of members, including those from friends or relatives.

Table 2: Employer Power Account Contributions during Quarter 4 (November 2017 – January 2018)

	Total
Number of Employers Participating	259
Number of Members on Whose Behalf an Employer Makes a Contribution	431
Total Amount of Employer Contributions	$15,230.95
Average Amount of Employer Contributions	$35.34

*Source: OMPP Quality and Reporting

Table 3: Non-Profit Organization Power Account Contributions during Quarter 4 (November 2017 – January 2018)

	Total
Number of Non Profit Organizations Participating	144
Number of Members on Whose Behalf a Non Profit Makes a Contribution	2,258
Total Amount of Non Profit Contributions	$34,545.41
Average Amount of Non Profit Contributions	$15.30

*Source: OMPP Quality and Reporting

DISENROLLMENT

Table 4 represents the number of individuals that were dis-enrolled from the program for failure to pay their required POWER Account Contribution. In this quarter, out of the 68,871 members with incomes over 100% of the FPL, 3,383 members were disenrolled, which is about 4.9% of the population.

Table 4: Closure for Failure to Pay Power Account during Quarter 4 (Nov – December 2017)

FPL	Count	Description
FPL >100%	3,383	Failure to make payment to power account

*Source: SSDW/EDW

CLOSURES & REASONS

Table 5 documents that 34,930 individuals left the HIP 2.0 program in Q4 2017. 3,470 of those were individuals who moved to a different Medicaid program outside of HIP. 31,460 individuals were closed out of the Medicaid program all together. The closure reasons listed in the tables below

continue to reflect non-compliance with redetermination and an increase in income as the main reasons for leaving the program. The numbers below show closures and do not account for the members who may have come back to the State and been reopened. Upon termination, individuals can have their eligibility restored if they return their paperwork within 90 days.

Table 5: Closures during Quarter 4 (Nov – December 2017)

HIP category	Moved to Another Medicaid Category (Non HIP)	Moved Out of the Medicaid Program
Regular Plus	996	11,364
Regular Basic	612	9,652
State Basic	515	5,309
State Plus	1,323	4,912
Other	24	223
Totals	3,470	31,460
Total	**34,930**	

*Source: SSDW/EDW

Table 6 lists the five most common reasons for all HIP 2.0 closure (above and below 100% FPL). The most common reason for closure in this quarter was that the individual failed to comply with or complete redetermination. The second most common closure reason was that the individual's income exceeded program eligibility standards. The same two reasons were the most common last quarter. There are many other closures for a variety of other reasons and the below counts do not include all closures.

Table 6: All Closures -Top 5 reasons during Quarter 4 (Nov – December 2017)

Number of Closures	Reason
11,637	Individual failed to comply with or complete redetermination
5,656	Individual income exceeds program eligibility standards
3,386	Individual failed to make POWER Account contribution
3,222	Failure to provide all required information
2,773	Receipt of or increase in earned or self-employment income

*Source: SSDW/EDW

When the closure reasons are broken out for those above and below 100% FPL there are some differences. **Table 7** shows the most common closure reason for members under 100% FPL was failure to comply with or complete redetermination. **Table 8** shows the most common closure

reason for members above 100% FPL, is an increase in income that exceeds program eligibility standards. These individuals are referred to the Marketplace for coverage.

Table 7: Closures 100% FPL and Under – Top 5 Reasons in Quarter 4 (Nov – December 2017)

Number of Closures	Reason
10,338	Individual fails to comply with or complete redetermination
2,629	Failure to provide all required information
1,900	Individual is not an Indiana resident
1,785	Individual income exceeds program eligibility standards
687	Individual eligible for SSI related income

*Source: SSDW/EDW

Table 8: Closures 100% FPL and Above – Top 5 Reasons in Quarter 4 (Nov – December 2017)

Number of Closures	Reason
3,871	Individual income exceeds program eligibility standards
3,383	Individual failed to make POWER Account contribution
2,235	Receipt of or increase in earned or self-employment income
1,299	Individual fails to comply with or complete redetermination
593	Failure to provide all required information

*Source: SSDW/EDW

EMERGENCY ROOM UTILIZATION

Table 9 below documents the number of emergency room visits by HIP 2.0 members for calendar quarter 4. The data is collected on a paid basis not an incurred basis, meaning that this data reflects the claims paid during the experience period with a 90 day claims lag time. In this instance, November 2017 - January 2018 reporting period, shows the claims payment activity for the August - October 2017(Q3) experience period. The State also submits a revised table of utilization data for quarter 3 in table 10.

Table 9: Emergency Room Utilization Calendar Quarter 4 (November 2017 – January 2018 reporting period)

Category	Number of ER visits in the period	Number of ER visits deemed emergent	Number of visits deemed non-emergent	Number of Adjudicated ER claims per 1,000 members	Percent of claims deemed emergent	Percent of claims deemed non-emergent
Plus	37,582	25,300	12,282	60	67.3%	32.7%
Basic	21,766	15,869	5,897	117	73%	27%
State Plan	67,098	50,280	16,818	138	74.9%	25.1%

*Source: OMPP Quality and Reporting

Table 10 below documents the corrected number of emergency room visits by HIP 2.0 members for calendar quarter 3. The data is collected on a paid basis not an incurred basis, meaning that this data reflects the claims paid during the experience period with a 90 day claims lag time. In this instance, Aug - October 2017 reporting period, shows the claims payment activity for the May - July 2017(Q3) experience period.

Table 10: Emergency Room Utilization Calendar Quarter 3 (August – October 2017 reporting period)

Category	Number of ER visits in the period	Number of ER visits deemed emergent	Number of visits deemed non-emergent	Number of Adjudicated ER claims per 1,000 members	Percent of claims deemed emergent	Percent of claims deemed non-emergent
Plus	34,279	26,436	7,843	83	77.1%	22.9%
Basic	19,679	15,199	4,480	110	77%	23%
State Plan	67,642	52,943	14,698	149	78%	22%

*Source: OMPP Quality and Reporting

ELIGIBILITY DETERMINATION and PROCESSING

Table 11 shows the typical processing time for each aid category by number of days from application to authorization and then from authorization to full eligibility. The State continues to report excellent application processing times.

Table 11: Eligibility Processing in Quarter 4 (Nov – December 2017)

Case Type	Average number of days from application to Authorization	Average number of days from HIP authorization to Full Eligibility	Number of pending HIP applications
Regular Plus	23.47	2.84	30,838
Regular Basic	19.56	1.65	1,836
State Plan Plus	20.13	3.3	4,945
State Plan Basic	11.27	9.33	49
HIP Link	NA	NA	NA

*Source: OMPP Quality and Reporting

HIP EMPLOYER LINK

In this quarter, the HIP Employer Link program did not enroll new members or employers.

Remaining HIP Link members were transferred to HIP Plus effective January 1, 2018. **Tables 12 and 13** outline program details.

Table 12: HIP Employer Link Enrollment in Quarter 4 (Nov – December 2017)

	Quarter	Program to Date
Employer enrollment	0	100
Employee enrollment	0	69
Grievances	0	0
Participants moving from ESI to HIP Plus	0	10

*Source: SSDW/EDW

Table 13: HIP Employer Link POWER Account Balances in Quarter 4 (Nov – December 2017)

POWER Account Balance	Number of Employees
$4,000-$3,000	31
$3,000-$2,000	15
$2,000-$1,000	12
$1,000-$0	6

**Note: all account balances will start at $4,000*
*Source: DXC HIP Employer Link

PRESUMPTIVE ELIGIBILITY

The Presumptive Eligibility (PE) program continues to be very active in Indiana. **Table 14** details the activity for all Qualified Providers (QPs) in the program. The number of full IHCP applications submitted for the final 2 months in Q4 are on the same trend as the previous quarter. The overall number remains low at approximately 32.9% for approved applications. The top denial reasons have been identified, and continued monitoring will be conducted for any changes. These denials include: failure to cooperate in verifying income, income exceeding program eligibility standards, and failure to verify Indiana residency.

Table 14: PRESUMPTIVE ELIGIBILITY APPLICATIONS and PERFORMANCE in Quarter 4 (Nov – December 2017)

Provider Type	PE Applications Submitted	PE Applications Approved	% PE Applications Approved	IHCP Applications Submitted	IHCP Applications Approved*	% IHCP Applications Approved**
Acute Care Hospital	11,734	9,625	82.0%	6,740	2,091	31.0%
Community Mental Health Center	967	806	83.4%	350	91	26.0%
Federally Qualified Health Center	25	24	96.0%	19	12	63.2%
Psychiatric Hospital	1,851	1,634	88.3%	1,186	541	45.6%

Rural Health Clinic	457	369	80.7%	197	57	28.9%
County Health Department	37	31	83.8%	27	14	51.9%
Grand Total	**15,071**	**12,489**	**82.9%**	**8,519**	**2,806**	**32.9%**

*****Source: EDW
*Applications submitted in the performance quarter may have still been pending when data was run.
**This number only reflects those that have had a determination made at that time. It may change over time.

Table 15 provides information on the number of Qualified Providers (QPs) that are completing HPE/PE applications for individuals. The number in column (a) is the number of provider entities that are signed up to perform QP activities, broken out by provider type. The number in column (b) shows the number of physical locations where the entity operates and carries out QP activities. The number in column (c) shows the total number of provider entities that are eligible to sign up to be a QP. To date, 216 out of 329 (65.7%) eligible entities are signed up to be a QP.

Table 15: PRESUMPTIVE ELIGIBILITY QUALIFIED PROVIDERS in Quarter 4 (Nov – December 2017)

Provider Type	No. of Qualified Provider Entities (a)	No. of Qualified Provider Locations (b)	Total Potential Provider Entities by Type (c)
Acute Care Hospital	117	119	121
Community Mental Health Center	21	55	25
Federally Qualified Health Center	26	152	26
Psychiatric Hospital	20	20	41
Rural Health Clinic	22	22	67
County Health Department	10	10	49
Total	**216**	**378**	**329**

*Source: CORE MMIS