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

Eric J. Holcomb
Governor

January 31, 2017

The Honorable Norris Cochran
Acting Secretary of the Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Healthy Indiana Plan §1115 Demonstration Waiver Extension (Project No. 11-W- 00296/5)

Dear Acting Secretary Cochran,

I am pleased to submit Indiana's application to extend the Healthy Indiana Plan ("HIP") §1115 demonstration waiver through January 31, 2021.

First approved by CMS in 2008, HIP is the nation's first consumer-driven health plan for Medicaid beneficiaries and has demonstrated remarkable success in empowering participants to become engaged consumers of healthcare services. This is a plan built by Hoosiers for Hoosiers, and it has succeeded in measurably improving behaviors and healthy outcomes. I request the flexibility to maintain and develop our innovative model as Congress and the Administration develop much needed plans for repealing and replacing ObamaCare.

There are now 400,000 members currently enrolled, and our consumer skin-in-the-game approach has yielded better health outcomes and helped members be better informed and more active participants in their health outcomes. Here are examples:

- Of the nearly 70 percent of members who have enrolled in HIP Plus, 92 percent of members below the poverty line and 94 percent of those above the federal poverty level make regular contributions to an account similar to a health savings account.
- HIP members making contributions to their accounts are more likely to obtain primary care and preventive care, have better drug adherence, and rely less on the emergency room for treatment compared to those who do not.
- HIP provides a $2,500 deductible, which is funded by a combination of personal and state contributions. After their first year of enrollment, more than 62 percent of all HIP members successfully managed their POWER accounts, spending less than their $2,500 deductible.
- Nearly half of all HIP members (48 percent) earned the rollover incentive, with an average amount of $113 eligible to offset future contribution requirements

We plan to build upon these important successes, and through this waiver seek several program enhancements:

First, I request expanded access to substance use disorder (SUD) services for *all* Medicaid recipients to support our overall statewide SUD efforts. Specifically, this waiver will add new Medicaid-covered services for members, including residential treatment services and addiction recovery management. Additionally, we will expand access to providers to enable Medicaid recipients to receive these SUD and mental health services at more locations and new treatment centers throughout Indiana.

Far too many Hoosiers are caught in the strangling grip of drugs and the sad fact is that drug overdoses have increased 500 percent since 2000. Indiana is now 15th in the country in overdose fatalities, and this epidemic continues to cause ripple effects with devastating impacts on families, communities, government agencies, our economy, and our healthcare system. In one of my first acts as Governor, I created a cabinet-level position designed to develop and implement statewide solutions to respond and recover from the drug epidemic with real and measurable outcomes. The expanded access we seek for Hoosiers through this waiver extension will prove critical to the success of our efforts.

Additionally, I seek this extension to make program enhancements that further incentivize individuals to improve their health status through specific member incentives targeting tobacco cessation, SUD, chronic disease management, and participation in Gateway to Work, HIP's voluntary work referral and job training program.

Indiana has built a program that is delivering real results in a responsible, efficient, and effective way. We look forward to maintaining the flexibility to grow this remarkably successful tool and to preserve our ability to respond to the unique needs of Hoosiers. We are confident that your team will support us in these efforts and we look forward to working with our federal partners at the Centers for Medicare & Medicaid Services to enhance the program and strengthen its core principles of personal responsibility and consumer-driven healthcare. Please contact my office with any questions.

Sincerely,

[redacted]

Eric J. Holcomb
Governor of Indiana

Indiana Family and Social Services Administration

Healthy Indiana Plan (HIP)
Section 1115 Waiver Extension Application

Submitted January 31, 2017

Contents

Section 1: Executive Summary

The Healthy Indiana Plan (HIP) is the nation's first consumer-driven health plan for Medicaid beneficiaries. Since 2008, the HIP model has demonstrated remarkable success in transforming beneficiaries into engaged participants and improving health outcomes. The expanded "HIP 2.0" program has seen consistent results since 2015, proving that HIP's consumer driven model is scalable and remains successful in empowering enrollees to become active consumers of healthcare services.

HIP offers low-income Hoosiers a high deductible consumer-driven health plan paired with a Personal Wellness and Responsibility (POWER) account, similar to a health savings account. The POWER Account, valued at $2,500, pays for the full cost of the plan deductible. The POWER account contains contributions made by the State as well as the required monthly contributions from the member, equal to two percent (2%) of income. The POWER account gives participants "skin-in-the-game" and provides a financial incentive for members to become more invested and engaged in their healthcare by adopting healthy behaviors and to seek price transparency to make value conscious decisions, leading to better outcomes, including higher rates of primary and preventive care and lower emergency room usage.

Members are encouraged to actively manage their POWER account through the opportunity to rollover member funds remaining in the account at the end of the benefit period. The rollover amount may be doubled if the member obtains recommended preventive services during the benefit period. Any funds rolled over to the subsequent benefit period are used to offset the member's future required contributions to the plan. After their first year of enrollment, over 62% of all HIP members successfully managed to maintain a balance in their POWER account, and nearly half of all members (48%) earned the rollover incentive, with an average amount of $113.00 to offset future contribution requirements.[1]

In addition, HIP has introduced several market principles that align with standard commercial market policies to educate members and prepare them to eventually participate in the private market. First, unlike traditional Medicaid, HIP does not provide retroactive coverage, rather, HIP benefits become effective after the member makes a POWER account contribution (similar to premium payments required in commercial plans). In addition, similar to the commercial market, HIP offers members several benefit package options. The HIP Plus plan is the standard plan option, providing comprehensive benefits and requiring regular monthly POWER account contributions. HIP members with income at or below the federal poverty level who choose not to contribute to their POWER account are transferred to the reduced HIP Basic plan, which offers a more limited benefit package (for example not covering vision or dental services) and applies copayments to all healthcare services. While members at or below the poverty level transfer to the HIP Basic plan following non-payment and a 60-day grace period, members with income greater than the poverty level are terminated from HIP for six months. In addition to the HIP Plus and HIP Basic plan options, HIP includes the HIP Employer Link option which supports HIP eligible individuals enroll in their employer sponsored coverage in lieu of the standard HIP program.

[1] Indiana Family and Social Services Administration, Administrative Data, 2017.

The design of HIP provides a combination of complementary incentives and disincentives, intended to create a significant value proposition to incentivize members to proactively invest in their healthcare. This program design has been successful in encouraging active engagement as nearly two-thirds of all members are choosing to proactively make monthly contributions into their POWER account.[2] Despite the option for members below the poverty level to participate in the HIP Basic plan which does not require monthly contributions, almost 85% of these individuals are choosing to regularly contribute to their healthcare.[3] Further, members have found the monthly contributions are affordable, as the majority of surveyed members (90% of HIP Basic, and 80% of HIP Plus) indicated that they would be willing to pay more for HIP.[4] Further, only 5% of members who left the program did so for affordability reasons, while most (52%) left due to increased income and/or access to private market insurance.[5]

In addition, the POWER account has helped engage members and educate them about the cost of healthcare in a way that traditional Medicaid is unable to do. Among members who reported having a POWER Account, 40% of HIP Plus and 30% of HIP Basic members reported checking their POWER Account balance monthly, and nearly one in four HIP Plus members surveyed (27%) reporting asking their provider about the cost of care.[6] While an early member survey conducted within months of the program implementation found that only 48% and 35% of HIP Plus and HIP Basic members, respectively, understood they had a POWER account, the same evaluation found that nearly 97% and 78% of HIP members above and below the poverty level, respectively, understood that POWER account contributions were required to maintain HIP Plus coverage.[7] This fundamental understanding of the program structure is demonstrated by the fact that over two-thirds of HIP members choose to make regular contributions to their POWER account, even though the majority of members are not required to do so as a condition of eligibility. Finally, members making monthly contributions to their POWER account were more satisfied with the program than individuals who did not contribute to the account (86% to 71%).[8]

HIP has achieved extraordinary improvements in healthcare utilization patterns as compared to a traditional Medicaid model that provides little incentive for participants to consider the cost of their publicly funded care or to take personal responsibility for their health. The recent independent evaluation of the HIP found that members who contributed to their POWER Accounts (versus members who did not contribute) were twice as likely to obtain primary care (31% to 16%); had better drug adherence (84% to 67%); and relied less on the emergency room for treatment (775 to 1,034 visits per 1,000 member years).[9] Further, 87% of HIP Plus members used preventive health services during their first year of enrollment.[10]

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[2] THE LEWIN GROUP, INDIANA HEALTHY INDIANA PLAN 2.0 INTERIM EVALUATION REPORT (2016), *available at* http://www.in.gov/fssa/hip/files/Lewin_IN%20HIP%202%200%20Interim%20Evaluation%20Report_FINAL.pdf.

[3] *Id*.

[4] *Id*.

[5] *Id*.

[6] *Id*.

[7] *Id*.

[8] *Id*.

[9] *Id*.

[10] *Id*.

Through this waiver request, the State aims to continue its highly successful HIP demonstration waiver program for the maximum waiver extension period of three years in its current form with minor technical revisions, updates and enhancements aimed at improving member health outcomes through coordinated efforts targeting tobacco cessation, substance use disorder, chronic disease management, and increased employment among HIP members. In addition to the proposed enhancements in HIP, this waiver request also seeks to target one of the more pressing health challenges facing the State—substance use disorder. The State seeks to expand access to critical mental health and substance use disorder services to all Medicaid recipients.

Section 2: Historical Narrative and Program Description

2.1 Historical Narrative

2.1.1 Program History

HIP first passed the Indiana General Assembly in 2007 with bipartisan support. Indiana pioneered the concept of medical savings accounts in the commercial market and became the first 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 paired with the POWER account, which operates similarly to a health savings account. Following Center for Medicare & Medicaid Services (CMS) approval, HIP began enrolling working-age, uninsured adults in coverage on January 1, 2008.

In 2011, with the passage of the Patient Protection and Affordable Care Act (ACA), the Indiana General Assembly reinforced its support for the program by calling for HIP to be the coverage vehicle for Medicaid expansion in the State. The legislature passed Senate Enrolled Act 461 (codified at Indiana Code §12-15-44.2), to codify this requirement as well as to make several conforming changes to the HIP program related to the ACA.

In 2014, following several one year extensions of the original HIP waiver, Governor Mike Pence opted to seek expansion of Indiana's successful HIP program to cover individuals in the new adult group. Following a historic agreement with the Indiana hospitals that secured funding for the costs of expansion beyond the existing cigarette tax revenue, the State submitted a fiscally sustainable waiver to expand its existing HIP demonstration waiver. The HIP 2.0 waiver built on the early HIP experiences and outcomes to improve the program and strengthen the core values of personal responsibility and consumer driven healthcare. In January 2015, CMS approved the HIP 2.0 program through a three year waiver expiring in January 2018. Following implementation of HIP 2.0 on February 1, 2015, the Indiana General Assembly codified HIP 2.0 at Ind. Code §12-15-44.5. Through the 2016 codification efforts, the state legislature once again reinforced its support of HIP by expressly prohibiting the continuation of Medicaid expansion in the State except through the Healthy Indiana Plan, operated in a manner consistent with the statutory provisions.

2.1.2 HIP 2.0 Implementation & Current Operations

Immediately upon receiving CMS approval for HIP 2.0 on January 27, 2015, the State began accepting applications for the HIP program. Services began just days later, as the enhanced HIP 2.0 program launched on February 1, 2015. In addition to processing new program applications,

the launch of HIP 2.0 included the conversion of members previously enrolled in the original HIP program as well as all non-pregnant adults enrolled in Hoosier Healthwise—Indiana's traditional Medicaid managed care program. Over 222,000 individuals were enrolled in HIP 2.0 by the end of the first quarter of operations, and to date HIP has continued to meet its enrollment goals with over 394,000 individuals fully enrolled in HIP as of December 1, 2016.
The State also implemented new features of the program during the first year, including the fast track prepayment option which allows individuals to pre-pay their POWER account contribution either by credit card on their application or an invoice received during application processing. Other innovative features enhanced during the first year included the rollout of debit cards that allow members to make payments directly from their POWER account at the point of service and the ability for members to pay POWER account contributions to all MCEs at no additional charge at Wal-Mart locations. The State also rolled out enhancements including presumptive eligibility for the HIP population, including the addition of new providers that can make presumptive eligibility determinations including county health departments, federally qualified health centers, rural health centers, and community mental health centers. HIP presumptive eligibility integrates directly with HIP coverage by leveraging the same MCEs that provide HIP coverage and providing the fast track prepayment option to allow individuals found eligible to expedite their enrollment into HIP. In addition, at the direction of the Indiana General Assembly, the State implemented a program to provide presumptive eligibility to prison inmates who are being treated in inpatient settings while incarcerated. In addition, the State has leveraged this program to ensure that HIP applications are filed for inmates prior to release in order to improve continuity of care and continued access to prescriptions in order to reduce recidivism.

Beyond the HIP enhancements, the State implemented the HIP Employer Link program which provides HIP eligible individuals support to enroll in their employer sponsored insurance instead of HIP coverage. HIP Employer Link provides individuals with the benefits available on their employer-sponsored health insurance (ESI) plan through the provision of a $4,000 HIP Link POWER account. This account reimburses enrollees for the costs associated with the ESI plan, including premium costs that are in excess of the required monthly POWER account contribution and other out of pocket cost sharing (such as copayments) up to the $4,000 account limit. The HIP Employer Link program was operationalized following the approval of HIP 2.0. The development of HIP Employer Link included full design and testing of an online employer portal to allow for employer submission of health plan benefits and premium information as well as employer verification of participating employees. In November 2016, with the program fully operational, the State launched a new outreach campaign, which included rebranding the program to HIP Employer Link. The new campaign transitioned the existing outreach materials, such as the employer manual, employee handbook, member eligibility cards and other public facing materials to include the new logo and program name. In addition to the rebranding efforts, the State simultaneously launched a marketing campaign, which included a redesigned website, radio ads, program videos, and other similar marketing activities and materials. At the time of waiver submission, the HIP Employer Link outreach and marketing campaign is ongoing.

The State also coordinated with CMS on the approvals of three separate alternative benefit plans (ABPs) for HIP and HIP Employer Link, which detail the provision of benefits for members in the expansion population and index benefits to commercial market benefit packages. The HIP

Link ABP broke new ground by being the first approved ABP for employer sponsored insurance and the first to set three separate commercial market based benefit options.

Indiana has implemented a strong operational foundation through consistent communication with vendors and other stakeholders. In fact, to maximize public-relations initiatives, both member and other stakeholder research was used to inform the strategic plan to promote HIP 2.0. In addition, a team of experts from the State provided standard language on various HIP 2.0 written materials including, but not limited to: (i) member information, (ii) provider credentialing information, (iii) public promotional material, and (iv) MCE policy and procedure documentation. Further, since implementation, the HIP operations team has worked to develop a strong internal monitoring process, including regular program reporting and daily review of program metrics. This foundation has been in place since the start of the HIP waiver, and it will continue to support the waiver in the extension period.

In addition, to the enhanced operational processes, Indiana developed a specialized unit, the Customer Service Team (CST), to handle and streamline unique member concerns and identify any possible underlying systemic issues as quickly as possible. Processes have been put in place to triage member concerns and elevate issues in a manner seamless to the members. Member complaints received by the State or MCE call centers are reviewed, and any issues that require manual attention to resolve are elevated to CST. The CST coordinates responses across the various vendors and their respective systems to ensure accurate and timely resolution of member concerns. The prompt and coordinated member issue resolution process supported by the CST over the first two years of the HIP program has promoted ongoing operational success of the HIP program.

The HIP team has also met all of the submission deadlines for the protocols and reports that are required by the CMS Special Terms and Conditions (STCs). This includes the regular quarterly reporting and evaluation reporting, as well as completion of reports specific to the HIP program. While the State's submissions have been timely, due to approval delays some studies have been delayed. For example the study of the emergency room copayment could not be started on time due to delays of CMS approval of the study methodology. Ultimately, the HIP program has been documented through the numerous mandated protocols, reports, and evaluation documents required to be submitted throughout the demonstration period, including:

1. Retroactive Coverage Reporting;
2. Prior Claims Payment Program Reporting;
3. Presumptive Eligibility Report on Qualified Entities and Training;
4. Presumptive Eligibility Standards;
5. HIP Employer Link Protocol;
6. POWER Account Contributions and Copayments Infrastructure Operational Protocol;
7. POWER Account Contributions and Copayments Monitoring Protocol;
8. Emergency Room Copayment Protocol;
9. Annual Report on Provider Payment Rates;
10. Demonstration Annual Report;
11. Comprehensive State Quality Strategy;
12. Submission of Draft Evaluation Design;

13. NEMT Evaluation;
14. HIP Plus POWER Account Contribution Evaluation;
15. Emergency Department Copayment Evaluation;
16. Retroactive Coverage Evaluation;
17. Interim Evaluation Report; and
18. Final Evaluation Design and Implementation.

The STCs specifically set forth that the results of several of the reports would determine continuation of the applicable policy. For example, the non-emergency medical transportation (NEMT) waiver was limited to one-year pending the results of the NEMT evaluation. Due to delays in approving the NEMT evaluation design, CMS temporarily extended the NEMT waiver through November 30, 2016 to allow more time for adequate data collection. Following the completion of two distinct member surveys and program evaluations by a third-party independent evaluator, on August 1, 2016, Indiana requested an amendment of the HIP demonstration project to extend the NEMT waiver. Based on the favorable findings of the two evaluations, on November 25, 2016, CMS approved the amendment to extend the NEMT waiver for the duration of the demonstration period.

2.2 Program Description

HIP's consumer-driven health plan paired with the unique health savings account-like account, the POWER account, gives participants a financial incentive to adopt healthy behaviors and to proactively seek price and quality transparency to make value conscious health care decisions. HIP offers members three benefit packages—HIP Plus, HIP Basic, and HIP Employer Link. The enhanced benefits of the HIP Plus plan, which are only available to members making regular monthly contributions to their POWER account, create a significant value proposition to incentivize members to proactively invest and engage in their healthcare. Members with income at or below the federal poverty level are transferred to the HIP Basic plan if they do not make their contributions. The HIP Basic plan offers a more limited benefit package (for example not covering vision or dental services) and applies copayments to all healthcare services. By contrast, members with family income above the poverty level will be terminated from HIP for non-payment of required monthly contributions, consistent with commercial market policies. These members do not have access to the HIP Basic plan and cannot re-enroll for six months. Notwithstanding the foregoing, individuals determined medically frail, regardless of income, are exempt from non-payment penalties and do not lose benefits due to non-payment of POWER account contributions.

Unlike traditional premiums or copayments, HIP members own their POWER account contributions and are entitled to their portion of unused contributions when they leave the program. Due to the direct financial investment in the POWER account, HIP members are incentivized to manage their accounts judiciously and to take advantage of free preventive care services offered by the plan outside of the member's POWER account. For this reason, POWER accounts remain a critical feature of HIP and are provided to every HIP member, regardless of their benefit plan. To further incentivize healthy behaviors, members who obtain preventive services are eligible to reduce their future POWER account contributions amounts. Through the combination of incentives and disincentives, HIP has been able to actively engage HIP members in their healthcare and achieve improved outcomes as compared to traditional Medicaid.

2.1.1 Eligibility

HIP targets non-disabled adults between the ages of 19 and 64 with a household income less than 138% FPL, including individuals eligible for the adult group, low-income parents and caretakers eligible under Section 1931, and individuals eligible for transitional medical assistance. Individuals who become pregnant while on HIP may continue to be covered by the HIP program for the remainder of their current benefit period before transitioning to the Hoosier Healthwise program- Indiana's Medicaid program for children and pregnant women.

2.1.2 Benefits

All HIP members receive a comprehensive benefit package, consistent with private market plans and compliant with all mandated essential health benefits as required by the ACA. However, the HIP benefit package is more consistent with commercial plan benefits and does not include chiropractic services or non-emergency transportation. Notwithstanding the foregoing, low-income parents and caretakers eligible under Section 1931, low-income 19 and 20 year old dependents, individuals eligible for transitional medical assistance, and individuals identified as medically frail, will receive the same benefits as on the Medicaid State Plan, including non-emergency transportation and chiropractic services not otherwise available to HIP members. Except for members receiving State Plan benefits, vision and dental services are only available through the HIP Plus plan. Participation in HIP Plus requires members to regularly pay monthly contributions to their POWER account. The HIP Basic plan is only available to members below the federal poverty level who fail to make their monthly POWER account contributions. The HIP Basic plan is a more limited benefit plan, and does not cover vision and dental services.

For all plans, preventive services, such as annual examinations, smoking cessation programs, and mammograms, are covered without charge to the members and are not included in the deductible amount of $2,500. After the plan deductible is met by way of the $2,500 POWER account, the HIP program includes a comprehensive health plan benefits package.

Individuals enrolled in HIP Employer Link receive the benefits provided by their employer sponsored health plan and not the HIP Basic or Plus benefits. All approved employer sponsored health plans are reviewed by the HIP Employer Link team to ensure compliance with the benefit requirements.

2.1.3 Cost-Sharing

Each HIP member is provided a POWER account valued at $2,500 to pay for the cost of the plan deductible. The POWER account contains contributions made by the State as well as the required monthly contributions from the member. Member contributions are equal to two percent (2%) of income, but in no event will a member contribute less than $1.00 per month or more than $100.00 per month. By contrast, members not paying monthly POWER account contributions participating in HIP Basic are required to make copayments for all services. The copayments are established at maximum Medicaid allowable rates, ranging from $4 per office visit up to $75 per hospital stay, making it potentially more expensive than HIP Plus. Consistent with CMS rules, the program ensures that no member pays more than five percent (5%) of their income, except that HIP Plus requires a minimum $1.00 contribution, even among individuals with no reported income.

Consistent with commercial market practices, applicants are required to make their first month's POWER account contribution prior to the start of benefits. Once an individual pays the POWER account contributions, benefits begin the first day of the month in which the contribution was received. However, in order to expedite coverage, applicants are provided the opportunity to pay a ten dollar ($10.00) fast track POWER account prepayment, while their eligibility application is being processed to accelerate enrollment into the HIP Plus. Individuals with income below the federal poverty level who have not made their initial fast track prepayment or first monthly POWER account contribution within 60 days of invoice will be enrolled in the HIP Basic plan beginning the first day of the month of the expiration of the payment period. Individuals above the poverty level who do not make their first monthly POWER account contribution are not enrolled in HIP and must reapply for coverage and make a contribution to access benefits.

Other than the monthly contributions to the POWER account, the only other cost-sharing for HIP Plus members are copayments for non-emergency use of hospital emergency departments. HIP non-emergency use of hospital emergency copayments equal $8.00 for the first inappropriate visit, and $25.00 for each subsequent visit.

Individuals enrolled in HIP Employer Link have the payment for their employer sponsored insurance deducted from their pay check and receive a check in advance from their HIP Employer Link POWER account to cover the difference between their 2% of income contribution, and the amount their employer deducts for insurance. HIP Employer Link enrollees do not have any cost sharing applied to covered services, provided there are funds remaining in the individuals POWER account.

Section 3: Program Evaluation

Data from an independent evaluation of the HIP program indicates that HIP 2.0 is successfully meeting its goals in delivering affordable consumer-driven healthcare across Indiana. In its first year, HIP 2.0 provided coverage to 345,656[11] individuals, which exceeds the projected enrollment of 319,886.[12] In addition to surpassing enrollment estimates, HIP 2.0 is expanding access to healthcare among those who may not otherwise be able to obtain or afford it, as 60%[13] of members who enrolled into HIP 2.0 were previously uninsured.

A fundamental goal of HIP 2.0 is to promote personal accountability in consumer healthcare behavior, and the evidence demonstrates that HIP 2.0 is achieving this goal. An average of 70% of HIP 2.0 members choose to contribute to their Personal Wellness and Responsibility (POWER) account to enroll into HIP Plus, and over 92% of members continue to contribute

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[11] THE LEWIN GROUP, INDIANA HEALTHY INDIANA PLAN 2.0 INTERIM EVALUATION REPORT (2016), *available at* http://www.in.gov/fssa/hip/files/Lewin_IN%20HIP%202%200%20Interim%20Evaluation%20Report_FINAL. Total number members enrolled in HIP for at least one month.

[12] MILLIMAN, 1115 WAIVER – HEALTHY INDIANA PLAN EXPANSION PROPOSAL (2014), *available at* https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-Expansion-Proposal-06232014.pdf.

[13] THE LEWIN GROUP, INDIANA HEALTHY INDIANA PLAN 2.0 INTERIM EVALUATION REPORT (2016), *available at* http://www.in.gov/fssa/hip/files/Lewin_IN%20HIP%202%200%20Interim%20Evaluation%20Report_FINAL.

throughout their enrollment.[14] Moreover, nearly 60% of these members check the balance of their POWER account, and 40% check their balance at least once a month.[15] Importantly, HIP 2.0 is achieving its goals even amongst the very poor, as 86% of members who choose to contribute to participate in HIP Plus have incomes below the federal poverty level (FPL).[16] This demonstrates that HIP's promotion of value-based decisions among members is working, as members with income below the FPL have the option to not contribute, and accept a lower-value healthcare benefit package known as HIP Basic.

HIP's goal of promoting personal responsibility is driven by the research which indicates that individuals who are vested in their healthcare have better health outcomes.[17] The independent Interim Evaluation of HIP 2.0 confirms the principle of personal responsibility in healthcare, and finds that HIP members who contribute are twice as likely to obtain primary care (31% to 16%), have better prescription drug adherence (84% to 67%), and rely less on the emergency room for routine treatment (775 to 1,034 visits per 1,000 member years), compared to members who choose not to contribute.[18] Further, among members enrolled for the first full twelve months of the program, HIP Plus members obtained more preventive care services than HIP Basic members (87% to 62%).[19] Just as important, HIP members themselves have embraced the value of personal responsibility, as evidenced by the fact HIP Plus members who contribute to their POWER account are more likely to report being satisfied with the program (86%) as compared to HIP Basic members (71%) who are not required to financially contribute to their account. Moreover, 95% of HIP Plus members would re-enroll if they left the program and became eligible again, and 80% would *pay more* to be in the program.[20]

In addition to successfully engaging members, HIP 2.0 is also attracting more healthcare providers. HIP maintains the reimbursement rates established by the original HIP program, which compensates HIP providers at higher Medicare reimbursement rates (or 130% of Medicaid reimbursement rates where a comparable Medicare rate does not exist). This policy initiative has enabled Indiana to add over 6,700[21] new providers to serve both Medicaid and HIP members since the implementation of HIP 2.0. Importantly, almost 30% of providers surveyed indicated they have seen a decline in bad debt, and nearly 40% of providers have seen a reduction in charity care since the introduction of HIP 2.0.[22]

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[14] *Id*.

[15] *Id*.

[16] *Id*.

[17] ROBERT WOOD JOHNSON FOUNDATION, INFOGRAPHIC: STABLE JOBS = HEALTHIER LIVES (2013), *available at* http://www.rwjf.org/content/dam/files/rwjf-web-files/Infographics/Better%20Jobs%20Healthier%20Lives%20Infographic.pdf.

[18] THE LEWIN GROUP, INDIANA HEALTHY INDIANA PLAN 2.0 INTERIM EVALUATION REPORT (2016), *available at* http://www.in.gov/fssa/hip/files/Lewin_IN%20HIP%202%200%20Interim%20Evaluation%20Report_FINAL.

[19] *Id*.

[20] *Id*.

[21] Indiana Family and Social Services Administration, Office of Medicaid Management and Policy (2016).

[22] THE LEWIN GROUP, INDIANA HEALTHY INDIANA PLAN 2.0 INTERIM EVALUATION REPORT (2016), *available at* http://www.in.gov/fssa/hip/files/Lewin_IN%20HIP%202%200%20Interim%20Evaluation%20Report_FINAL.

The following sections provide a detailed analysis on the accomplishments of HIP 2.0.

3.1 Progress on Program Goals

3.1.1 Reduce the number of uninsured, low income Hoosiers and increase access to healthcare services.

Independent analysis of the available data demonstrates that HIP 2.0 has reduced the number of uninsured, low income Hoosiers. In its first year, HIP 2.0 provided coverage to 345,656 unique individuals, which exceeded the projected enrollment count of 319,886 cited to meet budget neutrality.[23] Specific data regarding the reduction in the number of uninsured, low-income Hoosiers is seen in the fact 60% of HIP members were previously uninsured.[24]

Analyses also indicate that HIP is increasing access to healthcare services in two important ways. First, HIP has added over 6,700 new healthcare providers to serve both Medicaid and HIP members. [25] Moreover, HIP requires that each of its three managed care entities (MCEs) ensure that their assigned members have access to a primary medical provider within 30 miles of their residence, and all three MCEs have met this requirement.[26] HIP also requires that each MCE ensure that their assigned members have access to a vision provider and dental provider within 60 miles of their residence, and all three MCEs have met this requirement.[27]

In addition, HIP has been successful in helping low-income individuals maintain access to health insurance through affordable contributions. Approximately 70% of HIP members have elected to enroll in HIP Plus, and more than 92% of members have consistently contributed on a monthly basis to their POWER account.[28] In addition, nearly 90% of HIP members have income below the federal poverty level, demonstrating that participating in HIP is affordable even among very low-income members.[29] In addition, the HIP evaluation member survey found that over half (52%) of members who left the program did so because their income increased or because they acquired private insurance, while only 5% of members surveyed reported leaving the program due to affordability.[30] Further, 80% of HIP Plus members reported being willing to pay more to stay in the program, and 95% reported that they would try to re-enroll in the program if they left and became eligible again.[31]

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[23] MILLIMAN, 1115 WAIVER – HEALTHY INDIANA PLAN EXPANSION PROPOSAL (2014), *available at* https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-Expansion-Proposal-06232014.pdf.

[24] THE LEWIN GROUP, INDIANA HEALTHY INDIANA PLAN 2.0 INTERIM EVALUATION REPORT (2016), *available at* http://www.in.gov/fssa/hip/files/Lewin_IN%20HIP%202%200%20Interim%20Evaluation%20Report_FINAL.

[25] Indiana Family and Social Services Administration, Office of Medicaid Management and Policy (2016).

[26] THE LEWIN GROUP, INDIANA HEALTHY INDIANA PLAN 2.0 INTERIM EVALUATION REPORT (2016), *available at* http://www.in.gov/fssa/hip/files/Lewin_IN%20HIP%202%200%20Interim%20Evaluation%20Report_FINAL.

[27] *Id*.

[28] *Id.*

[29] *Id.*

[30] *Id*.

[31] *Id*.

3.1.2 Promote value-based decision-making and personal health responsibility.

Evidence indicates that HIP is promoting value-based decision-making and personal health responsibility. This fact is demonstrated by five key points.

1. Nearly 70% of all HIP members choose to enroll into HIP Plus, which provides comprehensive healthcare coverage (including dental and vision benefits) with zero copayments in exchange for income-based member contributions to their POWER account.[32] Importantly, HIP 2.0 is promoting value-based decision making even among the very poor, as the vast majority (86%) of individuals who contribute have incomes below the federal poverty level (FPL).[33] The fact that most HIP Plus members have income below the FPL demonstrates that these members are making an active value-based decision to participate in HIP Plus, as members with incomes below the FPL have the option to not contribute and enroll in a reduced-value healthcare benefit package called HIP Basic. Like HIP Plus, HIP Basic provides preventive healthcare coverage free of charge, but requires copayments for non-preventive services, and does not provide coverage for dental or vision services. To summarize, the overwhelming majority (86%) of HIP Plus members have the option to not contribute, and maintain healthcare coverage through a reduced benefit package (HIP Basic), but instead make an active value-based decision to secure healthcare coverage through HIP Plus.[34]

2. In addition to making a value-based decision to contribute to their POWER account, early evidence suggests that HIP Plus members are also taking personal responsibility for their health by checking their POWER account balances. A survey of HIP members conducted less than one year after the start of HIP found that, even with only a few months of program experience, nearly 60% of HIP Plus members check the balance of their POWER account, and 40% check their balance at least once a month.[35]

3. Nearly half of all HIP members (48%) qualified for rollover of their unused POWER account funds during the first year of the program. On average, HIP members with rollover earned $113.00 in remaining funds to reduce their future POWER account contribution amounts, with nearly one in five (18%) of members with rollover earning at least $200 in rollover. Of the members who earned rollover, 47% also earned State-matching funds, which members earn by receiving recommended preventive care services. In the first year, HIP members received over $1.6 million in State-matching rollover funds. In addition, HIP Basic members also successfully managed their POWER accounts. For the first year of HIP rollover, 80% of HIP Basic members who qualified for rollover by managing their account well and receiving preventive care were able to earn the maximum discount amount of 50% off their future HIP Plus contributions.[36]

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[32] *Id*.
[33] *Id*.
[34] *Id*.
[35] *Id*.
[36] Indiana Family and Social Services Administration, Administrative Data, 2017.

4. HIP Plus members also demonstrate personal responsibility by attending primary and specialty appointments, and adhering to the medications prescribed during these appointments at rates considerably higher than HIP Basic members. Specifically, HIP Plus members are nearly twice as likely to obtain primary care (31% to 16%), 40% more likely to obtain specialty care (46% to 28%), and are 20% more likely to adhere to adhere to their prescription drug regimens (84% to 67%) compared to HIP Basic members.[37]

5. In addition to prescription drug adherence and primary care, HIP 2.0 is also promoting value-based decision-making and personal health responsibility in preventive care. Specifically, among members who were enrolled for the full twelve months of the first demonstration year of HIP 2.0 (February 1, 2015 – January 31, 2016), 87% of HIP Plus members have obtained preventive healthcare services.[38] This high rate of preventive care utilization demonstrates HIP's success in encouraging members to take personal responsibility for their healthcare decisions. This high preventive healthcare utilization rate also reflects HIP's success in encouraging members to make value-based decisions. In particular, HIP Plus members who obtain preventive care are able to double the amount of their remaining POWER account contributions rolled over at the end of their benefit period, which can greatly reduce or even eliminate their cost-sharing for the next benefit period. Evidence that HIP's enhanced rollover for preventive care policy is promoting value-based decision-making is shown by the fact over half (52%) of all HIP members surveyed in December 2015 (after less than a year of program experience) reported being aware of this policy.[39]

6. HIP members are relying less on the emergency room for non-emergency healthcare treatment. First, members who contribute (HIP Plus members) are 25% less likely to use the emergency room for non-emergency issues compared to members who choose not to contribute (HIP Basic members).[40] Second, data indicate that HIP's emergency room copayment policy—which requires an $8 copayment for the first non-emergency visit, followed by a $25 copayment for additional non-emergency visits—is reducing non-emergency utilization of the emergency room. As the State did not receive approval from CMS to implement the emergency room copayment policy until February 2016, the State has had a limited opportunity to obtain data regarding the policy's impact on emergency room utilization. However, data from Anthem, the largest of the three MCEs servicing HIP members, found that members who transitioned from the State's traditional Medicaid program (Hoosier Healthwise) had 30% lower emergency room utilization.[41] This finding

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[37] THE LEWIN GROUP, INDIANA HEALTHY INDIANA PLAN 2.0 INTERIM EVALUATION REPORT (2016), *available at* http://www.in.gov/fssa/hip/files/Lewin_IN%20HIP%202%200%20Interim%20Evaluation%20Report_FINAL.

[38] *Id*.

[39] *Id*.

[40] *Id*.

[41] ANTHEM PUBLIC POLICY INSTITUTE, HEALTHY INDIANA PLAN 2.0: ENHANCED CONSUMER ENGAGEMENT AND DECISION-MAKING ARE DRIVING BETTER HEALTH (2016), *available at* https://www.antheminc.com/cs/groups/wellpoint/documents/wlp_assets/d19n/mjuy/~edisp/pw_g252936.pdf.

is significant, because Anthem services over 40% of all HIP members.[42] A comprehensive evaluation of the impact of HIP's emergency room copayment policy will be available approximately two years from CMS approval to implement the policy (December 2017), commensurate with the timelines established within the HIP 2.0 Special Terms and Conditions.

3.1.3 Promote disease prevention and health promotion to achieve better health outcomes.

The available data demonstrate that HIP 2.0 is promoting disease prevention and health promotion to achieve better health outcomes. As stated within the previous section, the vast majority of HIP Plus members (who were enrolled in the full first year) are obtaining preventive healthcare (87%).[43] Further exploration of the data on preventive service utilization among HIP members reveals the cumulative time-sensitive enrollment effect of HIP 2.0, in that the longer members are enrolled in HIP, the more likely they are to obtain preventive healthcare services. In fact, after one month of HIP enrollment, less than 10% of HIP Plus members and less than 5% of HIP Basic members receive preventive healthcare.[44] By twelve months of enrollment, however, those numbers increase to 87% and 62% respectively.[45] This linear relationship between length of enrollment and increasing likelihood of obtaining preventive healthcare is a strong indication that HIP policy is promoting disease prevention and health promotion. As the length of time of member enrollment in HIP increases, so does member awareness and understanding of HIP policies and therefore become increasingly more likely to engage in the health promotion behaviors incentivized by the policies.

3.1.4 Promote private market coverage and family coverage options to reduce network and provider fragmentation within families.

Evidence indicates that HIP 2.0 is promoting private market coverage and family coverage options to reduce network and provider fragmentation within families. HIP 2.0 builds upon the existing private healthcare insurance market by providing premium assistance to low-income families who are offered health insurance coverage through their employer. Leveraging the established private healthcare market conserves Medicaid resources, and keeps families together under a single healthcare insurance plan. HIP Employer Link is an optional program for HIP members whose employers are willing to participate.

In June 2015, the HIP Employer Link program implemented an employer portal to receive employer applications for participation, which allowed the State to approve employers and employer health plans that offer HIP Employer Link to their employees. As of October 2016, HIP Employer Link has enrolled 62 employers, which demonstrates the States aggressive approach in promoting private market coverage.[46] In addition, 31% of HIP Employer Link enrollees have their families enrolled (spouse; child; or spouse and child), which exhibits the program's success in reducing network and provider fragmentation within families.[47]

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[42] Indiana Family and Social Services Administration, *Medicaid Monthly Enrollment Reports*, INDIANA FAMILY & SOCIAL SERVICES ADMINISTRATION, http://www.in.gov/fssa/ompp/4881.htm (last visited Dec. 19, 2016).

[43] *Id*.

[44] *Id*.

[45] *Id*.

[46] Indiana Family and Social Services Administration, Office of Medicaid Management and Policy (2016).

[47] *Id*.

3.1.5 Facilitate HIP member access to job training and stable employment to reduce dependence on public assistance.

The available data demonstrate that HIP 2.0 is facilitating member access to job training and stable employment to reduce dependence on public assistance. The State developed the Gateway to Work program in order to assist unemployed individuals and those working fewer than 20 hours a week in securing new or better employment. Research demonstrates that employed individuals experience better health compared to unemployed individuals, therefore, helping HIP members secure employment is an effective health improvement strategy.[48] The Gateway to Work program launched in May 2015. As of August 2016, a total of 358,342 letters were mailed to inform HIP members of the Gateway to Work program. A total of 1,248 Gateway to Work orientations have been scheduled, with a total of 580 orientations attended.

3.1.6 Assure State fiscal responsibility and efficient management of the program.

HIP was designed to be a fiscally sustainable program to cover uninsured Hoosiers below 138% FPL, as the financing plan does not increase state taxes for Indiana taxpayers but is rather jointly financed through an existing cigarette tax and the Indiana hospitals. Further, HIP is cost-effective and continues to meet its federal budget neutrality requirements to date. In fact, the estimated total cumulative cost from February 1, 2015 through September 30, 2016 was $3.5 billion, including administrative costs.[49] The State has successfully managed the program, as total HIP expenditures to date are below the projected costs contained in the original program projections.

3.2 Health Plan Performance

Indiana has a robust quality oversight plan for continually monitoring the performance of the three managed care entities (MCEs) serving the HIP population: Anthem, MDwise, and MHS. Beginning in calendar year 2017, CareSource, the state's newest MCE, will also be included in the State's ongoing monitoring and quality oversight activities.

The Office of Medicaid Policy and Planning's (OMPP) Quality and Outcome section conducts oversight of the MCEs by regularly monitoring program wide data, required MCE quarterly and annual reporting documents, as well as contract compliance supervision. The State conducts multiple monitoring activities to assure quality and consistent delivery of healthcare services to members consistent with the State's quality strategy plan. Specifically, the various monitoring activities include the following:

- Quality Management and Improvement Program Work Plans (QMIPs);
- Data analysis;
- Enrollee hotlines operated by the State's enrollment broker;
- Geographic mapping for provider network;
- External quality review (EQR);
- Network adequacy assurance submissions;
- On-site monitoring reviews;
- Recognized performance measure reports; and
- Surveys.

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[48] ROBERT WOOD JOHNSON FOUNDATION, INFOGRAPHIC: STABLE JOBS = HEALTHIER LIVES (2013), *available at* http://www.rwjf.org/content/dam/files/rwjf-web-files/Infographics/Better%20Jobs%20Healthier%20Lives%20Infographic.pdf.

[49] Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning (2016).

Each of the contracted health plans are required to develop and maintain a quality management and improvement program (QMIP). The program must incorporate and address data from the plans' Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, quality metrics obtained from the Healthcare Effectiveness Data and Information Set (HEDIS) collected by the National Committee for Quality Assurance (NCQA), as well as address any opportunities for improvement identified in the annual external quality review.

The State utilizes Burns & Associates, Inc. to annually conduct an external quality review (EQR) of each of the MCEs. The current EQR report in production is based on 2015 program data, reflective of the first year of implementation of the expanded HIP 2.0 program. In addition to validating general performance measures and the performance improvement projects, the 2016 EQR for the 2015 calendar year will focus on initiation and engagement of alcohol and other drug treatment, an audit of provider directories, timeliness of prenatal care, and access to dental services. As of the date of publication of this HIP demonstration waiver extension application, the results of the EQR report have not yet been published.

One of the areas of particular focus for the HIP program oversight was related to the medically frail process. Individuals with certain physical, mental and behavioral health conditions are eligible for enhanced benefits aligned with the standard Medicaid state plan benefits. Therefore, appropriate identification of medically frail individuals is a critical MCE function. Throughout 2015, OMPP gathered extensive data regarding members identified as medically frail to ensure that individuals were properly identified and receiving necessary healthcare services. Of the 38,655 individuals in 2015 that were identified as medically frail, a random audit of 10% of the medically frail members revealed a 0.96% error rate, as only 37 HIP medically frail members could not be determined medically frail by the compliance audit team. Based on the results of this first medically frail audit, the MCEs are compliant with the contract terms.

In addition to the formal quality oversight processes, the State maintains consistent and open lines of communications with the health plans. Since 2014, the State has held weekly "office hours" with all three of the MCEs to discuss the operations of the HIP program. In addition, State and MCE executive level staff for all of the MCEs meet once every three weeks. During these regular meetings, the State and MCEs are able to collaborate and address member concerns identified by the customer service team (CST) and to discuss results of the various regular operational reports that support continued program operations. For example, the MCEs are required by contract to submit regular HIP specific operational reports to the State in accordance with the HIP MCE Reporting Manual, which include, but is not limited to a POWER account report, preventive care report, and roll-over report.

Section 4: Requested HIP Program Enhancements

The HIP program has been successful in achieving the underlying program goals of expanding access to care and promoting personal responsibility in a fiscally responsible manner. Therefore, the State desires to maintain the HIP program in its current form and will add the following enhancements.

1. Expand incentives program;

2. Require tobacco-user contribution surcharge;
3. Add new HIP Plus incentive;
4. Reestablish an open enrollment period;
5. Facilitate enrollment in HIP Maternity coverage for pregnant women; and
6. Technical updates to the 2015 Special Terms and Conditions.

4.1 Healthy Incentive Initiative

Private sector research demonstrates that corporations implementing member healthy incentive programs have seen reductions in individual healthcare claims and overall healthcare spending, resulting in lower-than-industry yearly growth in healthcare costs. In addition, industry research shows that lower dollar value incentives are insufficient to change member health behavior or even entice members to engage in a new program.[50]

Medicaid managed care programs have also utilized member incentive programs to influence appropriate healthcare utilization and encourage healthy behaviors, although the dollar value of incentives tends to be significantly lower than those offered in the private sector. Each of the HIP MCEs currently operate member incentive programs that primarily target preventive care and chronic disease management. While the programs vary, each one offers low monetary or gift card incentives (approximately $10-$25 value) to members after the completion of various activities, including participation in a health needs assessment, preventive exams, and prenatal care. Participation rates for these member incentive programs to date has only been between 5% and 15% of total HIP membership.

To increase HIP member participation in these programs and significantly reduce the growth of healthcare costs for Indiana, health incentives must be aligned with the target population and with the State's strategic health goals. One of the primary goals of HIP has always been to improve health outcomes for all members. To better accomplish this goal, the State will align member incentives with specific health challenges facing HIP members. Therefore, the HIP healthy incentive initiative will be targeted to address each of the following focus areas:

- Tobacco cessation;
- Substance use disorder treatment;
- Chronic disease management; and
- Employment related incentives.

The program will be designed to offer outcomes-based incentives to members who meet individually achievable relative goals, as well as some process and participation measures. For example, a member could earn incentives for participation in a disease management program and for decreasing their body weight by a certain percentage over a one year period. Outcomes-based incentives tend to lead to increased member engagement as opposed to the "sign up" types of incentives, as some people will sign up for a program to receive an incentive and thereafter do

[50] Jen Weiczner, *Your Company Wants to Make You Healthy*, THE WALL STREET JOURNAL, April 8, 2013, *available at* http://www.wsj.com/articles/SB10001424127887323393304578360252284151378. *See also GE Brings Wellness to Life,* CORPORATE WELLNESS MAGAZINE, http://www.corporatewellnessmagazine.com/cwminterviews/ge-brings-wellness-to-life/ (last visited Dec. 19, 2016).

not participate in the program.[51] For this reason, the healthy incentive program will offer both types of incentives to encourage initial member sign-up as well as long-term member engagement.

Further, to attain comparable cost reductions experience by the private sector, the State seeks to significantly enhance its existing member incentive program by removing the current low-dollar incentive limitation, and increase available member healthy incentives to a maximum of $200 per initiative, with a total of no more than $300 per member per year in total incentives. To accompany this initiative, the State will launch an outreach campaign to promote member utilization of the program and ensure that incentives are equally available to all members.

The overall healthy incentive initiative will not be limited to members, but will also include components to align MCE and provider quality incentives with the program's strategic health improvement goals. First, the State's managed care contracts will be revised to align MCE withholds and bonuses with the member health focus areas outlined above. Further, as positive health outcomes are more likely to occur when patients work in partnership with their care teams, provider incentives will also be aligned with these focus areas.

4.1.1 Tobacco Cessation Initiative

Tobacco use remains the leading cause of preventable disease and death in the United States, with a disproportionate impact on Medicaid beneficiaries, the uninsured, American Indian/Alaska Natives and multiracial adults, and those living in poverty.[52] It contributes to increased risk for cancers, cardiovascular disease, strokes, and lung diseases. Tobacco use also contributes to health risks for pregnant women and their babies; impacts bone, teeth, and gum health; increases the risk for cataracts, diabetes, and inflammation; and decreases immune function. Family members and friends of smokers can also be adversely impacted, as secondhand smoke exposure has been shown to cause serious disease and death.[53]

Over the past ten years, the United States has seen a decrease in national adult smoking rates from 20.9% in 2005 to 16.8% in 2014.[54] In Indiana, the adult cigarette smoking rate in 2014 was 22.9% - over 6% higher than the national average.[55] A disparity also exists according to income. Nationally, smoking rates among individuals below the federal poverty level are 26.3%, compared to 15.2% for individuals at or above the poverty level. Low income Indiana residents have particularly high smoking rates, with 42.0% of adults with a household income under

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[51] *GE Brings Wellness to Life,* CORPORATE WELLNESS MAGAZINE, http://www.corporatewellnessmagazine.com/cwminterviews/ge-brings-wellness-to-life/ (last visited Dec. 19, 2016).

[52] ROBERT WOOD JOHNSON FOUNDATION, INFOGRAPHIC: STABLE JOBS = HEALTHIER LIVES (2013), *available at* http://www.rwjf.org/content/dam/files/rwjf-web-files/Infographics/Better%20Jobs%20Healthier%20Lives%20Infographic.pdf.

[53] U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, THE HEALTH CONSEQUENCES OF SMOKING—50 YEARS OF PROGRESS (2014), *available at* http://www.surgeongeneral.gov/library/reports/50-years-of-progress/full-report.pdf.

[54] A. Jamal et al., *Current Cigarette Smoking Among Adults — United States, 2005–2014*, 64 MORBIDITY AND MORTALITY WEEKLY REPORT, 44 (2015).

[55] *Behavioral Risk Factor Data: Tobacco Use (2011 to Present)*, U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION (2016), https://chronicdata.cdc.gov/Survey-Data/Behavioral-Risk-Factor-Data-Tobacco-Use-2011-to-pr/wsas-xwh5 (last visited Dec. 19, 2016).

$15,000 a year describing themselves as current smokers.[56] By comparison, 14.2% of adults with a household income over $50,000 per year reported current tobacco use.[57] Another study in Indiana suggests a smoking rate of 37.7% among individuals with a household income of less than $25,000 per year, which equates to approximately 414,400 low income Indiana residents who smoke—many of which are eligible for HIP. A recent report from the Centers for Disease Control and Prevention also indicated that smoking prevalence among Indiana Medicaid beneficiaries was 48.3% as of December 2015—one of the highest rates in the nation.[58] In addition, Indiana has the 4th highest secondhand smoke exposure rate in the country. In 2012, 53.4% of Hoosiers reported exposure to secondhand smoke within the past seven days.[59]

The costs associated with smoking are substantial. In all, costs attributable to direct healthcare expenditures and lost productivity related to tobacco use and secondhand smoke in the United States now approach $300 billion annually.[60] In Indiana, tobacco contributes to over 11,000 deaths, and an estimated $6.1 billion in tobacco-associated medical costs and productivity losses, annually.[61] Finally, an estimated $589.8 million in tobacco-associated medical costs for services such as cancer treatment, respiratory disease management, diabetes management, etc. are covered by Indiana Medicaid annually.[62]

As of December 1, 2016, over 394,000 people were enrolled in the current Healthy Indiana Plan.[63] Of the members who completed the Health Needs Screening (approximately 93,239 individuals), over 35,400 members, or approximately 38%, were identified as current tobacco users. Further, out of the 89,464 members with a formal "tobacco use disorder" diagnosis, only 7,008 individuals had a claim for tobacco cessation medication in calendar year 2015.[64]

This low utilization rate is consistent with national utilization rates. One of the most likely reasons for low utilization of Medicaid tobacco dependency treatment benefits is the lack of

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[56] BRFSS Prevalence and Trends Data, U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/brfss/brfssprevalence/ (last updated Aug. 18, 2016).

[57] *Id*.

[58] A. DiGiulio et al., *State Medicaid Expansion Tobacco Cessation Coverage and Number of Adult Smokers Enrolled in Expansion Coverage—United States, 2016*, 65 MORBIDITY AND MORTALITY WEEKLY REPORT 1364 (2016).

[59] *Tobacco Control State Highlights: Indiana*, U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION, http://www.cdc.gov/tobacco/data_statistics/state_data/state_highlights/2012/states/indiana/index.htm (last reviewed Dec. 9, 2014).

[60] L. Bach, *Toll of Tobacco in the United States of America*, CAMPAIGN FOR TOBACCO FREE KIDS, http://www.tobaccofreekids.org/facts_issues/toll_us (last updated Nov. 29, 2016).

[61] U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, THE HEALTH CONSEQUENCES OF SMOKING—50 YEARS OF PROGRESS (2014), *Toll of Tobacco in the United States: The Toll of Tobacco in Indiana,* CAMPAIGN FOR TOBACCO FREE KIDS, https://www.tobaccofreekids.org/facts_issues/toll_us/indiana (last updated Nov. 1, 2016).

[62] *Id*.

[63] Indiana Advanced Information Management (Indiana*AIM*) (2016). Total of all members fully open and enrolled.

[64] Indiana Family and Social Services Administration (2016).

awareness among beneficiaries and providers.[65,66] This lack of awareness is demonstrated throughout the literature. For example, a study by Vt. Tong et al., found that among surveyed obstetricians-gynecologists, 83% were unaware of the ACA requirements to provide tobacco cessation services without cost-sharing for pregnant Medicaid beneficiaries. Another study of two states with comprehensive tobacco cessation benefits for Medicaid beneficiaries found that only 36% of Medicaid-enrolled smokers and 60% of Medicaid physicians knew that their state program offered any coverage for tobacco dependence.[67] Finally, in those states where utilization of Medicaid tobacco dependency treatment benefits is particularly high (e.g., Massachusetts and Wisconsin), public health and Medicaid programs report collaborating to develop beneficiary and provider-specific education campaigns to promote awareness of smoking cessation benefits.[68]

To improve tobacco cessation service utilization, Indiana's Medicaid program has recently enhanced its benefit package to be one of the most robust in the country. Currently, all of the HIP health plans provide the Food and Drug Administration (FDA) approved tobacco cessation products, as well as a variety of counseling services (individual counseling, group counseling, and phone counseling) to ensure member access to smoking cessation tools and resources. Until recently, one key limitation on tobacco cessation coverage was the restriction allowing a single 12-week course of treatment every 12 months. In 2016, the State removed this restriction, as well as added several provider types eligible to provide treatment, including optometrists, clinical social workers, marriage and family counselors, mental health counselors, and others.[69]

To build upon these efforts, the State seeks to increase member utilization of these tobacco cessation services by: (1) improving member and provider awareness of the benefits; (2) offering an incentive program for participants to complete smoking cessation courses and to quit smoking and (3) discouraging tobacco use through a premium surcharge for HIP Plus members.

Research shows that other state Medicaid programs have been able to decrease adult smoking rates by 10% over two years and increase successful quit attempts by approximately 12%.[70] Specifically, one state saw substantial reductions in hospital inpatient admissions for acute heart attacks, reductions for other health disease-related services, and reductions in inpatient admissions for chest pain, implying health outcome improvements for members. In addition, it also saw financial benefits from the efforts—for every $1 invested in the effort, the Medicaid program saved a net $2.12.[71]

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[65] J. Green et al., *The Impact of Tobacco Dependence Treatment Coverage and Copayments in Medicaid,* 46(4) AMERICAN JOURNAL OF PREVENTIVE MEDICINE 331 (2014).

[66] V. Tong, *Clinicians' Awareness of the Affordable Care Act Mandate to Provide Comprehensive Tobacco Cessation Treatment for Pregnant Women Covered by Medicaid*. 2 PREVENTIVE MEDICINE REPORTS 686 (2015).

[67] S. McMenamin et al., *Physician and enrollee knowledge of Medicaid coverage for tobacco dependence treatments*, 26(2) AMERICAN JOURNAL OF PREVENTIVE MEDICINE 99 (2004).

[68] L. Ku et al., *Medicaid Tobacco Cessation: Big Gaps Remain In Efforts To Get Smokers To Quit*, 35(1) HEALTH AFFAIRS 62 (2016).

[69] 405 Ind. Admin. Code 5-37 (2016).

[70] MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH, MASSHEALTH SMOKING CESSATION BENEFIT: BRIEFING NOTES (2012), *available at* http://www.mass.gov/eohhs/docs/dph/tobacco-control/masshealth-smoke-cessation-benefit.doc.

[71] *Id*.

The Indiana Family and Social Services Administration (FSSA) would leverage a multitude of outreach strategies, as well as existing MCE knowledge of its provider and member communities and public health partners, to identify communication strategies that are most likely to be successful in Indiana. FSSA will collaborate with the HIP MCEs to develop a robust and consistent communication plan to inform both participating providers and beneficiaries of the available tobacco cessation benefits.

To enhance the tobacco cessation initiative, FSSA will encourage service utilization through the implementation of an incentive program. Both private companies and state Medicaid agencies have piloted incentive programs as a means of encouraging beneficiaries to discontinue their tobacco use. Studies on the impact of incentive programs find that the incentive does consistently increase program engagement and member satisfaction.[72,73]

Two studies of private company tobacco cessation incentive programs indicate that periodic and increasing incentive amounts will encourage members to participate in the program; and that these types of incentives make participants more likely to abstain from tobacco for longer periods of time than the control groups that do not receive incentives.[74] To leverage this private industry success, HIP aims to further encourage increased participation in tobacco cessation efforts by requiring its MCEs to offer incentives to members who participate in tobacco cessation treatments. All program participants will have access to all FDA-approved tobacco cessation medications and a variety of counseling formats including individual, group, and phone counseling.

To encourage MCE participation in the tobacco cessation incentives initiative, the State will also utilize financial incentives with the managed care contracts related to achieving specified smoking cessation outcomes.

Lastly, HIP will seek to encourage member level participation in these available tobacco cessation benefits and programs by leveraging an existing private market insurance policy—charging higher premiums on tobacco users. POWER account contributions will increase for tobacco users in accordance with the allowable ACA rating rules, as detailed in Section 4.2 of this demonstration extension application.

Ultimately, the HIP tobacco cessation initiative is a multi-faceted approach that builds off of the recent expansion of the tobacco cessation benefit to align with industry best-practice recommendations. For the demonstration period, HIP will seek to actively encourage member participation in tobacco cessation activities through a robust communication campaign to educate

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[72] K. Volpp et al., *A Randomized, Controlled Trial of Financial Incentives for Smoking Cessation*, 360 NEW ENGLAND JOURNAL OF MEDICINE 699 (2009), S. Halpern, *Randomized Trial of Four Financial-Incentive Programs for Smoking Cessation*, 372 NEW ENGLAND JOURNAL OF MEDICINE 2108 (2015).

[73] S. Halpern, *Randomized Trial of Four Financial-Incentive Programs for Smoking Cessation*, 372 NEW ENGLAND JOURNAL OF MEDICINE 2108 (2015).

[74] K. Volpp et al., *A Randomized, Controlled Trial of Financial Incentives for Smoking Cessation*, 360 NEW ENGLAND JOURNAL OF MEDICINE 699 (2009), S. Halpern, *Randomized Trial of Four Financial-Incentive Programs for Smoking Cessation*, 372 NEW ENGLAND JOURNAL OF MEDICINE 2108 (2015).

members about the available benefits and incentives, complementary incentive and disincentive structure, and the addition of MCE contractual requirements and financial incentives for positive outcomes.

4.1.2 Substance Use Disorder (SUD) Incentives

A recent report from the Substance Abuse and Mental Health Services Agency (SAMHSA) estimated that the prevalence of SUD among persons eligible for Medicaid is 21%.[75] An analysis of the HIP population estimates that there are approximately 81,000 HIP members living with SUD.[76] However, despite the growing drug crisis in the State and estimates of high prevalence of SUD among HIP members, utilization of available mental health and SUD treatment benefits remains relatively low among HIP participants. Specifically, an analysis of program claims data indicates that only 28% of HIP members with a formal substance use disorder diagnosis are receiving treatment for their addiction. Due to the nature of substance use disorder, many people do not seek treatment for their SUD.

As detailed in Section 6 of this waiver extension application, the State is seeking to add coverage for new SUD treatment in order to enhance current benefits to provide the full continuum of care for all Medicaid recipients. Additional services will include expansion of inpatient detoxification, additional residential services (as well as an expansion in the number of providers eligible to provide residential treatment services), and the addition of addiction specific outpatient treatment services, including, peer recovery supports and relapse prevention. By allowing reimbursement for residential services, persons recovering from SUD following detoxification treatment will have the opportunity to establish a meaningful period of sobriety prior to returning to unsupervised daily living. While this waiver will expand access to SUD treatment services, the State also seeks to encourage members to utilize these available benefits in a meaningful way by requiring MCEs to develop targeted member incentive programs aimed at addressing SUD and engaging individuals in treatment. Various studies have concluded that incentives for achieving drug abstinence are effective, with one study in particular finding that a linear increase in efficacy as incentives increased, with best outcomes obtained with incentives averaging nearly $16 per day.[77] The study further concluded that while the SUD incentive program costs may seem great, nearly every cost-effectiveness analysis conducted on such programs have found them to be cost-effective.[78]

The member incentive program will provide financial incentives for members who voluntarily complete specified activities related to SUD treatment and recovery, which may include compliance with the SUD treatment plan established by a licensed medical professional or achieving clean follow-up appointments. All MCE SUD member incentive programs must be approved by the State.

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[75] SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, BEHAVIORAL HEALTH TREATMENT NEEDS ASSESSMENT TOOLKIT FOR STATES (2013), *available at* https://store.samhsa.gov/shin/content/SMA13-4757/SMA13-4757.pdf.

[76] MILLIMAN, GROUP-UP SUD COST DEVELOPMENT METHODOLOGY (2015), on file with author.

[77] D. Hand et al., *Improving Medicaid Health Incentives Programs: Lessons from Substance Abuse Treatment Research*, 63 PREVENTIVE MEDICINE 87 (2014).

[78] *Id.*

4.1.3 Chronic Disease Management Incentives

Since the program was first implemented in 2008, HIP has long focused on encouraging members to engage in healthy behaviors, including obtaining preventive health and, if needed, engaging in chronic disease management activities. The MCEs all have robust chronic disease management programs available to their members as well as several member incentive programs to encourage participation. While the MCEs have relatively high initial member enrollment in their chronic disease management programs (approximately 115,000 HIP members), the State seeks to encourage more active member participation to more effectively improve health outcomes. Therefore, as part of the broader healthy incentive initiative, the State seeks to give increased flexibility to the MCEs to direct additional resources towards encouraging *active* member participation in their chronic disease management programs and producing improved health outcomes. MCEs will be expected to offer members incentives not only for enrollment in chronic disease management programs, but also completion of specified milestones and healthy targets in each of the various chronic disease management programs established by the MCE, including diabetes management, weight management, and pharmacy compliance initiatives.

4.1.4 Employment Related Incentives

In 2015, HIP introduced the new Gateway to Work program designed to promote employment by integrating the State's various work training and job search programs with HIP. Through this initiative, all eligible HIP members who are unemployed or working less than 20 hours per week are referred to available employment, work search and job training programs to assist the member in securing gainful employment. After the referral is made via Gateway to Work, member participation in the available employment and training related programs is voluntary. Due to the voluntary nature of the program, as of August 27, 2016, only 580 Gateway to Work orientations had been attended by members interested in participating in the available employment and training services available to them.

It has been well documented that employed individuals are both physically and mentally healthier, as well as more financially stable, as compared to unemployed individuals.[79] Due to the strong connection between employment and overall health, people who are unemployed have a higher mortality and poorer health outcomes, and, further, longitudinal studies have found that these effects of unemployment exist regardless of any pre-existing health conditions.[80] CMS has long-recognized this important connection and has consistently supported Medicaid employment initiatives. In fact, the enabling act for Medicaid explicitly states that one of the goals of the program is to connect Medicaid recipients to services aimed at assisting "families and individuals attain or retain capability for independence."[81] This goal is reinforced on CMS' website which states:

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[79] F.M. McKee-Ryan et al., *Psychological and physical well-being during unemployment: a meta-analytic study,* 90(1) JOURNAL OF APPLIED PSYCHOLOGY 53 (2005), K.I. Paul et al., *Latent deprivation among people who are employed, unemployed, or out of the labor force*, 143(5) JOURNAL OF PSYCHOLOGY 477 (2009).

[80] ROBERT WOOD JOHNSON FOUNDATION, WORK MATTERS FOR HEALTH (2008), *available at* http://www.commissiononhealth.org/PDF/0e8ca13d-6fb8-451d-bac8-7d15343aacff/Issue%20Brief%204%20Dec%2008%20-%20Work%20and%20Health.pdf.

[81] 42 U.S.C. §1396-1 (2015).

> *"The Center for Medicare & Medicaid Services (CMS) recognizes that employment is a fundamental part of life for people with and without disabilities. Employment provides a sense of purpose, how we contribute to our community and are associated with positive physical and mental health benefits. Meaningful work is part of building a healthy lifestyle as a contributing member to society and essential to individual's economic self-sufficiency, self-esteem and well-being."*[82]

Through this HIP extension application, the State seeks to encourage participation in the Gateway to Work program in order to connect members to gainful employment, which not only improves physical and mental health, but the individual's overall financial stability and well-being. To this end, the managed care entities will be required to develop member incentive programs specific to promoting employment, including but not limited to rewarding members for successful participation in the HIP Gateway to Work program through the completion of available job training, work search, or educational activities that will assist members in securing gainful employment. The State will investigate whether providing member incentives will improve participation in the various employment and training programs available to HIP members, and thus increase overall employment rates among HIP participants. Ultimately, these efforts to improve employment rates are critical to improving member health (including addressing the drug abuse epidemic) and reducing overall poverty.

4.2 Cost-Sharing Modification: Tobacco Contribution Surcharge

To compliment the positive incentives related to the tobacco cessation initiative as described above in Section 4.1.1 of this waiver extension application, the State will seek to strengthen this initiative by adding a tobacco-user surcharge to HIP Plus members. Currently, all HIP members are required to contribute two percent (2%) of income per month to their POWER account to maintain access to the enhanced HIP Plus plan. However, to encourage participation in the voluntary tobacco cessation initiative, members who are known tobacco users will be required to pay monthly contributions equal to three percent (3%) of income in their second year of eligibility. For individuals identified as a tobacco user, the tobacco surcharge will be waived for the first year of enrollment in order to provide the individual the opportunity to take advantage of the robust tobacco cessation benefits offered through HIP. During this 12-month period, the MCEs will be required to conduct active outreach and member education related to the tobacco cessation benefits available through HIP as well as the tobacco cessation member incentive program. If after a year, the member continues to be a tobacco user, their monthly premiums will increase beginning in the first month of their renewed benefit period.

The proposed tobacco surcharge is consistent with the Affordable Care Act (ACA) rating rules which allow qualified health plans on the Marketplace to charge up to 1.5 times the rate charged to a non-smoker. Tobacco use is defined in federal regulation as the "use of tobacco on average four or more times per week within no longer than the past six months." HIP will align with this definition by ensuring the MCE member Health Needs Screening captures tobacco use frequency

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[82] *Medicaid Employment Initiatives*, CENTERS FOR MEDICARE AND MEDICAID SERVICES, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Grant-Programs/Employment-Initiatives.html (last visited Dec. 19, 2016).

within the past six months, with an option to impose a higher usage threshold and/or shorter look-back period.

4.3 HIP Plus Incentive

The State will add chiropractic benefits to the HIP Plus plan to promote participation in HIP Plus through regular contributions to the member's POWER account. Specifically, the HIP Plus alternative benefit plan will be amended to add chiropractic services, limited to one (1) visit per day and six visits per covered person per benefit year. This benefit modification will further enhance the value proposition underlying the HIP plan structure, which will include vision, dental and chiropractic services.

4.4 Reestablish HIP Open Enrollment

Since 2008 when the program was first implemented, HIP has instituted various policies aimed at encouraging members to take personal responsibility. One such long standing HIP policy targeted compliance with annual redetermination processes in order to prepare members for the annual open enrollment processes typical in the commercial market. The original HIP program required a 12-month open enrollment period, whereby members who failed to comply with redetermination process had to wait 12 months prior to re-enrolling in HIP. In 2016, the Indiana General Assembly reconfirmed this policy and lowered the open enrollment period to six months, rather than 12 months, consistent with other 2015 HIP program modifications. Therefore, in accordance with Ind. Code 12-15-44.5-4.9(b), the State seeks to implement a member specific open enrollment period, whereby members who lose eligibility due to failure to comply with redetermination process will be required to wait six months until their next open enrollment period to re-enroll in HIP coverage.

All HIP members will be required to complete the annual redetermination process within the required timeframes. Approximately 3 months prior to the expiration of their 12 month benefit period, each HIP member will be notified of the upcoming redetermination period and may be asked to submit documentation necessary for the State to determine continued program eligibility. If the required documentation is not provided prior to the expiration of the current benefit period, the member will be disenrolled from HIP. The member can reenroll within 90 days from the end of the expired benefit period without a new application, if the former member submits the requested redetermination information. However, after the 90 day period, the member is required to wait another three months, or six months from the initial date of disenrollment, until their next open enrollment before being permitted to reenroll in HIP. Ultimately, all HIP members are given a total of six months (three months before the end of their benefit period and three months after their benefit period ends) to comply with the redetermination requirements, and receive numerous communications from the State and MCEs during this time.

In addition, the open enrollment policy does not apply to members who are medically frail, pregnant, low-income parents and caretakers, or low-income 19 and 20 year old dependents. In addition, individuals who experience a change in circumstances which prevented completion of

the redetermination process as detailed in 405 IAC 10-10-13(e) are also exempt from the open enrollment period and may reapply at any time.[83]

This long-standing redetermination and open enrollment policy in the original HIP program was successful in educating members about the importance of complying with commercial market open enrollment policies. When this policy was implemented in the original HIP program, eighty-five percent (85%) of members returned the redetermination packet in a timely manner in the first two years of the program. However, by the end of 2012 after the initial 5 year demonstration period, that proportion increased to ninety-two percent (92%). Improved compliance with redetermination requirements not only helps to prepare members for participation in the commercial insurance marketplace, but it also results in better continuity of care and improved health outcomes for members. Ultimately, as demonstrated in the original HIP waiver, the open enrollment policy will help to encourage completion of the required redetermination processes which will result in an overall increase in continuity of care for HIP members.

4.5 HIP Maternity Coverage

HIP members who become pregnant may choose to remain enrolled in HIP, or may transfer to the Hoosier Healthwise program- Indiana's traditional Medicaid managed care program for children and pregnant women. However, women who choose to remain in HIP are *required* to transfer from HIP to Hoosier Healthwise if they remain pregnant during their annual redetermination period. In addition, individuals who apply for Medicaid coverage while pregnant are automatically enrolled in Hoosier Healthwise, and then transition to HIP following the post-partum coverage period if their income is equal to or less than 138% FPL.

HIP provides maternity coverage that is equal to the coverage provided under the Hoosier Healthwise program, and, consistent with federal law, there is no cost sharing for pregnant women under either program. Further, the managed care entities managing the programs are the same. However, despite the fact that there is no functional difference between the programs, the required program transfers are burdensome for the member, providers, and the State. Therefore, the State requests to modify eligibility criteria to require enrollment in HIP for pregnant women with income under 138% FPL. The State would continue to track these individuals separately for purposes of federal medical assistance percentages (FMAPs) used to determine the federal matching funds. In addition, the Hoosier Healthwise program will be maintained for pregnant women with income greater than 138% FPL who would not be eligible for HIP following the end of pregnancy. The program consistency resulting from this policy modification would improve continuity of care for the member and reduce the administration for the State and providers, without negatively impacting member care.

[83] 405 Ind. Admin. Code 10-10-13(e) (2015). Indiana Administrative Code states that a member who is disenrolled may be reinstated prior to the expiration of the six (6) month period in the event the member experience one of the following qualifying events: (1) obtained and subsequently lost private insurance coverage; (2) had a loss of income after disqualification due to increased income; (3) took up residence in another state and later returned; (4) was a victim of domestic violence; (5) was residing in a county subject to a disaster declaration made in accordance with IC 10-14-3-12 at any time during the sixty (60) calendar days prior to or including the date such member was terminated from the plan.

4.6 Technical Revisions & Updates to Current HIP Special Terms and Conditions

In addition to the above, the State will seek the following minor technical updates to special terms and conditions, each of which, are discussed in more detail below:

1. Remove prior claims payment program;
2. Continue waiver allowing HIP emergency room copayment policy;
3. Continue waiver of non-emergency medical transportation for HIP Basic and HIP Plus;
4. Carve out hepatitis C drugs from managed care; and
5. Plan changes and member transitions.

4.6.1 Prior Claims Payment Program.

The 2015 HIP Special Terms and Conditions (STCs) included a waiver of retroactive coverage for all HIP members, but maintained a one year phase out program for a small subsection of newly enrolled HIP members. This "prior claims payment" program provides retroactive coverage for medical services received during the 90-day period prior to the new member's HIP enrollment. However, this limited program is only available to a small subsection of HIP members eligible pursuant to Section 1931 parents and caretakers who have not received Medicaid coverage within two (2) years of enrollment and who did not gain HIP coverage through presumptive eligibility. Due to the very small target population as well as the general lack of need for the transition program, the prior claims payment program initiative had very low utilization, as the State anticipated. Between February 1, 2015 and October 1, 2016, only 15,699 individuals (8% of the total Section 1931 group) were eligible for the program, and only 2,409 individuals (15% of the total individuals qualifying) actually utilized the benefit.[84]

This program was designed to help very low-income parents and caretakers transition to coverage without the financial burden of medical claims incurred immediately prior to enrollment. However, as demonstrated by the low utilization, this transitional assistance program is no longer needed for several reasons. First, due to the expanded HIP program and availability of tax credits, more individuals are moving to HIP from other coverage, meaning less individuals are enrolling in HIP with unpaid medical bills. Second, a survey of three of the largest hospital systems in the state (comprising nearly 45% of all hospitals) indicated that HIP members are not being billed for claims incurred prior to enrollment. Third, the expanded presumptive eligibility process has been very successful in enrolling uninsured individuals into coverage quickly at the site of care prior to the individual incurring non-covered claims. For these reasons, the State requests that CMS remove the transitional prior claims payment program for the waiver extension period.

4.6.2 Copayments for Non-Emergent Use of Hospital Emergency Department.

The State received a two-year Section 1916(f) waiver to test the application of graduated copayments, whereby HIP members are charged an $8.00 copayment for the first inappropriate emergency department visit, and $25 for each subsequent inappropriate emergency department visit. The STCs required CMS to approve an emergency room copayment protocol prior to implementation of the graduated copayment, including the detailed design and processes to support the initiative, as well as the establishment of a control group which would be subject to the standard $8.00 copayment for each visit. This final protocol was not finalized and approved

[84] Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning (2016).

for nearly a year, delaying implementation of the graduated copayment policy until February 2016. Due to the timing of the waiver extension application submission requirements, the initial independent evaluation of this policy has not yet been completed at the time of publication.

However, one of the HIP managed care entities (MCEs), Anthem, published a report in July 2016, citing internal data indicating that emergency room utilization was approximately 30% lower among HIP Plus members compared to emergency room utilization among the same group while enrolled in traditional Medicaid.[85] This is consistent with the data from the original HIP program, which experienced a 34% decrease in emergency department visits from 2009 to 2013 among the group subject to $25 copayments for inappropriate emergency department visits. Based on early program data, the State anticipates that the final report will demonstrate that the graduated copayment structure resulted in cost savings and better quality of care through avoidance of inappropriate emergency department visits.

Based on initial HIP 2.0 program data, results of MCE led focus groups, and the State's prior program experience demonstrating the effectiveness of $25 copayments for inappropriate emergency room utilization, the State requests that CMS renew the cost sharing waiver beyond the initial two-year Section 1916(f) waiver period, which is currently set to expire on January 31, 2018. Specifically, the State requests that CMS make the HIP emergency department copayment policy permanent, and not subject to the additional restrictions imposed during the previous waiver period.

4.6.3 Non-Emergency Medical Transportation (NEMT).

While Indiana previously operated HIP with an NEMT waiver for seven years, the HIP 2.0 STCs only granted the State a one-year waiver of this policy. On December 22, 2015, CMS temporarily extended the NEMT waiver through November 30, 2016, to allow more time for adequate data collection. On August 1, 2016, Indiana submitted a request to amend the current STCs to extend the NEMT waiver for the duration of the current demonstration.

To support this request, the State included extensive data from an independent evaluation of the impact of the NEMT waiver on member access to care. The State submitted an initial evaluation of the Indiana HIP NEMT waiver to CMS on March 1, 2016 based on a survey of 600 HIP members conducted in December 2015 and January 2016.[86] The State later funded a second survey – administered in June 2016 – with a much larger sample size: 5,173 HIP members as of May 2016. Of these, there were 4,357 completed surveys from Regular Plan members and 816 completed surveys from State Plan members. The larger sample size allowed for in-depth analysis of differences in member access to health care between those receiving and not receiving NEMT services. However, both of these separate member surveys found that HIP members *without* access to NEMT actually reported lower incidents of missed medical

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[85] ANTHEM PUBLIC POLICY INSTITUTE, HEALTHY INDIANA PLAN 2.0: ENHANCED CONSUMER ENGAGEMENT AND DECISION-MAKING ARE DRIVING BETTER HEALTH (2016), *available at* https://www.antheminc.com/cs/groups/wellpoint/documents/wlp_assets/d19n/mjuy/~edisp/pw_g252936.pdf.

[86] THE LEWIN GROUP, INDIANA HEALTHY INDIANA PLAN 2.0: EVALUATION OF NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) WAIVER (2016), *available at* https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-nemt-eval-03112016.pdf

appointments due to transportation-related issues as compared to HIP members *with* access to NEMT benefits.[87] Based on the clear data, state-provided NEMT benefits do not lead to improved member access to healthcare services for HIP members. Further, approximately two-thirds of members reported driving themselves to appointments in their own car, while over 90% reported using their own car or someone else's.[88]

Therefore, the State renews its request for a waiver of NEMT for the duration of the HIP extension waiver period. The HIP program is designed to provide commercial healthcare coverage to able-bodied adults. However, the more vulnerable and high risk members of the HIP population who are exempt from alternative benefit plans and receive Medicaid State Plan benefits will continue to be provided NEMT services, including pregnant women, individuals determined to be medically frail, Section 1931 parents and caretaker relatives, and individuals eligible for transitional medical assistance.

4.6.4 Hepatitis C Drug Coverage.

Effective September 1, 2016, all covered hepatitis C drugs were carved out of managed care, including HIP. HIP members are still able to access all such covered hepatitis C drugs through the Medicaid fee-for-service pharmacy benefit manager, rather than through their assigned MCE. The State requests that this program revision be documented in the revised STCs.

4.6.5 Plan Changes and Member Transitions.

Currently, HIP members select a managed care entity on the application, and can change their selection at any time prior to making their initial POWER account contribution. Thereafter, HIP members may change their health plan annually during their redetermination period, or anytime during the 12-month benefit period for one of the specified "for cause" reasons described in 405 IAC 10-8-2(b), such as receiving poor quality of care.[89] While the reasons for transitioning between plans is limited, members often leave and return to the program within a 12 month period, often resulting in changed health plans and new POWER accounts. The State seeks to maintain plan choice for members for the complete 12 month period. Therefore, if a member selects an MCE and begins eligibility, they will remain with that MCE for the full 12 months, even if the individual disenrolls and re-enrolls in HIP coverage within the same 12 month period. Members will continue to have the ability to change plans for "just cause" reasons specified in 405 IAC 10-8-2(b). In addition, rather than providing new POWER accounts, individuals who re-enroll in coverage in the same 12 month period will have their POWER account reinstated

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[87] *Id.* The member survey, conducted in 2015, found that transportation was reported as the primary reason for missing a healthcare appointment for 11% of HIP members with access to NEMT coverage, and only 6% among individuals without access to NEMT benefits. The 2016 member survey found that HIP members without state-provided NEMT benefits missed fewer appointments than members with state-provided NEMT (10.9% to 13.6%).

[88] *Id*.

[89] 405 Ind. Admin. Code 10-8-2(b) (2016). Indiana Administrative Code provides the following as "for cause" reasons for MCE disenrollment: (1) the causes for disenrollment set forth in 42 CFR 438.56(d)(2)(i) – (iii); (2) receiving poor quality care; (3) failure of the insurer to provide covered services; (4) failure of the insurer to comply with established standards of medical care administration; (5) lack of access to providers experienced in dealing with the member's health care needs; (6) significant language or cultural barriers; (7) corrective action levied against the insurer by the office; (8) limited access to a primary care clinic or other health services within reasonable proximity to a member's residence; (9) a determination that another insurer's formulary is more consistent with a new member's existing health care needs; and (10) other circumstances determined by the office to constitute poor quality of health care coverage.

rather than receiving a new POWER account. Minimizing changes associated with member transitions will result in improved continuity of care for the member as well as administrative savings for the State.

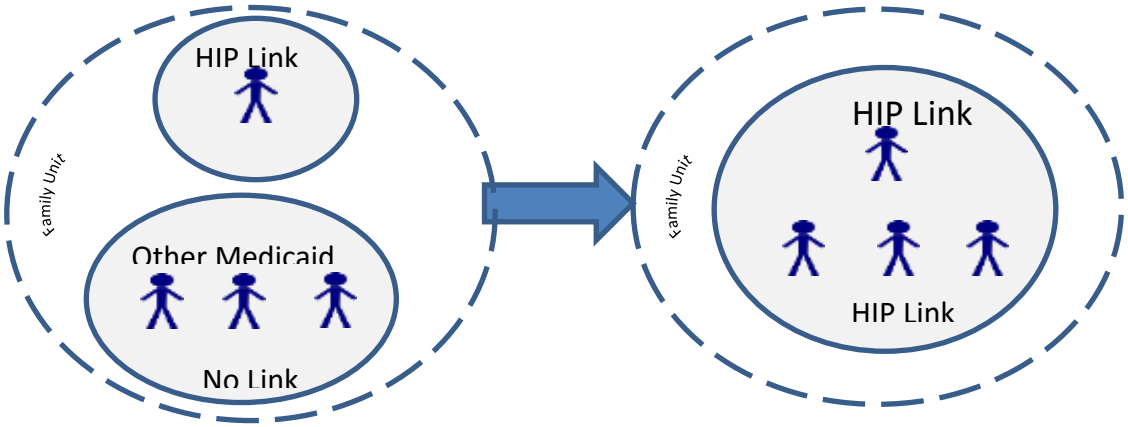
In addition, to ease transitions for members transitioning to HIP from other Medicaid categories or between types of HIP coverage, HIP eligible individuals making such a transition will be immediately enrolled in the HIP Basic plan with a 60-day opportunity to make an initial POWER account contribution to move to HIP Plus. This process avoids potential gaps in coverage during the critical transition periods for post-partum women transitioning from Hoosier Healthwise, incarcerated individuals transitioning back to the community, and other similar member transitions.

Section 5: Enhancements to HIP Employer Link

HIP Employer Link allows HIP eligible individuals who have access to qualifying employer sponsored insurance to enroll in the employer's health insurance instead of enrolling in HIP. Individuals enrolled in HIP Employer Link receive a $4,000 POWER account to cover the costs of the premiums and medical care on their employer sponsored plan. HIP Employer Link began enrolling employers in July of 2015 and coverage began for the first employee in November 2015. Today, HIP Employer Link is only available to HIP eligible individuals, while the other family members of HIP Employer Link eligible members in different Medicaid categories are not eligible to participate in this program. For example, children of HIP Employer Link members under age 19 are not currently eligible for HIP Employer Link premium assistance. This results in the HIP Employer Link eligible parent enrolling in their employer sponsored insurance with HIP Link premium support, and the child not having the option of premium support and remaining enrolled only in Medicaid.

HIP Employer Link builds upon one of the fundamental goals of the HIP program—to promote private market coverage and family coverage options to reduce network and provider fragmentation within families. To more fully achieve this goal, the State plans to extend the HIP Employer Link coverage option to all Medicaid eligible family members of HIP Employer Link enrollees. This would mean that in place of a parent receiving HIP Employer Link premium assistance and the children being enrolled in Medicaid, that the entire Medicaid eligible family of the HIP Employer Link enrollee would be eligible for premium assistance.

HIP Employer Link: Enhancement to offer Family Coverage



Non-HIP but Medicaid eligible family members of HIP Employer Link enrollees would have the option to enroll in the HIP Employer Link coverage, provided that the family coverage is affordable based on the HIP Employer Link affordability assessment. Specifically, any Medicaid eligible family member of HIP Employer Link enrollee, regardless of aid category, would be eligible to voluntarily enrollee in the HIP Employer Link Coverage, except for the eligibility groups that receive limited benefit coverage or are Medicare eligible duals listed in *Table 5.1* below.

Table 5.1: Eligibility Groups Excluded from Participation in HIP Employer Link Plans

Eligibility Group Name	Social Security Act & CFR Citations
Limited Services Available to Certain Aliens	42 CFR §435.139
Qualified Medicare Beneficiaries (QMB)	1902(a)(10)(E)(i) 1905(p)
Specified Low Income Medicare Beneficiaries (SLMB)	1902(a)(10)(E)(iii)
Qualified Individual (QI) Program	1902(a)(10)(E)(iv)
Qualified Disabled Working Individual (QDWI) Program	1902(a)(10)(E)(ii) 1905(s)
Family Planning	1902(a)(10)(A)(ii)(XXI)

Non-HIP eligible family members participating in HIP Employer Link coverage will not receive a HIP Link POWER account since they are not HIP eligible. In addition, these individuals will receive a benefit wrap to the full Medicaid State Plan benefit package, and standard State Plan cost sharing policies will apply. The primary HIP Employer Link employee will receive the full reimbursement for the family premium on their regular monthly check.

Employers that offer high deductible health plans are not excluded from HIP Link provided, that the overall premium contribution and cost sharing structure passes the HIP Link affordability assessment. In alignment with the HIP Link premium assistance process, premium assistance for family members of HIP Link employees will not exclude high deductible plans if the plan is otherwise affordable. As part of the HIP Link enhancement, the State requests authority to consider high deductible plans cost effective for family members of HIP Link enrollees, including children, provided that these plans meet the HIP Link affordability requirements.

Section 6: Substance Use Disorder

Through this waiver extension application, the State seeks to address the substantial drug abuse epidemic facing the State by adding critical new evidence-based substance use disorder (SUD) treatment services, as well as expanding access to qualified providers through a waiver of the long-standing CMS exclusion of IMD providers (IMD exclusion). The IMD exclusion currently prohibits federal financial participation for medically necessary, inpatient mental health services provided in freestanding psychiatric hospitals with greater than sixteen (16) beds for Medicaid eligible adults between 21 and 64 years of age. The IMD exclusion has created a significant access issue in the State. In fact, nearly 35% of all public comments received during the original HIP 2.0 waiver public comment period urged the State to include IMD providers in the HIP program. Since that time, in July 2015, CMS issued a letter indicating a willingness to waive the

IMD exclusion, provided the IMD waiver is only a component of broad based and comprehensive reforms to address SUD.

In September 2015, Governor Pence created the Taskforce on Drug Enforcement, Treatment and Prevention (Taskforce) to identify solutions to Indiana's drug abuse epidemic, recently exemplified by a March 2015 public health emergency in Scott County, Indiana, following a significant HIV outbreak.[90] As of September 15, 2016, the Indiana State Department of Health reported a total of 206 individuals testing positive for HIV in Scott County, with the vast majority of cases being linked to syringe-sharing partners injecting oxymorphone, a prescription opioid.[91] During its first meeting, the Taskforce recommended that the State explore the feasibility of pursuing the IMD waiver opportunity to address the significant SUD public health threat facing the state.

The historic HIV outbreak in Scott County is just one example of the devastating impact to families and communities caused by the heroin and opioid epidemic sweeping across the country. Drug addiction is a widespread problem in Indiana that affects the lives of far too many Hoosiers. The following statistics begin to outline the scope of the problem:

- Nearly six times as many Hoosiers died from drug overdose in 2014, as did in 2000 (twice the national rate).[92]
- The number of heroin overdose deaths increased by nearly 25 times between 2000 and 2014.[93]
- In 2014, Indiana had the 16th highest drug overdose death rate in the nation, which represented a statistically significant increase in the rate from 2013.[94]
- Since 2009, more Hoosiers have lost their lives due to a drug overdose than in automobile accidents on state highways.[95]

For over a year, the Taskforce has studied the issues and identified a number of recommendations. With respect to enforcement, the Taskforce recommendations included support of legislation to enhance penalties for serious drug dealing offenses; implementation of a Regional Therapeutic Communities pilot program in northwest Indiana; and implementation of a therapeutic substance use disorder treatment program for offenders awaiting adjudication and for

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[90] Governor Mike Pence, *Executive Order 15-05: Declaration of Public Health Emergency in Scott County, Indiana*, STATE OF INDIANA (March 26, 2016), http://www.in.gov/gov/files/Executive_Order_15-05.pdf.

[91] Press Release, Indiana State Department of Health, Scott County Public Health Emergency Declaration Extended (Aug. 3, 2016), *available at* http://www.in.gov/isdh/files/May_2_2016_SCOTT_COUNTY_PUBLIC_HEALTH_EMERGENCY_DECLARATION_EXTENDED.pdf.

[92] INDIANA STATE DEPARTMENT OF HEALTH, INDIANA: SPECIAL EMPHASIS REPORT, DRUG OVERDOSE DEATHS, 1999-2013 (2015), *available at* http://www.in.gov/isdh/files/2015_SER_Drug_Deaths_Indiana_Updated.pdf.

[93] *Id*.

[94] R. Rudd et al., *Increases in drug and opioid overdose deaths — United States, 2000–2014*, 64(50) MORBIDITY AND MORTALITY WEEKLY REPORT 1378 (2016).

[95] INDIANA STATE DEPARTMENT OF HEALTH, INDIANA: SPECIAL EMPHASIS REPORT, DRUG OVERDOSE DEATHS, 1999-2013 (2015), *available at* http://www.in.gov/isdh/files/2015_SER_Drug_Deaths_Indiana_Updated.pdf.

those serving sentences while in jail. Regarding treatment, in addition to seeking this 1115 SUD waiver, the Taskforce recommendations included implementation of a Gold Card program and promulgation of chronic pain, acute pain, and emergency department controlled substance prescribing guidelines. Finally, concerning prevention, the Taskforce recommendations included identification of best practices related to INSPECT, measures to increase provider access to the system, and expanded integration of prescription data with hospital patient records; efforts to increase awareness of Aaron's Law and access to naloxone, as well as supporting youth assistance and SUD education programs.[96]

As the State's broader drug enforcement, treatment, and prevention efforts take root, FSSA aims to support the Taskforce through the SUD initiative set forth in this waiver. This waiver extension application seeks to enhance the Indiana Medicaid and HIP benefit packages to provide a more comprehensive SUD continuum of care, as well as to improve access and quality of care across the entire mental health and SUD delivery system. Specifically, the State seeks to add new SUD benefits, such as residential treatment services and expanded intensive outpatient treatment services, so that all Medicaid recipients can access benefits across the full continuum of care in alignment with best practice standards set forth by the Association of Addiction Medicine (ASAM). As part of this request, the State seeks a waiver of the IMD exclusion for Medicaid beneficiaries ages 21-64 with short-term stays up to thirty (30) days, in order to expand access to treatment options. Ultimately, through this waiver, the State seeks to support the overall initiative by developing a robust SUD benefit that not only adds critical short-term inpatient and residential services, but also builds out sufficient recovery support services to maintain individuals in treatment at all stages of SUD recovery consistent with evidence-based practices. Taken together with the work of the Taskforce and the State's comprehensive multi-agency SUD initiative, the State meets the additional expectations and the requirements of a Section 1115 SUD program as detailed in the CMS Medicaid Director's letter dated July 27, 2015.

6.1 SUD Initiative Eligibility

The SUD initiative will include all mandatory and optional eligibility groups approved for full benefit Medicaid or CHIP coverage under the Indiana Medicaid and CHIP State Plans. Only the eligibility groups outlined in *Table 6.1* below will not be eligible for the enhanced SUD benefits described in this waiver, as they receive limited Medicaid benefits only.

Table 6.1: Eligibility Groups Excluded from the Demonstration

Eligibility Group Name	Social Security Act & CFR Citations
Limited Services Available to Certain Aliens	42 CFR §435.139
Qualified Medicare Beneficiaries (QMB)	1902(a)(10)(E)(i) 1905(p)
Specified Low Income Medicare Beneficiaries (SLMB)	1902(a)(10)(E)(iii)
Qualified Individual (QI) Program	1902(a)(10)(E)(iv)

[96] 119th Ind. Gen. Assemb., 1st Reg. Sess. (2015). S.E.A. 406. In 2015, the Indiana General Assembly passed, and Governor Pence signed into law House Enrolled Act 406, known as "Aaron's Law," which authorizes prescribers to use standing orders to dispense naloxone and provides civil immunity to individuals administering the medication in good faith.

Qualified Disabled Working Individual (QDWI) Program	1902(a)(10)(E)(ii) 1905(s)
Family Planning	1902(a)(10)(A)(ii)(XXI)

6.2 Enhanced Benefits

The current SUD benefit available to Medicaid enrollees (whether through the State Plan or waiver programs) will be expanded to provide the full continuum of evidence-based best practice care, allowing individuals to step down treatment in the best manner possible to prevent relapse and increase the long-term success.

6.2.1 Detoxification Services

In spring 2016, the Indiana General Assembly passed Senate Enrolled Act 297, which requires Medicaid coverage for inpatient detoxification services for the treatment of opioid or alcohol dependence in accordance with the most current edition of ASAM or other comparable clinical criteria. This change significantly increases access to these previously covered services, as former State coverage policy required a showing of immediate danger or death to themselves or others as a prerequisite for admission for inpatient detoxification services. Following this change, medical necessity for this level of care will be aligned with ASAM medical necessity criteria.

6.2.2 Residential Treatment

Following detoxification, residential treatment facilities provide persons recovering from SUD the opportunity to establish a pattern of healthy behaviors and a meaningful period of sobriety before returning to unsupervised daily living. Currently, Indiana Medicaid does not reimburse for residential treatment. Rather, the State provides grants to specific facilities for the provision of limited residential treatment services for specific vulnerable populations, such as pregnant women. Although residential treatment itself is not covered, Medicaid enrolled providers may receive Medicaid reimbursement for covered professional services delivered to beneficiaries in a residential setting, but this limited reimbursement opportunity does not fully address the needs of this population.

Through this waiver, the State seeks to add residential detoxification and SUD treatment services (ASAM levels 3.1, 3.5, and 3.7) as a Medicaid covered benefit. The State will comply with the requirements set forth CMS Medicaid Director's letter dated July 27, 2015.

6.2.3 IMD Exclusion

In addition, the State seeks to expand access to residential treatment providers in order to provide meaningful access to the new residential treatment benefit. Federal law currently prohibits all federal financial participation for medically necessary services provided by qualified healthcare providers in certain institutions that meet the definition of an IMD. The IMD exclusion has resulted not only in a lack of access to appropriate mental health services for certain Medicaid beneficiaries, but also an increase in the amount of uncompensated care IMDs provide to adult Medicaid beneficiaries and the indigent.

On June 30, 2016, Indiana Medicaid announced that effective for dates of services on or after July 5, 2016, contracted MCEs may authorize coverage for stays of up to 15 days in an IMD for inpatient services related to mental health, behavioral health, and SUD in lieu of other settings under the Medicaid State Plan. However, this limited IMD allowance only applies to Indiana

Health Coverage Program members enrolled in a managed care program (i.e. HIP, Hoosier Care Connect, and Hoosier Healthwise). Through this waiver extension application, the State seeks a waiver of the IMD exclusion for all Medicaid beneficiaries ages 21-64, regardless of delivery system, with short-term stays up to thirty (30) days, as a mechanism to increase access to residential treatment services across the State. Medicaid members with an SUD diagnosis, including members with dual SUD and mental health diagnoses, will be able to access services in an IMD through this waiver.

The waiver of the IMD exclusion would allow several psychiatric facilities the opportunity to provide reimbursable services to Medicaid recipients, and it would allow several additional psychiatric facilities, currently operating with less than 16 beds, the opportunity to increase capacity. Overall, the IMD exclusion waiver would allow Medicaid patients to access at least 15 new facilities across the state, and potentially increase capacity at 12 other facilities.

6.2.4 Intensive Outpatient Treatment- Addiction Recovery Supports

After receiving detoxification and/or residential treatment services, it is essential that persons recovering from SUD receive the ongoing treatment and support required to sustain their established period of sobriety. Currently, many of these critical recovery support services are only available through a Community Mental Health Center (CMHC). CMHCs serve as the State's mental health delivery safety net system, providing a source of mental health and SUD treatment for individuals with no other source of care. The State contracts with all 25 of the CMHCs operating in Indiana to provide a range of mental health and addiction services, to Medicaid enrolled individuals. Further, CMHCs play a critical role in the delivery of intensive outpatient mental health and addiction services, as they are the exclusive provider of all Medicaid Rehabilitation Option (MRO) services, which provides wrap-around support services to individuals living in the community undergoing intensive outpatient treatment.

To address the growing SUD epidemic, increased access to services is a critical need. Therefore, the State will add "Addiction Recovery Management Services" as a Medicaid covered benefit, available to members outside of MRO. This will allow all qualified providers (not just CMHCs) to provide critical intensive outpatient support services to individuals recovering from substance use disorder, which will significantly increase access to care throughout the state. Specifically, the new service will provide reimbursement for the essential recovery support services including:

- Recovery education;
- Peer recovery support services;
- Housing support services;
- Recovery focused case management; and
- Relapse prevention services.

6.3 Cost Sharing

All cost-sharing for SUD services provided through this waiver will be consistent with the Medicaid State Plan applicable to the individual's specific eligibility category.

Section 7: Evaluation Plan

As outlined in Section 3 of this waiver extension application, HIP has a comprehensive evaluation plan—approved by CMS—that has been successful in tracking HIP's progress toward achieving its stated goals. Throughout the HIP demonstration period, the evaluation tools have revealed the positive impact of incentives and consumer-driven design in improving health care utilization behaviors. During the new demonstration period, Indiana will maintain the original evaluation design, but will add new components in order to assess the impact of the new programs and policies presented within this waiver extension application. Specifically, Indiana will include an analysis of the following new components within its updated HIP evaluation plan:

1. Tobacco Cessation
2. Substance Use Disorder (SUD)
3. Chronic Disease Management
4. Employment Related Incentives

The following table outlines the evaluation methodology for the new program components within the HIP waiver extension:

Hypothesis	Methodology	Data Source
1. Tobacco Cessation		
HIP will increase utilization of tobacco cessation benefits among individuals who use tobacco	Track and compare rates of tobacco cessation utilization among individuals who use tobacco.	Claims Data • Number and percentage of members with tobacco cessation utilization codes MCE Data • Number and percentage of members with tobacco use indicated by MCE health risk assessment Pharmacy Benefit Data • Number and percentage of members with tobacco cessation prescriptions Member Survey Data • Member knowledge of tobacco-cessation benefits; member self-report of tobacco use; member self-report of tobacco cessation utilization
HIP's increased contribution requirement for tobacco users will discourage tobacco	Track and compare rates of tobacco use and tobacco cessation utilization among individuals who use tobacco.	Claims Data • Number and percentage of members with tobacco cessation utilization codes MCE Data

Hypothesis	Methodology	Data Source
use among current smokers		• Number and percentage of members with tobacco use indicated by MCE health risk assessment Pharmacy Benefit Data • Number and percentage of members with tobacco cessation prescriptions Member Survey Data • Member knowledge and perceptions of increased contribution for tobacco users; member self-report of tobacco use; member self-report of tobacco cessation utilization
2. Substance Use Disorder (SUD)		
HIP will increase access to SUD treatment among individuals with SUD	Track and compare rates of SUD treatment engagement among members with SUD	Claims Data • Number and percentage of members with SUD diagnosis codes • Number and percentage of members with SUD treatment codes MCE Data • Number and percentage of members with SUD indicated by MCE health risk assessment Pharmacy Benefit Data • Number and percentage of members with SUD treatment prescriptions Quality measures from the Medicaid Adult and Children's Core Sets for individuals with SUD • Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NQF #0004)
HIP will improve the continuum of care among individuals engaged in SUD treatment	Track and compare SUD treatment engagement following discharge from SUD treatment facilities and hospitals	Quality measures from the Medicaid Adult and Children's Core Sets for individuals with SUD • SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided

Hypothesis	Methodology	Data Source
		or Offered at Discharge (NQF #1664) • SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge (NQF #1664) measures • Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence (NQF #2605) • Timely Transmission of Transition Record (NQF #0648) • Transition Record with Specified Elements Received by Discharged Patients (NQF #0647)
HIP will reduce SUD readmission rates to the same level of care or higher	Track and compare rates of SUD treatment readmission	Claims Data • Number and percentage of members with SUD diagnosis codes • Number and percentage of members with SUD treatment codes Quality measures from the Medicaid Adult and Children's Core Sets for individuals with SUD • Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NQF #0004).
HIP will reduce emergency department utilization due to drug overdose	Track and compare rates of emergency department utilization due to drug overdose	Claims Data • Number and percentage of members with ER visits and admissions with drug overdose codes
HIP will reduce the rate of preventable hospitalization among members with SUD	Track and compare rates of preventable hospitalization among HIP members with SUD	Claims Data • Number and percentage of members with SUD and ambulatory case sensitive conditions who are hospitalized
3. Chronic Disease Management		
HIP's chronic disease management incentive structure will promote active engagement in MCE	Track and compare rates of chronic disease management program participation	MCE Data • Number and percentage of members engaged in chronic disease management programs Member Survey Data

Hypothesis	Methodology	Data Source
chronic disease management programs and activities		• Member knowledge and perceptions of chronic disease management program incentives
HIP's chronic disease management incentive structure will reduce the rate of preventable hospitalization among members enrolled in chronic disease management programs	Track and compare rates of preventable hospitalization among members enrolled in chronic disease management programs	MCE Data • Number and percentage of members engaged in chronic disease management programs Claims Data • Number and percentage of members engaged in chronic disease management with ambulatory case sensitive conditions who are hospitalized
4. Employment Related Incentives		
HIP's employment related incentive structure for MCEs will promote active member engagement the Gateway to Work Program	Track and compare rates of participation in the Gateway to Work Program	Administrative Data • Number and percentage of members enrolled in the Gateway to Work Program MCE Data • Number and percentage of members who earn incentives for engagement in the Gateway to Work program
HIP's employment related incentive structure for MCEs will promote employment among HIP members	Track and compare rates of employment among HIP members	Eligibility and Enrollment Data • Number and percentage of members who earn employment • Number and percentage of members who are disenrolled from HIP due to increased earnings from employment MCE Data • Number and percentage of members who earn incentives for obtaining employment

Section 8: Demonstration Financing and Budget Neutrality

A detailed financing and budget neutrality report is attached hereto as Attachment I.

Section 9: Requested Waivers

The State requests a renewal of all currently approved waivers, and only requests the following revisions and additions to the existing HIP waivers:

1. Premiums Section 1902(a)(14) and Section 1916
To enable the State to charge premiums in HIP Plus at levels not more than two percent of household income and not more than three percent of household income for tobacco-users after their first year of HIP enrollment. Total cost-sharing for a household is subject to a quarterly aggregate cap of five percent of household income, except that all HIP Plus households will be required to contribute, at a minimum, monthly one dollar ($1.00) POWER account contributions. Individuals at or below 100 percent of poverty will not have premiums as a condition of eligibility.

2. Amount, Duration, Scope, and Comparability Section 1902(a)(10)(B)
To the extent necessary to enable Indiana to permit Medicaid eligible individuals to choose to participate in an employer-sponsored health insurance plan through a HIP Employer Link participating family member, with wrap-around to their existing Medicaid benefits.

3. Reasonable Promptness Section 1902(a)(8)
To the extent necessary to enable Indiana to establish an open enrollment period for HIP, such that members who are disenrolled for failure to comply with the redetermination process will be required to wait until their next open enrollment period to re-enroll (up to six months).

4. Cost Not Otherwise Matchable
The State requests that expenditures related to providing services in an IMD be regarded as expenditures under the State's Medicaid Title XIX State Plan.

Section 10: Public Comment

The State held public hearings for this three-year HIP waiver extension 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 and formally opened the 30-day public comment period is included in Attachment II of this application. The notice was posted on the agency's website at the web address of the HIP program homepage: HIP.in.gov, as well as formally published in the Indiana Register on December 21, 2016. In addition, the Indiana Family and Social Services Administration sent electronic notification of the extension application to the agency's stakeholder distribution list. The public notice provided the option for any individual, regardless of whether he or she attended the public hearing, to submit written feedback to the State by email or by USPS mail. Electronic copies of all documents related to the HIP waiver extension application were also available on the HIP website.

In addition, the State initiated consultation and provided notice of the HIP waiver extension application and its contents to Indiana's federally recognized Indian tribe, the Pokagon Band of Potawatomi Indians, on December 2, 2016. The notice and opportunity for consultation was provided in accordance with 42 CFR 431.408(b). Following the 30-day comment period, the State received no comments or requests for additional consultation from members of the tribe.

Public hearings regarding the waiver were conducted on January 4, 2017 and January 5, 2017, as scheduled and publicized, at the Indiana Government Center Conference facilities and at the Indiana State Library. Three individuals testified regarding the HIP extension proposal on January 4, 2017, and eleven (11) individuals testified on January 5, 2017. Many of the individuals who testified later provided a written copy of their testimony. A court reporter

transcribed both hearings. The January 4, 2017 hearing was also made available to the public statewide via a live, free webcast.

On January 5, 2017, in addition to holding a public hearing, FSSA presented this waiver extension application to the Medicaid Advisory Committee, the State's Medical Care Advisory Committee that operates in accordance with 42 CFR 431.12. Also, pursuant to state law, the waiver extension application will also be presented to the Indiana Budget Committee in 2017 prior to implementing any revisions to the HIP waiver.

The State received a total of 32 public comments, both written and verbal, during the 30-day public comment period. The below summary combines the testimony offered at the public hearings as well as the comments received via mail and email.

10.1 Summary of Public Comments

The vast majority of the comments were supportive of the HIP waiver extension application, and there were no comments opposing the State's submission of the extension application. Many commenters shared support for several of the proposed program enhancements contained in the application, including the tobacco cessation initiative and other initiatives aimed at improving health outcomes. For example, the Indiana State Medical Association (ISMA) praised the State's efforts to address chronic disease management, SUD and tobacco cessation, noting that these areas are also a focus of ISMA and other interested groups throughout the State through the Alliance for a Healthier Indiana.

The majority of commenters were particularly enthusiastic to write in support of the SUD initiative, particularly the addition of SUD services for Medicaid members and expansion of access to qualified providers through seeking a waiver of the IMD exclusion. Over 50% of the comments received included positive comments regarding the steps the State is taking to address the opioid epidemic in Indiana through this waiver extension application. Several commenters, comprised of impacted providers, requested clarification regarding the scope of the IMD exclusion waiver, such as detailing covered services, defining the application of the 30-day limit, and clarifying eligible providers.

Several commenters also expressed appreciation of the aspects of the program that will remain intact, specifically the key design features of the program that continue to promote personal responsibility and consumerism. As Indiana University Health, one of the nation's busiest hospital systems, wrote, POWER accounts "empower [members] to demand price and quality transparency as they make cost-conscious health care decisions." Members of the healthcare community, including the Indiana Hospital Association, the Indiana State Medical Association, some of the state's largest hospital systems, and some of the state's managed care entities (MCEs) expressed support for the HIP program as an innovative, consumer-driven approach to expanding coverage. Some of these organizations praised HIP's ability to decrease use of the emergency department, increase use of preventive care, and improve consumer behavior. Members of the healthcare community also continue to support HIP's higher provider reimbursement rates and the associated decrease in cost-shifting to the private market.

A couple of commenters noted a general preference for HIP compared to no Medicaid expansion, but also expressed a desire for greater administrative simplification, particularly around the POWER account process. The State also received a few comments from individuals

noting concern with reestablishment of a HIP open enrollment period. While several commenters praised the tobacco cessation initiative, two of those commenters expressed concern with inclusion of the surcharge for known tobacco users. Additionally, the State received suggestions (two comments) to expand coverage for non-emergency medical transportation.

The MCEs currently serving HIP members commented that members seem to take pride in paying their monthly contributions. These entities continue to support HIP's consumer oriented program, and indicated that HIP's member responsibility provisions positively contribute to member health outcomes. The MCEs note HIP members have lower emergency room use and lower inpatient admissions and are more likely to complete recommended preventive services when compared to traditional Medicaid members. The plans all praised the State for its focus on improving the program with the program enhancements included in this application. One of the health plans recommended that the State consider permitting "ASAM aligned criteria," rather than specifically mandating the use of ASAM criteria, as it would allow greater flexibility for the State to quickly incorporate various innovations in SUD care ahead of formal adoption by the professional society.

10.2 State Response & Summary of Revisions

The State appreciates all comments received either during a public hearing or shared with the State in writing. The majority of the comments received did not include suggested revisions to the waiver extension, so the State has not addressed individual comments. However, the State has reviewed all comments in depth and will consider many of the comments in its discussions with CMS and in context of the program evaluation and outcomes data related to HIP's design features and the impact on the goals of the program.

The State has made the following revisions and clarifications to the application as a result of the public comment period.

1. ASAM. Based on concerns raised by one of the managed care entities, the State clarified that new SUD services will be provided based on ASAM or other ASAM-aligned criteria approved by the State.

2. Emergency Department Copayments. Based on a request for clarification, the State revised Section 4.6.2 of the waiver application to clarify its request to extend the current HIP copayment policy for non-emergency use of hospital emergency departments. Specifically, based on the favorable data to date and pending the results of the formal study, the State seeks to make this policy permanent for the duration of the extension period.

3. Substance Use Disorder. Due to several requests for clarification, the State removed the tables in Section 6.2.3 of the waiver application, which specifically listed existing IMD facilities throughout the state. The new reimbursement opportunity for IMDs is not limited to the facilities previously included on the tables, but rather will be available to any properly licensed facility that meets the Medicaid provider requirements. In addition, language was added to clarify that the IMD exclusion will allow reimbursement for short term residential stays for Medicaid eligible adults with an SUD diagnosis, including those with a dual SUD and mental health diagnosis.

4. New Rollover Data. Following the initial posting of this waiver extension application, the State received preliminary data related to the utilization of the rollover program feature. The waiver application was amended to reflect this newly available program data.

Other than the addition of the content of Section 10 of this application summarizing the public comment period, as well as the substantive changes identified above, this application is identical to the copy of the application initially posted on the FSSA website on December 21, 2016.

Section 11: Demonstration Administration

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Attachment I: Demonstration Financing and Budget Neutrality

1115 Waiver – Healthy Indiana Plan

Healthy Indiana Plan – First Renewal

Budget Neutrality Projections

State of Indiana

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BACKGROUND

INITIAL FILING

The Healthy Indiana Plan (HIP) 1115 Waiver was approved for a three-year period from February 1, 2015 through January 31, 2018. (Project Number 11-W-00296/5). The waiver was approved January 27, 2015, and technical corrections to the special terms and conditions (STCs) were issued May 14, 2015.

Through the HIP waiver, Indiana provides coverage to non-disabled adults between the ages of 19 and 64 with a household income less than 138 percent of the Federal poverty level (FPL). A Personal Wellness and Responsibility (POWER) account is established to pay for the $2,500 plan deductible. Those who make monthly contributions to the account are enrolled in HIP Plus, while those with incomes at or below 100 percent of FPL who do not make contributions are enrolled in HIP Basic. The accounts are intended to promote efficient use of healthcare. Those enrolled in HIP Plus receive an enhanced benefit package and are not subject to cost sharing, with the exception of copayments for non-emergency use of the emergency department services.

APPROVED TITLE XIX WAIVERS

HIP includes the following Title XIX waivers:

1. **Premiums** - Section 1902(a)(14) and Section 1916: HIP Plus premiums may not exceed 2% of household income, and total cost sharing may not exceed 5% of quarterly income. Enrollees at or below 100 percent of poverty are not required to contribute as a condition of eligibility, but those who do not contribute may be enrolled in HIP Basic.
2. **Freedom of Choice** - Section 1902(a)(23)(A**)**: HIP Employer Link providers may be limited to those participating in the network of a HIP Employer Link plan. This waiver does not apply to family planning providers.
3. **Reasonable Promptness** - Section 1902(a)(8**)**: Enrollment may begin on the first day of the month following which an individual makes their initial POWER account contribution, and, for those at or under 100 percent FPL, no later than the first day of the month in which the 60 payment period expires. Reasonable promptness is also waived to allow Indiana to prohibit reenrollment for 6 months for individuals over 100% of FPL who are dis-enrolled for failure to make POWER account premium contributions, subject to exceptions in the STCs. This provision is not waived for AI/AN enrollees.
4. **Methods of Administration** – Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53: Non-emergency medical transportation waiver for one year. Does not apply to pregnant women, the medically frail, or Section 1931 parents and caretakers.
5. **Comparability** – Section 1902(a)(17): Allows cost sharing requirements to vary between HIP Plus and HIP Basic.
6. **Retroactivity** – Section 1902(a)(34): Waives the requirement for retroactive coverage.
7. **Cost sharing for non-emergency use of the emergency department** – Section 1916(f): Allow the graduated co-payment up to $25 for all HIP populations for two years.
8. **Payment to providers** – Section 1902(a)(13) and Section 1902(a)(30): To permit Indiana to pay providers serving the HIP Employer Link population no more than rates paid by the employer sponsored insurance (ESI) plan, and such that amounts paid by the ESI plan plus payment from the POWER account and member cost sharing serves as payment in full.

EXECUTIVE SUMMARY

This report has been developed for the State of Indiana, Family and Social Services Association (FSSA) to document budget neutrality projections for the Healthy Indiana Plan (HIP) 1115 waiver renewal (Project Number 11-W-00296/5).

BUDGET NEUTRALITY – ACTUAL AND PROJECTED (DY01 – DY06)

The current waiver has been approved for the period February 1, 2015 through January 31, 2018. Indiana is currently requesting a three-year renewal.

Table 1 illustrates the actual and projected Waiver Margin for the Demonstration. Values were developed using CMS Schedule C reporting through September 30, 2016, with estimated adjustments for presumptive eligibility (PE) program reporting (described later in this report).

Table 1
State of Indiana, Family and Social Services Administration
1115 HIP Waiver Budget Neutrality Summary
HIP 2.0 Waiver Renewal (11-W-00296/5)
(Values in $Millions)

Calendar Year	Demonstration Year	Without Waiver Expenditures	With Waiver Expenditures	Total Savings	Waiver Margin	Cumulative Waiver Margin
2015	1	$ 2,058.9	$ 1,660.6	$ 398.3	$ 191.0	$ 191.0
2016	2	$ 3,295.2	$ 2,611.9	$ 683.3	$ 231.3	$ 422.3
2017	3	$ 3,848.0	$ 3,036.8	$ 811.3	$ 262.4	$ 684.7
2018	4	$ 4,116.9	$ 3,243.0	$ 873.9	$ 292.1	$ 976.8
2019	5	$ 4,284.0	$ 3,357.5	$ 926.5	$ 323.4	$ 1,300.2
2020	6	$ 4,481.7	$ 3,495.1	$ 986.6	$ 357.1	$ 1,657.2

Expenditures in Table 1 represent incurred expenditures for each demonstration year, and also reflect program adjustments proposed for the renewal period.

FIRST RENEWAL

Indiana seeks to renew the HIP waiver for an additional three years with the following enhancements:

1. **Member incentives**: The State will increase the upper limit on member health incentives to $300. The State will ask for focus on tobacco cessation, substance abuse management, and chronic disease management.
2. **Tobacco user surcharge**: The State would like to increase monthly contribution requirements for HIP Plus tobacco users from 2% of household income to 3%. This increase would take effect in the member's second year of eligibility.
3. **HIP Plus Enhancement**: The State would like to add chiropractic benefits for the HIP Plus population only (this benefit is already available to those receiving State plan services, including Section 1931 caretakers, pregnant women, and the medically frail). The service will have an annual limit of six spinal manipulation visits per covered person per benefit year.
4. **Open enrollment period**: Individuals who do not submit redetermination paperwork in a timely manner must wait six months following disenrollment until their next open enrollment period to re-enroll in HIP coverage.
5. **Substance use disorder benefits:** The State is requesting a waiver to reimburse for short-term stays of less than 30 days in an Institution of Mental Diseases (IMD). In addition, the State seeks to add other enhanced substance abuse services for all Medicaid populations.
6. **HIP Employer Link dependents**: To allow Medicaid-eligible family members of a HIP Employer Link participant, including children, to access coverage through the HIP Employer Link program.
7. **Enhanced health plan incentives**: To tighten focus on outcomes.

BASELINE PROJECTIONS

This section provides additional detail on the data, assumptions, and methodology associated with baseline projections for the 1115 waiver budget neutrality filing – before proposed changes to the waiver.

BUDGET NEUTRALITY MODEL

We continue to utilize the budget neutrality model provided for the first HIP waiver submission. It has been updated to reflect historical enrollment and expenditures through September 30, 2016, as reported by Indiana in Schedule C of the Form CMS 64.

We have also included an Excel file version of the development of the waiver budget neutrality exhibits: "HIP Budget Neutrality – 2018 HIP Renewal.xlsx".

BASELINE ENROLLMENT

1115 waiver populations for HIP

HIP enrollment, including the Section 1931 Caretaker population, was approximately 400,000 enrollees as of October 31, 2016, excluding conditional enrollees. Baseline enrollment is projected to expand to approximately 450,000 by the end of DY 06.

Eligibility data from the State of Indiana's Enterprise Data Warehouse, reported through October 31, 2016, was used to estimate enrollment for each 1115 Waiver population. The populations were identified as follows:

1. Section 1931 Parents: aid category SB or SP and not Medically Frail (as defined below)
2. New Adult Group: aid category RB or RP and not Medically Frail
3. Medically Frail: capitation code FB, FP, or PC
4. HIP Employer Link: aid category HL
5. HIP Presumptive Eligibility: aid category HA

Enrollment trends

Enrollment has been projected starting with actual October 31, 2016 enrollment. Enrollment growth rates are consistent with those used in the Medicaid budget forecast, and are illustrated in Table 2. Elevated growth rates continue to be projected for newly eligible populations through June 30, 2017, or halfway through DY 03. Presumptive eligibility was used heavily during DY 01, but has been declining, and is projected to continue to decline through the projection period, due to elevated enrollment penetration in the eligible population.

Table 2
State of Indiana
Family and Social Services Administration
Annual Enrollment Growth Assumptions

Population	Through June 2017	After June 2017
Section 1931 Parents	0.5%	0.5%
New Adult Group	5,000 per month	1.0%
Medically Frail	2.0%	1.0%
HIP Employer Link	Grow to 2,000	1.0%
HIP Presumptive Eligibility	reduced by 2% per month	

Enrollment projection - baseline

Actual and projected enrollment is illustrated in Table 3, *before* the impact of proposed renewal changes (baseline projection). The projection was developed with eligibility data through October 31, 2016.

Table 3 State of Indiana Family and Social Services Administration Actual and Projected Average Monthly Enrollment - Healthy Indiana Plan Baseline						
Population	**DY 01**	**DY 02**	**DY 03**	**DY 04**	**DY 05**	**DY 06**
Section 1931 Parents	93,881	114,834	117,189	117,567	117,976	118,408
New Adult Group	134,179	225,322	269,015	276,835	278,884	281,094
Medically Frail	21,585	40,268	46,226	46,392	46,587	46,843
HIP Employer Link	1	97	1,696	2,010	2,022	2,041
HIP Presumptive Eligibility	81	78	55	43	34	27
Total Healthy Indiana Plan enrollment	**249,728**	**380,598**	**434,181**	**442,847**	**445,503**	**448,413**

WITHOUT WAIVER PMPM COSTS AND TRENDS

The Without Waiver projection model requires a baseline trend rate to project PMPM expenditures for future demonstration years. Annual PMPM amounts and trend rates for the initial waiver, DY 01 to DY 03, were approved by CMS. For the renewal, we have retained the initial trend rates, and assumed a 3.0% trend for the New Adult Group and HIP Employer Link.

Table 4 State of Indiana Family and Social Services Administration Without Waiver PMPM Costs and Trend Rates				
Population	**Trend Rate**	**DY 01**	**DY 02**	**DY 03**
Section 1931 Parents	5.30%	$ 666.15	$ 701.46	$ 738.64
New Adult Group	1.10%	545.14	551.14	557.20
Medically Frail	4.30%	1,662.65	1,734.14	1,808.71
HIP Employer Link	1.10%	348.33	352.17	356.04
Population	**Trend Rate**	**DY 04**	**DY 05**	**DY 06**
Section 1931 Parents	5.30%	777.79	819.01	862.42
New Adult Group	3.00%	573.92	591.14	608.87
Medically Frail	4.30%	1,886.48	1,967.60	2,052.21
HIP Employer Link	3.00%	366.72	377.72	389.05

Please note that trend rates illustrated above for the renewal have not yet been reviewed by CMS.

WITH WAIVER EXPENDITURES

Historical HIP expenditures – DY 01 and partial DY 02

Expenditures for the HIP program were provided by FSSA, as reported on the Form CMS 64.9 Waiver and Schedule C, project number 11-W-00296, as reported through September 30, 2016. These were summarized by demonstration year (calendar year), according to dates of service.

Adjustments to historical expenditures

Several adjustments were made to historical expenditures, as described in Appendix 4 of this report. These include annualization of DY 02 expenditures, reallocation of presumptive eligibility expenditures based on each enrollee's ultimate eligibility population, adjustments for prior period payments reported after September 30, 2016, and adjustments for anticipated future payments.

WITH WAIVER PMPM COSTS AND TRENDS

PMPM costs

With Waiver PMPM costs for DY 01 and DY 02 were developed by dividing expenditures by member months. PMPM costs for future demonstration years were projected from DY 02 using trend assumptions.

With Waiver trend rate

With the exception of the Section 1931 Caretakers, the With Waiver projections assume annual trend rates consistent with those indicated in the Table 4 above as the Without Waiver trend rates. For the Section 1931 Caretakers, the with waiver trend rate is assumed to be 3.5%, which is lower than the Without Waiver trend rate, as the structure of the demonstration is expected to result in more thoughtful healthcare utilization by members.

The HIP Presumptive eligibility population (extension to day 60) is only included in With Waiver projections and uses a trend rate of 1.10% for the initial waiver period and 3.0% for the renewal period (same trend as the New Adult Population).

The enclosures illustrate additional detail, including enrollment and expenditures for each population.

PROPOSED RENEWAL MODIFICATIONS

Effective DY 04, estimated With Waiver PMPM costs have been adjusted to reflect Indiana's proposed enhancements.

PROPOSED MODIFICATIONS TO THE HIP PROGRAM

Enhanced member incentives

The State proposes to increase the upper limit on member health incentives from $50 to $300. The State will request the MCEs focus on tobacco cessation, substance abuse management, chronic disease management, and employment.

On average, HIP members are currently earning $0.51 PMPM as incentives for healthy behaviors. Assuming a minimum requirement of $1 PMPM, we have added $0.50 PMPM to the with waiver costs for HIP populations (Section 1931 Parents, New Adults, and the Medically Frail).

Tobacco user contribution surcharge

The State proposes to increase contribution requirements for HIP Plus tobacco users from 2% of household income to 3% of income. This will result in a 50% increase in contribution amounts for tobacco users.

Since POWER account contributions by members reduce the amount that must be contributed by the State, this should reduce net PMPM cost of the program. We have estimated the value of the tobacco user contribution increase in Table 5.

Table 5
State of Indiana
Family and Social Services Administration
Estimated savings from tobacco user premium

Population	Percent Plus	Average Monthly Contribution	Percent in Plus who smoke	Contribution PMPM	
				Currently Paid by Smokers	Proposed Increase
Section 1931 Parents	54%	$ 4.38	40%	$ 0.95	$ 0.47
New Adult Group	71%	$ 13.85	35%	$ 3.44	$ 1.72
Medically Frail	80%	$ 9.87	35%	$ 2.76	$ 1.38

Only members enrolled in HIP Plus make POWER account contributions. The percent of members who choose to enroll in HIP Plus and the average monthly contribution were developed based on current data. Multiplying these two amounts results in the PMPM cost reduction represented by member contributions.

The percentage of members enrolled in HIP Plus who use tobacco products was estimated based on Health Needs Screening responses. Multiplying values in the first three columns of Table 5 results in the PMPM value of the POWER account contributions from smoking members, illustrated in column 4.

The proposed increase in the contribution amount for tobacco users will increase tobacco user contributions by 50%. The increase is illustrated in the last column of Table 5, and subtracted from the With Waiver PMPMs as a cost reduction.

Chiropractic benefits

The State has proposed adding chiropractic benefits to the HIP Plus new adult alternative benefit plan (ABP). This service would not be made available to HIP Basic new adult members. However, in populations on the State plan ABP both plus and basic members already have access to chiropractic benefits, including Section 1931 caretakers, the medically frail, and pregnant women.

The State has proposed an annual limit of six spinal manipulation visits. Other services that may be provided by chiropractors, including diagnosis and physical therapy, are already covered under the existing ABP. We have estimated the spinal manipulation benefit will add approximately $0.85 PMPM to the benefit cost for HIP Plus new adult members, who constitute approximately 71% of the new adult population, resulting in an overall PMPM increase of $0.60 PMPM for the new adult population. This is projected to increase DY 04 expenditures for the HIP Plus population by approximately $2 million. This estimate was developed based on the PMPM cost for Section 1931 caretaker members, adjusted to reflect the annual limit of six spinal manipulations.

We have added $0.60 PMPM to the New Adult population as of DY 04, both With and Without Waiver, to reflect inclusion of chiropractic benefits.

Reestablish the open enrollment period

Under Indiana's redetermination policies, over 62% of enrollees are eligible for auto-renewal or passive renewal. However approximately 38% are required to provide information as part of the annual process. 15% of those required to take action, were closed for non-compliance and did not take corrective action within 90 days. This represents 6% (15% * 38%) of all renewals). Non-compliant individuals could be required to wait six months until their next open enrollment period to re-enroll in HIP coverage.

We have estimated approximately half of those who do not comply are no longer eligible, and would not have re-applied for HIP even in the absence of open enrollment policy. HIP annual lapse rates (turnover) are approximately 3%. Of the remainder who remain eligible, enforcement may encourage better compliance, reducing what might otherwise be a 3% impact to an estimated 2%. Since the open enrollment policy will affect eligibility for half the year, the projected final impact of the waiting period on enrollment is estimated as a 1% enrollment reduction, affecting mainly the new adult group.

The impact is phased in over redeterminations that will occur during DY 04. Resulting enrollment is projected in Table 6, which may be compared with Table 3 (baseline enrollment).

Table 6
State of Indiana
Family and Social Services Administration
Actual and Projected Enrollment - Healthy Indiana Plan with Open Enrollment Policy

Population	DY 01	DY 02	DY 03	DY 04	DY 05	DY 06
Section 1931 Parents	93,881	114,834	117,189	117,567	117,976	118,408
New Adult Group	134,179	225,322	269,015	274,863	274,915	277,099
Medically Frail	21,585	40,268	46,226	46,160	46,122	46,374
HIP Employer Link	1	97	1,696	2,010	2,022	2,041
HIP Presumptive Eligibility	81	78	55	43	34	27
Total Healthy Indiana Plan enrollment	**249,728**	**380,598**	**434,181**	**440,644**	**441,068**	**443,949**

HIP Employer Link dependents

The State proposes to allow all Medicaid-eligible family members of HIP Employer Link enrollees to enroll in HIP Employer Link. This will allow those participating in employer sponsored insurance a choice of whether to enroll as an individual or family, using any tier offered by the employer plan. Dependents may include adult and/or child dependents, as long as the employer's program for dependent coverage is determined to be cost effective. Dependents will receive full wrap-around to ensure children receive all benefits that they would be eligible for under Medicaid, including EPSDT services. The 57 individuals currently enrolled in HIP Employer Link have 74 family members, mostly children, who are enrolled in other Medicaid programs and could potentially transition to HIP Employer Link.

Milliman has estimated that allowing children to enroll as dependents will cost approximately $60 PMPM less than providing coverage under regular Medicaid. However, it is unclear how many children will enroll. In the renewal filing, we have not reflected a reduction in HIP Employer Link cost projections. This will ensure the Without Waiver HIP Employer Link PMPM is adequate to cover costs regardless of how many children enroll. This population is not permitted to generate waiver savings.

ENHANCED SUBSTANCE USE DISORDER BENEFITS FOR ALL POPULATIONS

Medicaid beneficiaries in the State of Indiana currently have access to a limited array of services to treat substance use disorders (SUDs). Under the expanded benefit that is proposed, beneficiaries may be eligible for the full spectrum of SUD services as defined by the American Society of Addiction Medicine (ASAM) guidelines. The State is requesting a waiver to provide Institution of Mental Diseases (IMD) services and other enhanced SUD services for all Medicaid populations.

Additional 1115 waiver populations for substance use disorder (SUD) benefits

The State would like to provide enhanced SUD benefits to all Medicaid populations, using 1115 waiver authority. This requires the State to add the following populations to the waiver:

1. Disabled children
2. Disabled adults under age 65
3. Aged population aged 65 and older
4. HHW children
5. HHW adults

The Hoosier Healthwise (HHW) child and adult populations are non-disabled but may include pregnant children and adults. These population have been added to the waiver, solely for the purpose of accessing these new SUD services, and will not be subject to other provisions of the HIP waiver.

Estimated substance abuse expenditures

The State proposes that expenditures for non-HIP populations will reflect only enhanced SUD service expenditures. HIP expenditures will reflect all costs for HIP enrollees, including but not limited to enhanced SUD services.

Table 7 illustrates estimated PMPM costs for enhanced SUD services.

Table 7 State of Indiana Family and Social Services Administration Estimated Substance Use Disorder treatment cost by population	Projected DY 04 Enrollment	Estimated DY 04 Expenditures	PMPM
Disabled Children Population	66,092	$ 1,562,415	$ 1.97
Disabled Under 65 Population	217,874	11,242,298	4.30
Aged Over 65 Population	126,813	1,263,057	0.83
HHW Child Population	648,676	15,334,701	1.97
HHW Adult Population	30,637	1,033,080	2.81
Section 1931 Caretakers	117,567	5,155,622	3.65
Other HIP enrollees	323,077	35,163,701	9.07
Composite	1,530,736	$ 70,754,873	$ 3.85

The assumptions and methodology used to develop these assumptions are described in Appendix 6:

LIMITATIONS

The information contained in this report has been prepared for the State of Indiana, Family and Social Services Administration (FSSA). 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 FSSA, approved December 16, 2015.

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.

APPENDIX 1: BUDGET NEUTRALITY EXHIBITS

Healthy Indiana Plan	*Summary Budget Neutrality Estimates - 1115 Waiver Application*			
	Updated December 20, 2016			
Without Waiver Summary	**DY 01**	**DY 02**	**DY 03**	**DY 01 - DY 03**
XIX - HIP Populations				
Section 1931 Caretakers	750,466,604	966,618,193	1,038,725,796	2,755,810,593
New Adult Group	877,758,261	1,490,205,952	1,798,738,553	4,166,702,766
Medically Frail	430,666,254	837,960,726	1,003,320,376	2,271,947,356
HIP Employer Link	5,225	407,813	7,247,906	7,660,944
Subtotal	*2,058,896,344*	*3,295,192,684*	*3,848,032,631*	*9,202,121,658*
XIX - Non-HIP Populations (SUD)				
Disabled Children Population				
Disabled Under 65 Population				
Aged Over 65 Population				
HHW Child Population				
HHW Adult Population				
Subtotal				
Total Without Waiver Costs	***2,058,896,344***	***3,295,192,684***	***3,848,032,631***	***9,202,121,658***
With Waiver Summary	**DY 01**	**DY 02**	**DY 03**	**DY 01 - DY 03**
XIX - HIP Populations				
Section 1931 Caretakers	*557,518,446*	*734,327,216*	*775,613,053*	*2,067,458,715*
New Adult Group	*617,541,597*	*1,283,468,739*	*1,549,200,703*	*3,450,211,039*
Medically Frail	*483,610,759*	*593,034,046*	*710,058,669*	*1,786,703,474*
HIP Employer Link	1,648	67,048	1,191,699	1,260,395
HIP Presumptive Eligibility	1,902,684	1,001,230	713,884	3,617,798
Subtotal	*1,660,575,134*	*2,611,898,280*	*3,036,778,007*	*7,309,251,421*
XIX - Non-HIP Populations (SUD)				
Disabled Children Population				
Disabled Under 65 Population				
Aged Over 65 Population				
HHW Child Population				
HHW Adult Population				
Subtotal				
Total With Waiver Costs	***1,660,575,134***	***2,611,898,280***	***3,036,778,007***	***7,309,251,421***
Total Waiver Margin	*398,321,210*	*683,294,404*	*811,254,624*	*1,892,870,238*
Waiver Margin excluding Newly Eligible	***191,045,474***	***231,289,747***	***262,398,859***	***684,734,079***
Coverage Estimates	**DY 01**	**DY 02**	**DY 03**	
Anticipated Enrollment				
Section 1931 Caretakers	93,881	114,834	117,189	
New Adult Group	134,179	225,322	269,015	
Medically Frail	21,585	40,268	46,226	
HIP Employer Link	1	97	1,696	
HIP Presumptive Eligibility	81	78	55	
Total HIP Enrollment	**249,728**	**380,598**	**434,181**	

Healthy Indiana Plan *Summary Budget Neutrality Estimates - 1115 Waiver Application*

Updated December 20, 2016

Without Waiver Summary	DY 04	DY 05	DY 06	DY 01 - DY 06
XIX - HIP Populations				
Section 1931 Caretakers	1,102,461,022	1,164,929,485	1,231,168,089	6,254,369,189
New Adult Group	1,924,889,329	1,983,016,878	2,058,725,504	10,133,334,476
Medically Frail	1,049,986,847	1,094,221,651	1,147,521,334	5,563,677,188
HIP Employer Link	8,847,120	9,164,620	9,529,002	35,201,686
Subtotal	*4,086,184,318*	*4,251,332,634*	*4,446,943,929*	*21,986,582,539*
XIX - Non-HIP Populations (SUD)				
Disabled Children Population	1,562,423	1,645,916	1,735,844	4,944,183
Disabled Under 65 Population	11,242,296	11,978,760	12,770,721	35,991,777
Aged Over 65 Population	1,263,060	1,353,980	1,448,436	4,065,476
HHW Child Population	15,334,694	16,274,236	17,310,441	48,919,370
HHW Adult Population	1,341,921	1,399,525	1,459,644	4,201,090
Subtotal	*30,744,394*	*32,652,417*	*34,725,085*	*98,121,896*
Total Without Waiver Costs	***4,116,928,712***	***4,283,985,050***	***4,481,669,014***	***22,084,704,435***
With Waiver Summary	**DY 04**	**DY 05**	**DY 06**	**DY 01 - DY 06**
XIX - HIP Populations				
Section 1931 Caretakers	*809,826,690*	*841,086,280*	*873,712,025*	*4,592,083,710*
New Adult Group	*1,656,597,280*	*1,706,628,334*	*1,771,794,772*	*8,585,231,425*
Medically Frail	*743,788,626*	*775,124,864*	*812,881,638*	*4,118,498,601*
HIP Employer Link	1,454,738	1,506,975	1,566,817	5,788,925
HIP Presumptive Eligibility	576,620	466,155	376,999	5,037,572
Subtotal	*3,212,243,953*	*3,324,812,608*	*3,460,332,251*	*17,306,640,232*
XIX - Non-HIP Populations (SUD)				
Disabled Children Population	1,562,423	1,645,916	1,735,844	4,944,183
Disabled Under 65 Population	11,242,296	11,978,760	12,770,721	35,991,777
Aged Over 65 Population	1,263,060	1,353,980	1,448,436	4,065,476
HHW Child Population	15,334,694	16,274,236	17,310,441	48,919,370
HHW Adult Population	1,341,921	1,399,525	1,459,644	4,201,090
Subtotal	*30,744,394*	*32,652,417*	*34,725,085*	*98,121,896*
Total With Waiver Costs	***3,242,988,347***	***3,357,465,024***	***3,495,057,336***	***17,404,762,128***
Total Waiver Margin	*873,940,365*	*926,520,026*	*986,611,678*	*4,679,942,307*
Waiver Margin excluding Newly Eligible	***292,057,712***	***323,377,050***	***357,079,066***	***1,657,247,908***
Coverage Estimates	**DY 04**	**DY 05**	**DY 06**	
Anticipated Enrollment				
Section 1931 Caretakers	117,567	117,976	118,408	
New Adult Group	274,863	274,915	277,099	
Medically Frail	46,160	46,122	46,374	
HIP Employer Link	2,010	2,022	2,041	
HIP Presumptive Eligibility	43	34	27	
Total HIP Enrollment	**440,644**	**441,068**	**443,949**	
Disabled Children Population	66,092	66,907	67,595	
Disabled Under 65 Population	217,874	222,819	227,886	
Aged Over 65 Population	126,813	129,692	132,641	
HHW Child Population	648,676	655,162	661,714	
HHW Adult Population	30,637	30,372	30,108	
Total Non-HIP Enrollment	**1,090,092**	**1,104,952**	**1,119,944**	
Grand Total Enrollment	**1,530,736**	**1,546,020**	**1,563,893**	

APPENDIX 2: WITHOUT WAIVER PROJECTIONS

Healthy Indiana Plan

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION

HIP POPULATIONS					
ELIGIBILITY GROUP	**Trend**	**DEMONSTRATION YEARS (DY) DY 01**	**DY 02**	**DY 03**	**TOTAL WOW**
Section 1931 Caretakers					
Eligible Member Months		1,126,573	1,378,009	1,406,268	
Total Cost Per Eligible	5.30%	$ 666.15	$ 701.46	$ 738.64	
Total Expenditure		$ 750,466,604	$ 966,618,193	$ 1,038,725,796	$ 2,755,810,593
New Adult Group					
Eligible Member Months		1,610,152	2,703,861	3,228,174	
Total Cost Per Eligible	1.10%	$ 545.14	$ 551.14	$ 557.20	
Total Expenditure		$ 877,758,261	$ 1,490,205,952	$ 1,798,738,553	$ 4,166,702,766
Medically Frail					
Eligible Member Months		259,024	483,214	554,716	
Total Cost Per Eligible	4.30%	$ 1,662.65	$ 1,734.14	$ 1,808.71	
Total Expenditure		$ 430,666,254	$ 837,960,726	$ 1,003,320,376	$ 2,271,947,356
HIP Employer Link					
Eligible Member Months		15	1,158	20,357	
Total Cost Per Eligible	1.10%	$ 348.33	$ 352.17	$ 356.04	
Total Expenditure		$ 5,225	$ 407,813	$ 7,247,906	$ 7,660,944

Healthy Indiana Plan

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION

HIP POPULATIONS					
ELIGIBILITY GROUP	**Trend**	**DY 04**	**DY 05**	**DY 06**	**TOTAL WOW**
Section 1931 Caretakers					
Eligible Member Months		1,410,807	1,415,708	1,420,901	
Total Cost Per Eligible	5.30%	$ 781.44	$ 822.86	$ 866.47	
Total Expenditure		$ 1,102,461,022	$ 1,164,929,485	$ 1,231,168,089	$ 6,254,369,189
New Adult Group					
Eligible Member Months		3,298,359	3,298,980	3,325,191	
Total Cost Per Eligible	3.00%	$ 583.59	$ 601.10	$ 619.13	
Total Expenditure		$ 1,924,889,329	$ 1,983,016,878	$ 2,058,725,504	$10,133,334,476
Medically Frail					
Eligible Member Months		553,922	553,459	556,490	
Total Cost Per Eligible	4.30%	$ 1,895.55	$ 1,977.06	$ 2,062.07	
Total Expenditure		$ 1,049,986,847	$ 1,094,221,651	$ 1,147,521,334	$ 5,563,677,188
HIP Employer Link					
Eligible Member Months		24,125	24,263	24,493	
Total Cost Per Eligible	3.00%	$ 366.72	$ 377.72	$ 389.05	
Total Expenditure		$ 8,847,120	$ 9,164,620	$ 9,529,002	$ 35,201,686

NON-HIP POPULATIONS					
ELIGIBILITY GROUP	**Trend**	**DY 04**	**DY 05**	**DY 06**	**TOTAL WW**
Disabled Children					
Eligible Member Months		793,108	802,886	811,142	
Total Cost Per Eligible	4.3%	$ 1.97	$ 2.05	$ 2.14	
Total Expenditure		$ 1,562,423	$ 1,645,916	$ 1,735,844	$ 4,944,183
Disabled Adults Under 65					
Eligible Member Months		2,614,487	2,673,830	2,734,630	
Total Cost Per Eligible	4.3%	$ 4.30	$ 4.48	$ 4.67	
Total Expenditure		$ 11,242,296	$ 11,978,760	$ 12,770,721	$ 35,991,777
Aged - Age 65 and Over					
Eligible Member Months		1,521,759	1,556,299	1,591,687	
Total Cost Per Eligible	4.3%	$ 0.83	$ 0.87	$ 0.91	
Total Expenditure		$ 1,263,060	$ 1,353,980	$ 1,448,436	$ 4,065,476
HHW Child					
Eligible Member Months		7,784,109	7,861,950	7,940,569	
Total Cost Per Eligible	5.30%	$ 1.97	$ 2.07	$ 2.18	
Total Expenditure		$ 15,334,694	$ 16,274,236	$ 17,310,441	$ 48,919,370
HHW Adult					
Eligible Member Months		367,650	364,460	361,298	
Total Cost Per Eligible	5.30%	$ 3.65	$ 3.84	$ 4.04	
Total Expenditure		$ 1,341,921	$ 1,399,525	$ 1,459,644	$ 4,201,090

APPENDIX 3: WITH WAIVER PROJECTIONS

Healthy Indiana Plan **DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION**

HIP POPULATIONS					
ELIGIBILITY GROUP	**Trend**	**DEMONSTRATION YEARS (DY) DY 01**	**DY 02**	**DY 03**	**TOTAL WW**
Section 1931 Caretakers					
Eligible Member Months		1,126,573	1,378,009	1,406,268	
Total Cost Per Eligible	3.5%	$ 494.88	$ 532.89	$ 551.54	
Total Expenditure		$ 557,518,446	$ 734,327,216	$ 775,613,053	$ 2,067,458,715
New Adult Group					
Eligible Member Months		1,610,152	2,703,861	3,228,174	
Total Cost Per Eligible	1.1%	$ 383.53	$ 474.68	$ 479.90	
Total Expenditure		$ 617,541,597	$ 1,283,468,739	$ 1,549,200,703	$ 3,450,211,039
Medically Frail					
Eligible Member Months		259,024	483,214	554,716	
Total Cost Per Eligible	4.3%	$ 1,867.05	$ 1,227.27	$ 1,280.04	
Total Expenditure		$ 483,610,759	$ 593,034,046	$ 710,058,669	$ 1,786,703,474
HIP Employer Link					
Eligible Member Months		15	1,158	20,357	
Total Cost Per Eligible	1.10%	$ 109.87	$ 57.90	$ 58.54	
Total Expenditure		$ 1,648	$ 67,048	$ 1,191,699	$ 1,260,395
HIP Presumptive Eligibility					
Eligible Member Months		971	933	658	
Total Cost Per Eligible	1.10%	$ 1,959.51	$ 1,073.13	$ 1,084.93	
Total Expenditure		$ 1,902,684	$ 1,001,230	$ 713,884	$ 3,617,798

Healthy Indiana Plan **DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION**

HIP POPULATIONS					
ELIGIBILITY GROUP	**Trend**	**DY 04**	**DY 05**	**DY 06**	**TOTAL WW**
Section 1931 Caretakers					
Eligible Member Months		1,410,807	1,415,708	1,420,901	
Total Cost Per Eligible	3.5%	$ 574.02	$ 594.11	$ 614.90	
Total Expenditure		$ 809,826,690	$ 841,086,280	$ 873,712,025	$ 4,592,083,710
New Adult Group					
Eligible Member Months		3,298,359	3,298,980	3,325,191	
Total Cost Per Eligible	3.0%	$ 502.25	$ 517.32	$ 532.84	
Total Expenditure		$ 1,656,597,280	$ 1,706,628,334	$ 1,771,794,772	$ 8,585,231,425
Medically Frail					
Eligible Member Months		553,922	553,459	556,490	
Total Cost Per Eligible	4.3%	$ 1,342.77	$ 1,400.51	$ 1,460.73	
Total Expenditure		$ 743,788,626	$ 775,124,864	$ 812,881,638	$ 4,118,498,601
HIP Employer Link					
Eligible Member Months		24,125	24,263	24,493	
Total Cost Per Eligible	3.0%	$ 60.30	$ 62.11	$ 63.97	
Total Expenditure		$ 1,454,738	$ 1,506,975	$ 1,566,817	$ 5,788,925
HIP Presumptive Eligibility					
Eligible Member Months		516	405	318	
Total Cost Per Eligible	3.0%	$ 1,117.48	$ 1,151.00	$ 1,185.53	
Total Expenditure		$ 576,620	$ 466,155	$ 376,999	$ 5,037,572

NON-HIP POPULATIONS					
ELIGIBILITY GROUP	**Trend**	**DY 04**	**DY 05**	**DY 06**	**TOTAL WW**
Disabled Children					
Eligible Member Months		793,108	802,886	811,142	
Total Cost Per Eligible	4.3%	$ 1.97	$ 2.05	$ 2.14	
Total Expenditure		$ 1,562,423	$ 1,645,916	$ 1,735,844	$ 4,944,183
Disabled Adults Under 65					
Eligible Member Months		2,614,487	2,673,830	2,734,630	
Total Cost Per Eligible	4.3%	$ 4.30	$ 4.48	$ 4.67	
Total Expenditure		$ 11,242,296	$ 11,978,760	$ 12,770,721	$ 35,991,777
Aged - Age 65 and Over					
Eligible Member Months		1,521,759	1,556,299	1,591,687	
Total Cost Per Eligible	4.3%	$ 0.83	$ 0.87	$ 0.91	
Total Expenditure		$ 1,263,060	$ 1,353,980	$ 1,448,436	$ 4,065,476
HHW Child					
Eligible Member Months		7,784,109	7,861,950	7,940,569	
Total Cost Per Eligible	5.3%	$ 1.97	$ 2.07	$ 2.18	
Total Expenditure		$ 15,334,694	$ 16,274,236	$ 17,310,441	$ 48,919,370
HHW Adult					
Eligible Member Months		367,650	364,460	361,298	
Total Cost Per Eligible	5.3%	$ 3.65	$ 3.84	$ 4.04	
Total Expenditure		$ 1,341,921	$ 1,399,525	$ 1,459,644	$ 4,201,090

APPENDIX 4: DOCUMENTATION ON WITH WAIVER ADJUSTMENTS TO THE SCHEDULE C

ADJUSTMENTS TO HISTORICAL WITH WAIVER EXPENDITURES

This appendix provides additional information on the data, assumptions, and methodology underlying adjustments made to the historical experience in Schedule C filings.

All adjustments described in this report were developed based on data from the State of Indiana's Enterprise Data Warehouse, as reported through October 31, 2016.

Reallocation of HIP presumptive eligibility expenditures

Compliance with original intent

In the most recent CMS Schedule C, as of September 30, 2016, Indiana is reporting *all* presumptive eligibility (PE) expenditures under the "PE Program" eligibility group. However, Indiana is in the process of correcting PE Program reporting in order to comply with the original intent, as clarified by CMS in an addendum to the STCs (Appendix 5). As requested by CMS:

- PE program expenditures for individuals who, after formal submission of a complete application, are found to be fully eligible under the new adult category: will be treated as new adult expenditures. These expenditures will be eligible for the enhanced match and will count on both sides of the budget neutrality agreement.
- PE program expenditures for individuals who are deemed presumptively eligible and do not submit a full application or submit an application but are not eligible for the new adult category: will be eligible for the standard match, but will be excluded from 1115 waiver reporting.
- Any expenses related to extension of the PE period beyond the time period specified in the PE regulations, specifically 42 CFR 435.1101 (CFR PE period), will only appear on the "With Waiver" under "PE Program".

Allocation of PE expenditures into the categories above cannot be completed until each individual's ultimate eligibility is determined under the regular Medicaid process. As a result, the allocation must be done retrospectively, and often several months in arrears. The PE period itself may last up to two months, and if a regular application is submitted during the PE period, the approval process may require two to three additional months, especially if additional information is requested.

Results of allocation analysis for DY 01

We have analyzed the experience during DY 01, and have developed the following allocation groups:

1. 48.3% of DY 01 PE expenditures were for individuals who, after formal submission of a complete application, were found to be fully eligible under the new adult category, either the New Adult Population or the Medically Frail Population.
2. 51.2% of DY 01 PE expenditures were for individuals who did not submit a full application or who, after formal submission of a complete application, were either determined not eligible or found to be fully eligible under a Medicaid category that was not the new adult category.
3. 0.5% of DY 01 PE expenditures did not meet the criteria above, and extended beyond the time period specified in the 42 CFR 435.1101 PE regulations.

The data and process used to generate the allocation is described below.

Data and methodology for allocation of HIP PE expenditures

For this analysis, we used data and information stored in the State of Indiana's Enterprise Data Warehouse (EDW), as reported through September 2016. We began with all HIP PE expenditures incurred in CY 2015. These may be identified by the capitation code 'AP'. For each PE enrollee, the EDW contains the following data fields:

- **HIP PE determination date**: The hospitals and other qualified providers make the original HPE determination. This date is stored in the EDW under Date_PE_Added , and marks the beginning of the CFR PE period.
- **HIP PE application date**: The HPE enrollee has until the end of the months following the HPE determination date to apply for Medicaid eligibility. This date is stored in the EDW under Application_Date. If an application is never filed, the CFR PE period ends at the end of the second month after the determination.
- **Regular Medicaid determination date**: After the HPE enrollee submits a regular Medicaid application, it is processed by FSSA, and a regular Medicaid eligibility determination is made. If the application is approved, this date is stored in the EDW under Date_Medicaid_Determine, and signals an end to the CFR PE period.
- **Denied date:** After the HPE enrollee submits a regular Medicaid application, it is processed by FSSA, and a regular Medicaid eligibility determination is made. If the application is denied, this date is stored in the EDW under Date_Denied, and signals an end to the CFR PE period

For HIP PE enrollees who did not submit a regular Medicaid application, the CFR PE period began on the HIP PE determination date, and ended on the last day of the following month. PE expenditures related to enrollment during the CFR PE period for individuals who did not submit a regular Medicaid application (17.8% of expenditures) were excluded from 1115 waiver reporting.

For those who submitted a regular Medicaid application, the CFR PE period ended on the regular Medicaid determination date. For the last month of PE, we assigned PE capitation payments to the CFR PE period using the logic employed by the fiscal agent. That is, if the CFR PE period included 17 or fewer days during the last month, 0.5 a month of capitation payments was allocated, and if the CFR PE period included 18 or more days, then a full month capitation payment was allocated.

For individuals who received an adverse determination (denied), eligibility should end immediately after the determination. PE expenditures related to enrollment during the CFR PE period for individuals who were denied on the regular process (25.0% of expenditures) were excluded from 1115 waiver reporting.

For individuals who were determined eligible for a HIP or non-HIP program, eligibility may be transitioned immediately. Again, there should be no HIP PE expenditures beyond the CFR PE period.

For individuals who were determined eligible for HIP, it may have been necessary to extend the PE period for the remainder of the month in order to avoid a gap in coverage. In cases where the need to extend the PE period resulted in an additional half month of HIP PE capitation, this will count against the program for purposes of budget neutrality. These PE expenditures beyond the CFR PE period were retained under the PE program heading on the "With Waiver" summary (allocation group 3 above).

Where the enrollee submitted an application before the end of the CFR PE period and was approved for regular HIP or Medicaid eligibility, we have allocated HIP PE expenditures to the recipient's regular eligibility group.

Additional presumptive eligibility payments for DY 02

Starting with DY 02, the State has begun reporting the first two calendar months of presumptive eligibility payments outside of the Schedule C. Approximately $107.9 million in presumptive eligibility payments were paid for the first two months of presumptive eligibility from January 1, 2016 through September 30, 2016. The amount of $33.4 million reported in the Schedule C reflects only the third and later months of presumptive eligibility payments. The total amount of PE payments for the period January 1, 2016 through September 30, 2016 is approximately $141.3 million.

As with DY01 amounts reported on the Schedule C under the PE program, the amounts reported as PE program for DY 02 may be reallocated as newly eligible, Medicaid, or remain in the PE population. The DY 02 PE payments *not* reported on the Schedule C (the first two months) may ultimately remain in Medicaid or be reassigned as newly eligible. Because some of these payments will ultimately be reported as newly eligible, we have also considered the additional presumptive eligibility payments for DY 02 in the overall reallocation.

Re-allocation of Schedule C HIP presumptive eligibility expenditures for DY 01 and DY 02

We have reallocated PE program expenditures reported on the Schedule C in the manner described above. This is illustrated in Table 4.1.

Table 4.1
State of Indiana
Family and Social Services Administration
Allocation of Presumptive Eligibility expenditures

Population	Allocation	DY01	DY02
Section 1931 Parents	5.3%	$ 19,837,308	$ 7,522,326
New Adult Group	34.3%	127,674,797	48,414,407
Medically Frail	14.0%	52,212,437	19,799,007
HIP Employer Link	0.0%	-	-
Remains with PE Program	0.5%	1,883,446	714,205
Other Medicaid (not on 1115)	45.9%	170,952,183	64,825,233
Total PE Program expenditures	**100.0%**	**$372,560,171**	**$141,275,178**

FSSA is in the process of revising reported values to conform to requirements clarified in the addendum to the STCs.

Retroactive payments made in October 2016

Table 4.2 illustrates payments incurred through September 2016, but paid in October 2016. The largest component of the retroactive payments concerned POWER account payments for continuing members, delayed to reflect reconciliation from the prior benefit period. These have been added to Schedule C expenditures for DY 01 and DY 02.

Table 4.2
State of Indiana
Family and Social Services Administration
Additional payments in October 2016

Population	DY 01	DY 02
Section 1931 Parents	$ 4,211,304	$ 76,765,443
New Adult Group	3,288,862	77,315,879
Medically Frail	1,098,168	25,797,621
HIP Employer Link	-	-
HIP Presumptive Eligibility	-	-
Total	**$ 8,598,335**	**$ 179,878,943**

Health insurer fee

The health insurer fee for DY 01 has been paid, but for DY 02, the capitation rates have not yet been retroactively adjusted to reflect the fee, spread over the full contract year. We have estimated the fee will increase rates by 2.0% of capitation. During DY 02, one of the three contracted health plans was not subject to the fee. Due to the moratorium, there is no health insurer fee projected for DY 03. For DY 04 through DY 06, we have estimated the fee will increase capitation rate by approximately 1.7%. During this time period, two of four contracted health plans will not be subject to the fee.

MCO performance payments

Capitation withholds for CY 2015 are anticipated to be paid at the end of CY 2016. The capitation rates assume that approximately half of amounts withheld will be returned to plans. To reflect the 2.0% withhold, we have increased expenditures by 1.0% for DY 01 and DY 02.

Physician specialty network access fee

In the initial filing, Indiana has proposed a physician specialty network access fee to assure continued access to physician specialty networks by providing enhanced reimbursement. The request has not yet been approved by CMS, although it is still under discussion with CMS. We have not adjusted the 'with waiver' rates to reflect this fee.

Annualization of DY 02 expenditures

Schedule C expenditures for DY 02 (January 2016 through December 2016) reflected incurred expenditures paid through September 2016. These have been adjusted for completion through October 2016, allocation of presumptive eligibility expenditures, and payment of the health insurer fee. After these adjustments, we have also annualized expenditures, assuming expenditures incurred in October 2016 through December 2016 will reflect the same PMPM as other DY 02 expenditures.

APPENDIX 5: CMS CLARIFICATION ON BUDGET NEUTRAL PE ACCOUNTING

Presumptive Eligibility (PE) Reporting for the Healthy Indiana Plan 2.0 1115 waiver:

The state will report expenses related to presumptively eligible individuals in the following manner, as discussed with CMS on 12/15/2015. The state will update previous reports delivered to CMS to comply with this change. Please confirm our understanding of the process.

1) Individuals that are deemed presumptively eligible and then after formal submission of a complete application are found to be fully eligible under the new adult category:

a) All expenses for these individuals will be counted on both the "with waiver" and "without waiver" sides of the budget neutrality agreement.
b) As these individuals meet the eligibility requirements of the new adult group, all of their expenses for both the PE period and their regular eligibility period will be eligible for the new adult category enhanced match.

2) Individuals that are deemed presumptively eligible and do *not* submit a full application, or submit an application but are not eligible for the new adult category:

a) All expenses for these individuals will be excluded from reporting of expenses for the 1115 waiver. However, any expenses related to the extension of the PE period, beyond the time period specified in the PE regulations, specifically 42 CFR 435.1101, will be counted in the waiver and will only appear on the "with waiver." The state is not required to track these expenses on an individual member basis and may take a sample or average of this expense that can be extrapolated to the larger group.
b) As these individuals are not eligible for the new adult category, their PE expenses will be matched at the state's FMAP rate.

The points below articulate how the state will report PE expenses.

- All Hospital Presumptive Eligibility capitation payments for the time period specified in 42 CFR 435.1101, the month of PE determination and the following month will initially be included and reported as Base Medicaid expenses.
- PE capitation payments after this period will be reclassified as PE expenses against the HIP 2.0 1115 Waiver and reported on a Medicaid Eligibility Group (MEG) form of the CMS-64 for the PE Program group.
- An analysis of PE capitation payments will be conducted to determine a representative amount of the payments that are for the PE period under 42 CFR 435.1101 and the payments following that period.
- Individuals that are deemed presumptively eligible and then after formal submission of a complete application are found to be fully eligible as Newly Eligible under either the New Adult Group or Medically Frail MEG will have all PE capitation payments reclassified for both the PE period and their regular eligibility period will be eligible for the new adult category enhanced match.
- Individuals that are deemed presumptively eligible and do *not* submit a full application, or submit an application but are not eligible under a Newly Eligible MEG will not have any reclassification of their PE capitation payments

For example,

Individual that are deemed presumptively eligible will have PE capitation payments reported as shown in the table below following disposition for their PE status. The rows represent the individual's status immediately after the PE time period ends while the columns represent the final reporting of their PE capitation payments all reclassifications.

	Medicaid	1115 PE MEG	New Adult Group	Medically Frail
New Adult Goup			All PE payments	
Medically Frail				All PE payments
LIPC	42 CFR 435.1101	After CFR PE period		
Other Medicaid	42 CFR 435.1101	After CFR PE period		
Denied	42 CFR 435.1101	After CFR PE period		
No Application	42 CFR 435.1101	After CFR PE period		

APPENDIX 6: DOCUMENTATION OF SUBSTANCE USE DISORDER ESTIMATES

DOCUMENTATION OF SUBSTANCE USE DISORDER ESTIMATES

This appendix provides additional information on the data, assumptions, and methodology underlying substance use disorder PMPM cost estimates.

Population assumptions

SUD prevalence

Table 6.1 illustrates composite prevalence estimates by population.

Table 6.1
State of Indiana
Family and Social Services Administration
Estimated Substance Use Disorder prevalence

	Projected DY 04 Enrollment	Estimated prevalence	Estimated lives with SUD diagnosis
Disabled Children Population	66,092	2.5%	1,652
Disabled Under 65 Population	217,874	13.0%	28,324
Aged Over 65 Population	126,813	2.5%	3,170
HHW Child Population	648,676	2.5%	16,217
HHW Adult Population	30,637	8.5%	2,604
Section 1931 Caretakers	117,567	8.5%	9,993
Other HIP enrollees	323,077	21.1%	68,169
Composite	1,530,736	8.5%	130,130

Indiana-specific prevalence estimates were provided by the 2013 SAMHSA Behavioral Health Treatment Needs Toolkit for States (http://store.samhsa.gov/shin/content/SMA13-4757/SMA13-4757.pdf). In this report, the prevalence of substance use disorder is 11.0% for the existing Medicaid population and 21.1% for the estimated Medicaid expansion population. Both figures are midpoint estimates for the age 18 to 64 age group. We have redistributed the overall prevalence for existing Medicaid adults to reflect differences by age and disabled status. We have increased the Disabled under 65 prevalence and lowered the HHW adult prevalence in our analysis. The under 18 age group prevalence of 2.5% was estimated using data provided by the Indiana Division of Mental Health and Addiction (DMHA) on the relative prevalence of SUD for children compared with adults. We are also utilizing a 2.5% prevalence estimate for the age 65 and over population to reflect lower benchmark SUD experience relative to other adult populations.

SUD take-up rates

Many individuals with a SUD diagnosis choose not to seek treatment. The overall take-up rates below were selected from a SAMHSA report (http://www.samhsa.gov/data/sites/default/files/1/1/NSDUHsaeIndiana2014.pdf) specifically focused on the State of Indiana. We have stratified the rates by addictive substance, and have reflected a lower take-up rate for marijuana and a higher take-up rate for opiates based upon a report provided by the State Epidemiology and Outcomes Workgroup (SEOW).

Table 6.2
State of Indiana
Family and Social Services Administration
SUD diagnosis take-up rate

	Take-up Rate	% Relapse and Re-Present	Unique Episodes as % of SUD Members
Alcohol	10.00%	20.0% of take-up	12.00%
Marijuana (Adults)	8.30%	20.0% of take-up	10.00%
Opiates	33.30%	20.0% of take-up	40.00%
Illicit Drugs	13.00%	20.0% of take-up	15.60%

Utilization assumptions

Treatment plans

Persons seeking treatment for SUD will receive a treatment plan specific to the needs of the individual. For modeling purposes, we have developed a set of core treatment plans for each primary substance for the adult SUD population. We have also developed a set of core treatment plans for the child population. We did not split the treatment plans by primary disorder for the child population because there is less treatment variation based on primary drug of choice. Table 6.3 illustrates the percentage of individuals entering each treatment plan by diagnosis group for adults and in aggregate for children.

Table 6.3
State of Indiana
Family and Social Services Administration
Percent of Individuals Entering Treatment Plan by Diagnosis Group

	24 Hour Treatment	IOP Treatment	Partial Hospitalization Treatment	Outpatient Treatment Only
Adult				
Alcohol/Depressant disorder	10.00%	30.00%	30.00%	30.00%
Marijuana disorder	10.00%	30.00%	10.00%	50.00%
Opiate disorder	10.00%	8.00%	7.00%	75.00%
Meth/Stimulants	25.00%	30.00%	25.00%	20.00%
All other SUDs	25.00%	30.00%	25.00%	20.00%
Children				
All SUDs	30.00%	25.00%	10.00%	35.00%

Treatment plans are categorized by the highest level of treatment required for an individual after potentially receiving inpatient detoxification treatment. We have used this convention because an individual's treatment plan often begins with inpatient detoxification; however, an individual may transition from detox into several different settings.

- **24 Hour Treatment**: An individual with a 24-hour treatment plan would receive residential treatment either initially or after receiving inpatient detoxification treatment. Individuals then step down to less intensive treatment.
- **Intensive Outpatient Program (IOP) Treatment**: An individual with an IOP treatment plan would receive intensive outpatient treatment either initially or after receiving inpatient detoxification treatment. Individuals then step down to less intensive treatment.
- **Partial Hospitalization Treatment**: An individual with a partial hospitalization treatment plan would receive partial hospitalization either initially or after receiving inpatient detoxification treatment. Individuals then step down to less intensive treatment.
- **Outpatient Treatment Only**: An individual with an outpatient only treatment plan would receive outpatient treatment either initially or after receiving inpatient detoxification treatment. These individuals step down to less intensive outpatient treatment.

Prescribed utilization by treatment plan

For each entering treatment and diagnosis group, DMHA clinicians have assisted us with developing a treatment plan. An example is provided in Table 6.4 for the adult alcohol/depressant disorder 24 hour care treatment plan. The number of hours or days included in the prescribed treatment plan, as listed in the left column of Table 6.4, represents what the prescribing practitioner would suggest at initiation of treatment, and what an individual would receive if he or she completed the full treatment plan and did not opt-out of treatment. The right column illustrates the percentage of each portion of the prescribed treatment plan that may be utilized by an average recipient.

Table 6.4 State of Indiana Family and Social Services Administration Adult Alcohol/Depressant Diagnosis 24 Hour Care Treatment Plan	
Treatment Plan	**% of Services Actually Utilized**
70% - 3 days IP detox	66.00%
28 days of High-Intensity Residential	61.00%
90 days of Low-Intensity Residential	15.00%
2 hours per week for 90 days of Outpatient	5.00%

For an adult with an alcohol or depressant diagnosis in the 24 hour care treatment plan, we assume that 70% of the individuals that have the 24 hour care treatment plan will be prescribed inpatient detoxification first. We are assuming that full treatment for individuals entering/receiving inpatient detoxification on average will be three days. Individuals will then step down (or begin if no inpatient detox) into high-intensity residential services for the next 28 days on average, transition into low-intensity residential services for the next 90 days, and finally step down into outpatient treatment for the next 90 days for two hours per week on average.

Percentage of prescribed utilization received

Individuals who enter into the delivery system and receive a treatment plan do not always complete the treatment plan that was prescribed. As a result, we need to estimate the average percentage of the prescribed utilization that will actually be utilized. Table 6.4 illustrates the estimated percentage of services actually utilized by individuals on average. For example, we estimate that 66% of the prescribed inpatient detoxification utilization (3 days for 70% of the people or 2.1 days) will actually be utilized (66% * 2.1 days = 1.4 days).

Reimbursement assumptions

Unit cost by individual service

We utilized benchmark Medicaid Rehabilitation Option (MRO) services to estimate the cost of the individual components of service that will be provided within the ASAM levels of care. Table 6.5 illustrates the service description and unit cost for the individual components that will be provided as part of each ASAM level of care.

Table 6.5 illustrates unit costs under Medicaid reimbursement. HIP reimbursement is 30% higher.

Table 6.5 State of Indiana Family and Social Services Administration Individual Service Unit Cost Development			
Service Description	**Unit Type**	**Benchmark MRO Service**	**Cost per Unit**
Individual/Family Therapy	Hour	H0004	$ 108.97
Group Therapy	Hour	H0004 group	27.23
Skills Training	Hour	H2014	104.56
Medical Management	Hour	H0034	74.48
Recovery Supports	Hour	H0038	34.20
Case Management	Hour	T1016	58.12
Drug Testing	Encounter	80101	19.03
Room and Board	Day		100.00

Bundled unit cost

In many cases, the daily rate for treatment will include a mix of services. We have estimated daily rates based on the services that may be required.

Table 6.6 illustrates the bundled cost per unit utilized in the cost development for each ASAM level of care.

Table 6.6 State of Indiana Family and Social Services Administration Bundled Cost Per Unit			
ASAM Level of Care	**Unit Type**	**Adult Cost per Unit**	**Child Cost per Unit**
0.5 Early Intervention	Encounter	$117.63	$117.63
1.0 Outpatient Services (First 90 Days)	Hour	$39.08	$101.33
1.0 Outpatient Services (After 90 Days)	Hour	$47.52	$101.27
2.1 Intensive Outpatient Services	Hour	$35.28	$100.88
2.5 Partial Hospitalization	Day	$236.33	$400.87
3.1 Clinically Managed Low-Intensity Residential	Day	$126.13	$137.53
3.3 Clinically Managed Population Specific High-Intensity Residential	Day	$0.00	$0.00
3.5 Clinically Managed High-Intensity Residential	Day	$392.57	$550.75
3.7 Medically Monitored Intensive Inpatient	Day	$800.00	$800.00
4.0 Medically Managed Intensive Inpatient	Day	$900.00	$900.00

Attachment II: Public Notice

Public Notice for Indiana HIP 2.0 1115 Waiver Renewal

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 on **January 4, 2017, at 9:00 a.m., at the Indiana Government Center South, Conference Center Rooms 4 and 5, 402 West Washington Street, Indianapolis, Indiana 46204,** the Indiana Family and Social Services Administration (FSSA or State) will hold a public hearing on the Healthy Indiana Plan 2.0 Section 1115 demonstration waiver extension application (HIP Waiver) that will be submitted to the Centers for Medicare and Medicaid Services (CMS) to extend the current program for calendar years 2018 through 2020 with minor technical revisions and several program enhancements. The public hearing will be accessible via web conference at https://indiana.adobeconnect.com/infssa. In addition, FSSA will present the HIP Waiver to the **Medicaid Advisory Committee (MAC) at its meeting on January 5, 2017, at 1:00 p.m., at the Indiana State Library, Room 211, 315 West Ohio Street, Indianapolis, IN 46204.** The public is welcome to attend and comment at the MAC meeting.

This notice also serves to open the 30-day public comment period, which closes January 20, 2017 at 5:00 p.m.

SUMMARY AND OBJECTIVES OF WAIVER

Since 2008, the Healthy Indiana Plan (HIP) model has demonstrated remarkable success in activating beneficiaries into engaged participants and improving outcomes. The expanded HIP 2.0 program has seen consistent results since 2015, proving that HIP's consumer driven model is scalable and remains successful in empowering enrollees to become active consumers of healthcare services. Through the HIP Waiver extension, the State's objective is to continue its highly successful HIP 2.0 program for the maximum waiver renewal period of three (3) years in its current form with the following minor technical revisions and program enhancements:

1. Expand Incentives Program: In general, member incentives in the commercial market carry a substantially higher dollar value than the member incentive programs operated in Medicaid managed care programs. Private sector research has demonstrated that member healthy incentive programs can be effective in reducing individual healthcare claims and overall healthcare spending, resulting in lower-than-industry yearly growth in healthcare costs for the companies utilizing these incentives. Based on this extensive research, the State seeks to significantly enhance its existing member incentive program by removing the current low-dollar incentive limitation (approximately $10-$25 provided through varied managed care entity (MCE) programming), and increase available member healthy incentives to a maximum of $200 per initiative, with a total of no more than $300 per member per year in total incentives. The expanded healthy incentive initiative will target each of the following four focus areas:

    - Tobacco cessation;
    - Substance use disorder;
    - Chronic disease management; and
    - Employment related incentive program.

2. Require Tobacco-User Premium Surcharge: Currently, all HIP members are required to contribute two percent (2%) of income per month to their Personal Wellness and Responsibility (POWER) account to maintain access to the enhanced HIP Plus plan. However, to encourage participation in the expanded

voluntary tobacco cessation incentive initiative described above, and consistent with Marketplace policies, members who are known tobacco users will be required to pay monthly contributions equal to three percent of income after their first year of enrollment in HIP.

3. HIP Plus Incentive: The State will add chiropractic spinal manipulation benefits to the HIP Plus plan to promote participation in HIP Plus through regular contributions to the member's POWER account. Specifically, the HIP Plus alternative benefit plan will be amended to add chiropractic spinal manipulation services, limited to one (1) visit per day and six (6) visits per covered person per benefit year. This benefit modification will further enhance the value proposition underlying the HIP plan structure, which will include vision, dental and chiropractic services.

4. Reestablish an Open Enrollment Period: One of the primary goals of HIP is to promote personal health responsibility. However, personal responsibility for one's healthcare is not limited to responsible utilization of healthcare services, but can also be demonstrated in maintaining health insurance coverage. Improved compliance with eligibility redetermination requirements not only helps to prepare members for participation in the commercial insurance marketplace, but it also results in better continuity of care and improved health outcomes for members. Therefore, to support these important program goals, the State will seek to implement a member specific open enrollment period, whereby members who lose eligibility due to failure to comply with redetermination process will be required to wait six months prior to re-enrolling in coverage. Ultimately, as demonstrated in the original HIP waiver, this policy helps to encourage completion of required redetermination process which results in an increase in continuity of care for members.

5. Facilitate Enrollment for Pregnant Women: Currently, HIP members who become pregnant may choose to remain enrolled in HIP, or may transfer to the Hoosier Healthwise program—Indiana's traditional Medicaid managed care program for children and pregnant women. However, women who choose to remain in HIP are *required* to transfer from HIP to Hoosier Healthwise if they are still pregnant at the time of their annual redetermination period. In addition, individuals who apply for Medicaid coverage while pregnant are automatically enrolled in Hoosier Healthwise, and then transition to HIP following the post-partum coverage period if their income is equal to or less than 138% FPL. HIP provides maternity coverage that is equal to the coverage provided under the Hoosier Healthwise program and, consistent with federal law, there is no cost sharing for pregnant women under either program. Further, the MCEs managing both programs are the same. However, although there is no functional difference between the programs, the required program transfers are burdensome for the member, providers, and the State. Therefore, the State will request to modify eligibility criteria to require enrollment in HIP for pregnant women with income under 138% FPL. The Hoosier Healthwise program will be maintained for pregnant women with income greater than 138% FPL who would not be eligible for HIP following the end of pregnancy. The program consistency resulting from this policy modification would improve continuity of care for the member and reduce the administration for the State and providers, without negatively impacting member care.

6. Technical updates to the 2015 Special Terms and Conditions: In addition to the above program enhancements, the State will seek the following minor technical updates to special terms and conditions (STCs):
   - *Prior Claims Payment Program:* The 2015 HIP 2.0 STCs included a waiver of retroactive coverage for all HIP members, but maintained a one year phase out program for a small subsection of newly enrolled HIP members. This "prior claims payment" program provides retroactive coverage for medical services received during the 90-day period prior to the new member's HIP enrollment. However, this limited program is only available to a small subsection of HIP members. Due to the very small target population as well as the general lack of need for the transition program, the prior claim payment program initiative had very low utilization, as the State anticipated. This program

was designed to help very low-income parents and caretakers transition to coverage without the financial burden of medical claims incurred immediately prior to enrollment. However, as demonstrated by the low utilization, this transitional assistance program is no longer needed for several reasons. First, due to Medicaid expansion and availability of tax credits, more individuals are moving to HIP from other coverage, meaning less individuals are enrolling in HIP with unpaid medical bills. Second, a survey of three of the largest hospital systems in the State (comprising nearly 45% of all hospitals) indicated that HIP 2.0 members are not being billed for claims incurred prior to enrollment. Third, the expanded presumptive eligibility process has been very successful in enrolling uninsured individuals into coverage quickly at the site of care prior to the individual incurring non-covered claims.

- *Copayments for Non-Emergent Use of Hospital Emergency Department:* The State received a two-year waiver to test the application of graduated copayments, whereby HIP members are charged an $8.00 copayment for the first inappropriate emergency department visit, and $25 for each subsequent inappropriate emergency department visit. The State will request renewal of the cost sharing waiver beyond the initial two-year period, which is currently set to expire on January 31, 2018.

- *Non-Emergency Medical Transportation (NEMT):* The 2015 HIP 2.0 STCs only granted the State a one-year waiver of this policy. Based on findings from two separate member surveys conducted as part of the State's independent evaluation of HIP, members with state-provided NEMT benefits do not experience better access to healthcare services than members without the benefit. Therefore, the State will renew its request for a waiver of NEMT for the duration of the HIP extension waiver period.

- *Hepatitis C Drug Coverage:* Effective September 1, 2016, all covered hepatitis C drugs were carved out of managed care, including HIP. HIP members are still able to access all such covered hepatitis C drugs through the Medicaid fee-for-service pharmacy benefit manager, rather than through the member's assigned MCE.

- *Member Transitions & MCE Changes*: Currently, HIP members select an MCE on the application and can change their selection at any time prior to making their initial POWER account contribution. Thereafter, HIP members may change their MCE annually during their redetermination period, or anytime during the 12-month benefit period for one of the specified "for cause" reasons (e.g., quality of care concerns). Many individuals leave and return to the program within a 12-month period. The State will seek to maintain plan choice for members for a 12-month period, regardless of enrollment status. Therefore, if a member selects an MCE and begins eligibility, they will remain with that MCE for the full 12 months even if the individual disenrolls and re-enrolls in HIP coverage within the same 12-month period. Members will continue to have the ability to change plans for "just cause." In addition, rather than providing new POWER accounts, individuals who re-enroll in coverage in the same 12-month period will have their POWER account reinstated rather than receiving a new POWER account. Further, members transitioning from other Medicaid eligibility categories to HIP or between types of HIP coverage will be immediately enrolled in the HIP Basic plan with a 60-day opportunity to make an initial POWER account contribution to move to HIP Plus. This process avoids potential gaps in coverage during the critical transition periods for post-partum women transitioning from Hoosier Healthwise, incarcerated individuals transitioning back to the community, and other similar member transitions. Minimizing changes associated with member transitions will result in improved continuity of care for the member as well as administrative savings for the State.

7. Enhancements to HIP Employer Link: The State will also seek to enhance the HIP Employer Link program through the HIP Waiver. HIP Employer Link allows HIP eligible individuals who have access to qualifying employer sponsored insurance to enroll in the employer's health insurance instead of enrolling in HIP. A primary goal of HIP Employer Link is to increase support for commercial market family coverage. To achieve this goal, the State plans to extend the HIP Employer Link coverage option to all Medicaid eligible family members of HIP Employer Link enrollees. For example, in place of a parent receiving HIP Employer Link premium assistance and the children being mandatorily enrolled in Medicaid, the entire Medicaid-eligible family of the HIP Employer Link enrollee would have the option to participate in the premium assistance program.

8. Substance Use Disorder Enhancements: In addition to the proposed enhancements in HIP, this waiver request will also seek to target substance use disorder (SUD), one of the more pressing health challenges currently facing the State. The State seeks to expand access to critical mental health and substance use disorder services to all Medicaid recipients. Specifically, the State seeks to add new SUD benefits so that all Medicaid recipients can access benefits across the full continuum of care in accordance with best practice standards set forth by the Association of Addiction Medicine (ASAM), including the following:

    - Detoxification Services: Medical necessity for this level of care will be based on ASAM medical necessity criteria.

    - Residential Treatment: Following detoxification, residential treatment facilities provide persons recovering from SUD the opportunity to establish a pattern of healthy behaviors and a meaningful period of sobriety before returning to unsupervised daily living. Currently, Indiana Medicaid does not reimburse for residential treatment. The State will seek to add residential detoxification and SUD treatment services (ASAM levels 3.1, 3.5, and 3.7) as a Medicaid covered benefit.

    - Institutions for Mental Disease (IMD) Exclusion: The State will seek a waiver of the IMD exclusion for Medicaid beneficiaries ages 21-64 with short-term stays up to thirty days, in order to expand access to treatment options.

    - Intensive Outpatient Treatment – Addiction Recovery Supports: After receiving detoxification and/or residential treatment services, it is essential that persons recovering from SUD receive the ongoing treatment and support required to sustain their established period of sobriety. The State will add "Addiction Recovery Management Services" as a Medicaid covered benefit. The new service will provide reimbursement for the essential recovery support services including:
        - Recovery education;
        - Peer recovery support services;
        - Housing support services;
        - Recovery focused case management; and
        - Relapse prevention services.

BENEFICIARIES, ELIGIBILITY, & FINANCING

HIP continues to target non-disabled adults between the ages of 19 and 64 with a household income less than 138% of the federal poverty level (FPL), including individuals eligible for the adult group, low-income parents and caretakers eligible under Section 1931 of the Social Security Act (Section 1931), and individuals eligible for transitional medical assistance. Individuals who become pregnant while on HIP may continue to be covered by the HIP program for the remainder of their current benefit period.

HIP enrollment is projected to expand health coverage to approximately 444,000 members by calendar year 2020, which is demonstration year six. Over the three-year demonstration renewal period (2018 - 2020), HIP 2.0 is expected to cost approximately $1.5 billion in state funds, and $10.1 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 2018 – 2020 (in millions)

Calendar Year	Demonstration Year	Expenditures without Waiver	Total HIP Expenditures	State Share of HIP Expenditures	Waiver Margin
2018	4	$4,116.9	$3,243.0	$433.5	$292.1
2019	5	4,284.0	3,357.5	474.7	323.4
2020	6	4,475.9	3,489.3	569.4	357.1

BENEFITS AND HEALTH CARE DELIVERY SYSTEM

All HIP members receive a comprehensive benefit package, consistent with private market plans and compliant with all mandated essential health benefits as required by the Patient Protection and Affordable Care Act (ACA). However, the HIP benefit package is more consistent with commercial plan benefits and does not include non-emergency transportation. Notwithstanding the foregoing, low-income parents and caretakers eligible under Section 1931, low-income 19 and 20-year-old dependents, individuals eligible for transitional medical assistance, and individuals identified as medically frail receive the same benefits as the Medicaid State Plan, including non-emergency transportation and other services not otherwise available to HIP members. Except for members receiving these HIP State Plan benefits, vision and dental services are only available through the HIP Plus plan. Participation in HIP Plus requires members to regularly contribute to their POWER account. The HIP Basic plan is only available to members below the federal poverty level who fail to make their monthly POWER account contributions. The HIP Basic plan is a more limited benefit plan, and does not cover vision and dental services.

For all plans, preventive services, such as annual examinations, smoking cessation programs, and mammograms, are covered without charge to the members and are not included in the deductible amount of $2,500. After the plan deductible is met by way of the $2,500 POWER account, the HIP program includes a comprehensive health plan benefits package.

Individuals enrolled in HIP Employer Link receive the benefits provided by their employer sponsored health plan and not the HIP Basic or Plus benefits. All approved employer sponsored health plans are reviewed by the HIP Employer Link team to ensure compliance with the benefit requirements.

All HIP medical benefits are currently provided through three (3) MCEs: Anthem, MDwise, and Managed Health Services (MHS). Beginning in calendar year 2017, CareSource, the state's newest MCE will also be available to provide health benefits to HIP members. In addition, HIP members have access to enrollment brokers, who provide counseling on the full spectrum of available MCE choices, assist applicants with their MCE selection, and, if applicable, provide counseling regarding the HIP Employer Link option, including assistance evaluating their ESI plan. For HIP members, once an MCE has been selected, the member must remain in the MCE 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: POWER account contributions and co-payments to promote consumerism and personal responsibility. Each HIP member is provided a POWER account valued at $2,500 to pay for the cost of the plan deductible. The POWER account, which operates similarly to a health savings account, contains contributions made by the State as well as the required monthly contributions from the member. Member contributions are equal two percent (2%) of income, but in no event will a member contribute less than $1.00 per month or more than $100.00 per month. By contrast, members not paying monthly POWER account contributions participating in HIP Basic will be required to make copayments for all services. The copayments are established at Medicaid allowable rates, ranging from $4 per office visit up to $75 per hospital stay, making it potentially more expensive than HIP Plus. Consistent with CMS rules, the program ensures that no member pays more than five percent (5%) of their income, except that HIP Plus requires a minimum $1.00 contribution, even among individuals with no reported income.

Consistent with commercial market practices, applicants are required to make their first month's POWER account contribution prior to the start of benefits. Once an individual pays the POWER account contributions, benefits begin the first day of the month in which the contribution was received. However, to expedite coverage, applicants are provided the opportunity to pay a ten dollar ($10.00) fast track POWER account prepayment, while their eligibility application is being processed to accelerate enrollment into the HIP Plus plan. Individuals with income below the federal poverty level who have not made their initial fast track prepayment or first monthly POWER account contribution within 60 days of invoice will be enrolled in the HIP Basic plan beginning the first day of the month of the expiration of the payment period. Individuals above the poverty level who do not make their first monthly POWER account contribution are not enrolled in HIP and must reapply for coverage and make a contribution to access benefits.

Other than the monthly contributions to the POWER account, the only other cost-sharing for HIP Plus members are copayments for non-emergency use of hospital emergency departments. HIP non-emergency use of hospital emergency copayments equal $8.00 for the first inappropriate visit and $25.00 for each subsequent visit.

The State seeks to add a tobacco use surcharge to HIP Plus members in order to encourage participation in the voluntary tobacco cessation initiative. HIP Plus members who are known tobacco users will be required to pay monthly contributions equal to three percent (3%) of income in their second year of eligibility. The tobacco surcharge will be waived for the first year of enrollment in order to provide the individual who identifies as a tobacco user to have the opportunity to take advantage of the robust tobacco cessation benefits offered through HIP. If the member continues to be a tobacco user, their monthly premium will increase beginning in the first month of their renewed benefit period. This proposed change is consistent with ACA rating rules which allow qualified health plans on the Marketplace to charge up to 1.5 times the rate charged to a non-smoker.

Individuals enrolled in HIP Employer Link have the payment for their employer sponsored insurance deducted from their pay check and receive a check in advance from their HIP Employer Link POWER account to cover the difference between their 2% of income contribution, and the amount their employer deducts for insurance. HIP Employer Link enrollees do not have any cost sharing applied to covered services, provided there are funds remaining in the individual's POWER account.

HYPOTHESES & EVALUATION

HIP currently utilizes a CMS-approved comprehensive evaluation plan that has been successful in tracking HIP's progress toward achieving its stated goals. During the new demonstration period, the State will maintain the original evaluation design, but will add new components to assess the impact of the new programs and policies presented within the waiver renewal application. Specifically, the State will include an analysis of the following new components within its updated HIP evaluation plan:

1. Tobacco Cessation
2. Substance Use Disorder (SUD)
3. Chronic Disease Management
4. Employment Related Incentives

The following table outlines the hypotheses for the new program components within the HIP waiver renewal as well as the methodology and data source the State will use for evaluation of each hypothesis:

Hypothesis	Methodology	Data Source
1. Tobacco Cessation		
HIP will increase utilization of tobacco cessation benefits among individuals who use tobacco	Track and compare rates of tobacco cessation utilization among individuals who use tobacco.	Claims Data • Number and percentage of members with tobacco cessation utilization codes MCE Data • Number and percentage of members with tobacco use indicated by MCE health risk assessment Pharmacy Benefit Data • Number and percentage of members with tobacco cessation prescriptions Member Survey Data • Member knowledge of tobacco-cessation benefits; member self-report of tobacco use; member self-report of tobacco cessation utilization
HIP's increased contribution requirement for tobacco users will discourage tobacco use among current smokers	Track and compare rates of tobacco use and tobacco cessation utilization among individuals who use tobacco.	Claims Data • Number and percentage of members with tobacco cessation utilization codes MCE Data • Number and percentage of members with tobacco use indicated by MCE health risk assessment Pharmacy Benefit Data

Hypothesis	Methodology	Data Source
		• Number and percentage of members with tobacco cessation prescriptions Member Survey Data • Member knowledge and perceptions of increased contribution for tobacco users; member self-report of tobacco use; member self-report of tobacco cessation utilization
2. Substance Use Disorder (SUD)		
HIP will increase access to SUD treatment among individuals with SUD	Track and compare rates of SUD treatment engagement among members with SUD	Claims Data • Number and percentage of members with SUD diagnosis codes • Number and percentage of members with SUD treatment codes MCE Data • Number and percentage of members with SUD indicated by MCE health risk assessment Pharmacy Benefit Data • Number and percentage of members with SUD treatment prescriptions Quality measures from the Medicaid Adult and Children's Core Sets for individuals with SUD • Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NQF #0004)
HIP will improve the continuum of care among individuals engaged in SUD treatment	Track and compare SUD treatment engagement following discharge from SUD treatment facilities and hospitals	Quality measures from the Medicaid Adult and Children's Core Sets for individuals with SUD • SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge (NQF #1664)

Hypothesis	Methodology	Data Source
		• SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge (NQF #1664) measures • Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence (NQF #2605) • Timely Transmission of Transition Record (NQF #0648) • Transition Record with Specified Elements Received by Discharged Patients (NQF #0647)
HIP will reduce SUD readmission rates to the same level of care or higher	Track and compare rates of SUD treatment readmission	Claims Data • Number and percentage of members with SUD diagnosis codes • Number and percentage of members with SUD treatment codes Quality measures from the Medicaid Adult and Children's Core Sets for individuals with SUD • Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NQF #0004).
HIP will reduce emergency department utilization due to drug overdose	Track and compare rates of emergency department utilization due to drug overdose	Claims Data • Number and percentage of members with ER visits and admissions with drug overdose codes
HIP will reduce the rate of preventable hospitalization among members with SUD	Track and compare rates of preventable hospitalization among HIP members with SUD	Claims Data • Number and percentage of members with SUD and ambulatory case sensitive conditions who are hospitalized
3. Chronic Disease Management		
HIP's chronic disease management incentive structure will promote active engagement in MCE chronic disease management	Track and compare rates of chronic disease management program participation	MCE Data • Number and percentage of members engaged in chronic disease management programs Member Survey Data

Hypothesis	Methodology	Data Source
programs and activities		• Member knowledge and perceptions of chronic disease management program incentives
HIP's chronic disease management incentive structure will reduce the rate of preventable hospitalization among members enrolled in chronic disease management programs	Track and compare rates of preventable hospitalization among members enrolled in chronic disease management programs	MCE Data • Number and percentage of members engaged in chronic disease management programs Claims Data • Number and percentage of members engaged in chronic disease management with ambulatory case sensitive conditions who are hospitalized
4. Employment Related Incentives		
HIP's employment related incentive structure for MCEs will promote active member engagement the Gateway to Work Program	Track and compare rates of participation in the Gateway to Work Program	Administrative Data • Number and percentage of members enrolled in the Gateway to Work Program MCE Data • Number and percentage of members who earn incentives for engagement in the Gateway to Work program
HIP's employment related incentive structure for MCEs will promote employment among HIP members	Track and compare rates of employment among HIP members	Eligibility and Enrollment Data • Number and percentage of members who earn employment • Number and percentage of members who are disenrolled from HIP due to increased earnings from employment MCE Data • Number and percentage of members who earn incentives for obtaining employment

WAIVER & EXPENDITURE AUTHORITIES

The State is requesting an extension of all currently approved waivers and only requests revisions necessary to implement the proposed program enhancements. A complete list of the existing and proposed HIP waiver and expenditure authorities are as follows:

1. Premiums Section 1902(a)(14) and Section 1916 of the Social Security Act
To enable the State to charge premiums in HIP Plus at levels not more than two percent of household income and not more than three percent of household income for tobacco-users after their first year of HIP enrollment. Total cost-sharing for a household is subject to a quarterly aggregate cap of five percent of household income, except that all HIP Plus households will be required to contribute, at a minimum,

monthly one dollar ($1.00) POWER account contributions. Individuals at or below 100 percent of poverty will not have premiums as a condition of eligibility.

2. Freedom of Choice Section 1902(a)(23)(A) of the Social Security Act
To the extent necessary to enable Indiana to restrict the freedom of choice of providers for HIP Employer Link enrollees to a choice of providers participating in the network of the HIP Employer Link plan. No waiver of freedom of choice is authorized for family planning providers.

3. Amount, Duration, Scope, and Comparability Section 1902(a)(10)(B) of the Social Security Act
To the extent necessary to enable Indiana to permit Medicaid eligible individuals to choose to participate in an employer-sponsored health insurance plan through a HIP Employer Link participating family member, with wrap-around to their existing Medicaid benefits.

4. Reasonable Promptness Section 1902(a)(8) of the Social Security Act
To the extent necessary to enable Indiana to start enrollment in HIP Plus on the first day of the month in which an individual makes their initial contribution to the POWER account, or, for members under 100 percent FPL who fail to make an initial POWER account payment within 60 days following the date of invoice, the first day of the month in which the 60 day payment period expires, except for individuals who apply through presumptive eligibility.

To the extent necessary to enable Indiana to prohibit reenrollment for 6 months for individuals with income over 100 percent of the FPL who are disenrolled for failure to make POWER Account premium contributions, subject to the exceptions and qualifying events described in the terms and conditions.

To the extent necessary to enable Indiana to establish an open enrollment period for HIP, such that members who are disenrolled for failure to comply with the redetermination process will be required to wait until their next open enrollment period to re-enroll (up to six months).

5. Methods of Administration Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53
To the extent necessary to relieve Indiana of the requirement to assure transportation to and from medical providers for HIP 2.0 demonstration populations. No waiver of methods of administration is authorized for pregnant women, individuals determined to be medically frail, and Section 1931 parents and caretaker relatives. This waiver authority will expire January 31, 2016 unless explicitly renewed under the conditions described in the terms and conditions.

6. Comparability Section 1902(a)(17) of the Social Security Act
To the extent necessary to enable the state to vary cost sharing requirements for individuals from cost sharing to which they otherwise would be subject under the state plan such that beneficiaries who are in HIP Plus will be charged only one co-payment (for non-emergency use of the emergency department) and individuals who are in HIP Basic will be subject to copayments at Medicaid permissible levels except for non-emergency use of the emergency department, as described in the terms and conditions.

7. Retroactivity Section 1902(a)(34) of the Social Security Act
To the extent necessary to enable Indiana not to provide medical coverage to HIP members in the HIP Plus plan for any time prior to the first day of the month in which an individual pays the first contribution to the POWER account or fast track prepayment.

To allow Indiana not to provide medical coverage to HIP members under 100 percent FPL who failed to make an initial POWER account payment or fast track payment, as applicable, within 60 days following

the date of invoice, for any time prior to the first day of the month in which the 60 day payment period expired.

8. Cost sharing for Emergency Department Section 1916(f) of the Social Security Act
To the extent necessary to enable Indiana to require a graduated co-payment up to $25 for all HIP 2.0 demonstration populations, for non-emergency use of the emergency department as described in 42 CFR 447.54. This waiver authority will end two years from the effective date of the demonstration.

9. Payment to Providers Section 1902(a)(13) and Section 1902(a)(30) of the Social Security Act
To the extent necessary to permit Indiana to provide for payment to providers that is not more than the rates paid by an employer sponsored insurance (ESI) plan providing primary coverage for services to the HIP Link population, such that payment by the ESI Plan (plus any payment from the individual's POWER account and remaining cost sharing due from the individual under the ESI plan from the beneficiary) serves as payment in full and the state has no further payment obligation to the provider.

10. Cost Not Otherwise Matchable
The State requests that expenditures related to providing services in an IMD be regarded as expenditures under the State's Medicaid Title XIX State Plan.

REVIEW OF DOCUMENTS AND SUBMISSION OF COMMENTS

The proposed HIP 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 Waiver will be accepted through 5:00 p.m. on January 20, 2017 and may be sent to the FSSA via mail at 402 West Washington Street, Room W374, Indianapolis, Indiana 46204, Attention: Natalie Angel or via electronic mail at HIP2.0@fssa.in.gov.

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

HEALTHCARE AND HUMAN SERVICES POLICY, RESEARCH, AND CONSULTING—WITH REAL-WORLD PERSPECTIVE.

Indiana Healthy Indiana Plan 2.0: Interim Evaluation Report

Prepared for: **Indiana Family and Social Services Administration (FSSA)**

Submitted by: **The Lewin Group, Inc.**

July 6, 2016

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Executive Summary

The purpose of this report is to evaluate the progress of the Healthy Indiana Plan (HIP) 2.0 made in the first year of a three-year demonstration period that runs February 1, 2015 through January 31, 2018, as required by the Centers for Medicare & Medicaid Services (CMS).[1] HIP 2.0 affords health insurance coverage to most non-disabled Indiana adults ages 19 to 64 whose family income is at or below 138 percent of the federal poverty level (FPL) and who are not eligible for other Medicaid programs or Medicare. HIP 2.0 has several cost-sharing features more characteristic of commercial plans than of traditional Medicaid products, the goals of which are to incentivize members to seek preventive care and to be cost-conscious and health-conscious when seeking all types of healthcare.

The program provides coverage through a high-deductible health plan, administered by a Managed Care Entity (MCE), paired with a Personal Wellness and Responsibility (POWER) Account valued at $2,500, which operates similarly to an HSA. Under HIP 2.0, members who consistently make required contributions to their POWER Account, called POWER Account Contributions (PACs), are enrolled in HIP Plus – a plan that includes enhanced benefits such as dental and vision coverage.[2] Members with income below percent the (Federal Poverty Level) FPL who do not make PACs are placed in the HIP Basic plan, a more limited benefit plan that does not include coverage for dental services, vision services, bariatric surgery or temporomandibular joint (TMJ) treatment, and that requires co-payments for most services.

HIP 2.0 also introduced HIP Link and Gateway to Work (GTW). HIP Link provides enrolled individuals with a defined contribution to help pay for the costs of employer sponsored insurance (ESI). Under HIP Link, each member receives a POWER Account valued at $4,000, which they can use to pay for ESI premiums, deductibles, co-payments and co-insurance. GTW is a free and voluntary program for eligible HIP members, which connects members with job training and job search resources.

This interim evaluation report is based on data available as of June 2016. This includes utilization and enrollment data for the first 12 months of the program, during which 64 percent enrolled of members were enrolled for 6 months or longer. About one quarter of members enrolled during the first demonstration year were enrolled for a full 12 months. Survey respondents had up to 10 months of program experience on which to base their responses. Due to the unavailability or inadequacy of certain data at the time of this report, preliminary findings are available for many but not all of the evaluation questions formulated in the Final Evaluation Plan agreed to by Indiana and CMS. The Final Evaluation Report to be submitted to CMS in 2018 will address a wider range of questions using data from three years of program experience. This report presents preliminary findings based on the data available for the first demonstration year.

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1 HIP 2.0 Special Terms and Conditions, Section XIII. Evaluation, paragraph 9, pg.50. Retrieved April 2, 2016 from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-ca.pdf.

2 Native American and pregnant women are exempt from POWER Account Contributions.

Key Findings

Goal 1: Reduce the Number of Uninsured Low-income Indiana Residents and Increase Access to Healthcare Services

A fundamental objective of HIP 2.0 is to insure low-income adults who are not eligible for other coverage. In the first year, 407,746 Indiana residents were enrolled in HIP 2.0 for at least one month. This is the equivalent of nearly 73 percent of the population of 559,000 Indiana residents who were projected to be eligible for HIP 2.0 at the time of its inception.[3] By the end of the first demonstration year, about 60 percent of HIP 2.0 members were previously uninsured or underinsured, or experienced an income change that made them eligible for HIP 2.0. About 40 percent of HIP 2.0 members were previously insured through Hoosier Healthwise or HIP 1.0.

Approximately 61,500 members (15 percent) disenrolled from HIP Plus or HIP Basic in the first year. A survey of people leaving the program showed the primary reasons for disenrollment were a change in income or having secured insurance from another source.

Over 90 percent of Plus members made their POWER Account Contributions (PACs) and remained in HIP Plus. HIP Plus members with incomes below 100 percent of the FPL are transitioned to HIP Basic when they do not pay the PAC. In the first year, about eight percent of members who had already made at least one PAC payment to be in HIP Plus did not make a subsequent required PAC payment, and thus moved from HIP Plus to HIP Basic. Over 80 percent of HIP Basic members indicated other reasons aside from affordability for not making PACs. When HIP Plus members with incomes above the poverty level do not pay their PAC, they are disenrolled from HIP 2.0 and are not eligible to re-enroll for six months. Six percent of HIP Plus enrollees with incomes above poverty were disenrolled from HIP 2.0 for not making a PAC.

PAC contributions were never or rarely a concern for 52 percent of HIP Plus members , whereas 16 percent *always* worried about being able to afford their PAC payment and another 29 percent worried *usually* or *sometimes*. Nonetheless, a large majority of enrollees reported they would pay more to remain enrolled in HIP 2.0. Almost 90 percent of HIP Basic and about 80 percent of HIP Plus members reported that they would be willing to pay $5 more a month to retain their health insurance. A majority of each would be willing to pay $10 more a month.

To reduce gaps in coverage, individuals have the option to enroll in temporary coverage immediately through presumptive eligibility (PE), and may pay a premium at the time of application to expedite the start of HIP coverage – an option called Fast Track payments. In the first year, 208 PE providers (about 62 percent of potentially qualifying providers) made a PE eligibility determination. Surveyed PE providers found the process either very or somewhat effective at eliminating gaps in healthcare coverage. In total, 111,224 individuals had a PE benefit segment during the first demonstration year, 77 percent of whom completed a full Medicaid application. Of these, 26,606 members were approved for and enrolled in full Medicaid coverage. Nearly 31,000 members made a Fast Track payment to start their coverage faster.

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[3] Milliman. 2014. 1115 Waiver—Healthy Indiana Plan Expansion Proposal.

To assess access to needed care, member survey results and self-reported data on MCEs' network adequacy was reviewed. Current members reported having a greater likelihood of accessing routine care, specialist care and prescription drugs, compared to respondents who were disenrolled or never enrolled. Current HIP 2.0 members reported rates of satisfaction with access comparable to national Medicaid Consumer Assessment of Healthcare Providers and Systems (CAHPS) reports.[4] All three MCEs satisfied the network standards for PMPs, dental and vision services. The MCEs also met the requirements for most specialist types.

A majority of survey respondents (80 percent) were either very satisfied or somewhat satisfied with their experience with HIP 2.0. Plus members were more likely to be very or somewhat satisfied than Basic members (86 percent of Plus members, compared to 71 percent of Basic members).[5] Further, 93 percent of surveyed members reported that they would choose to re-enroll in HIP if they left but then became eligible again.

Goal 2: Promote Value-based Decision Making and Personal Health Responsibility

HIP 2.0 has financial incentives for members to be prudent managers of their POWER Account funds and their health. Participation in HIP Plus is encouraged by the state's additional benefits, and a favorable rollover of the account to subsequent years. Failing to contribute to the POWER Account can result in either movement to Basic with its lower value or disenrollment from HIP 2.0 for those whose income is above the poverty level.

According to a current member survey, 60 percent of respondents reported hearing of the HIP POWER Account. The proportion was higher for members required to make PACs—i.e., Plus members (66 percent). About 72 percent of HIP Plus members and 76 percent of HIP Basic members who reported hearing of the POWER Account also reported having one. Among members who reported having a POWER Account, 40 percent of HIP Plus and 30 percent of HIP Basic members reported checking their POWER Account balance monthly. A previous survey of members in HIP 1.0, which also required PACs, also asked about POWER Account awareness. In that survey, which was conducted after the HIP 1.0 program had been implemented for several years, 77 percent of respondents reported hearing about the POWER Account. At the time of the HIP 2.0 survey, many members had only been in the program for a few months, which may explain some of the difference.

Over 90 percent of members maintained their PAC payments. Also a large majority of Plus members surveyed indicated that they were aware that if they did not make payments they would be disenrolled from HIP or required to make co-payments.

Preventive care is provided at no cost to members; members are not required to make co-payments or use POWER Account funds to pay for services. Members who enroll in HIP Plus

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[4] National CAHPS baselines were generated using the AHRQs online CAHPS database. Retrieved May 16, 2016 from https://www.cahpsdatabase.ahrq.gov/cahpsidb/

[5] Under HIP 1.0, 94.7 percent of members were either very or somewhat satisfied with their overall experience in HIP. Note that the members surveyed under HIP 1.0 likely had more program experience compared to HIP 2.0 members surveyed. Also, to remain enrolled, HIP 1.0 members were required to pay POWER Account contributions. Source: Healthy Indiana Plan Section 1115 Demonstration 2013 Annual Report and Interim Evaluation. Indiana Office of Medicaid Policy and Planning. October 2014.

and have a preventive care visit receive a POWER Account rollover, which reduces the amount of required member contributions during the next benefit period. While many members do get preventive care (see Goal 3), a majority of those surveyed are unaware it is provided at no cost to the member. The lack of awareness of preventive care coverage is not unique to HIP 2.0. Previous surveys, such as the HIP 1.0 member survey as well as the survey of non-group health insurance enrollees, have found similarly large proportions of members with a lack of awareness about rules for coverage regarding preventive services.[6]

Incentives are anticipated to steer sicker patients to HIP Plus where total costs to the patient may be lower compared to costs in HIP Basic. Preliminarily, members appear to follow the more cost-effective path and enroll in Plus, regardless of income. Plus members with incomes below poverty were more likely to have physical and/or behavioral health conditions compared to Plus members above poverty, Basic members, and individuals who moved from Plus to Basic. Utilization was higher for the lower-income Plus members, regardless of whether members had chronic physical or behavioral health conditions. Basic members were generally the lowest utilizers of care, with the exception of emergency services. Basic members show higher rates of Emergency Department (ED) use overall and non-emergency use of the ED, compared to Plus members. In addition, Plus members demonstrated greater medication adherence than Basic members. This may be due to differential prescription drug benefits in Plus compared to Basic (including coverage for longer day supplies and mail order drugs), as well as greater need and use of care by Plus members.

HIP Plus members are paying attention to the cost of care. More than one in four HIP Plus members surveyed (27 percent) reported asking their provider about the cost of care. About one percent of Plus members and two percent of Basic members reported missing appointments due to cost.

Goal 3: Promote Disease Prevention and Health Promotion to Achieve Better Health Outcomes

Goal 3 further examines the use of healthcare services and the potential impact of benefit plan incentives, specifically rollover incentives. Members have until the end of their benefit period (a full 12 months) to obtain preventive care and qualify for rollover incentives. Only 25 percent of members enrolled during the first demonstration year (105,361 members) were enrolled for a full 12 months. Over three-quarters of these members received a qualifying preventive care service according to the available claims data. By completing preventative care, these members would be able to rollover POWER Account funds to reduce required PACs the following year (for members who subsequently enroll in HIP Plus).[7]

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[6] Healthy Indiana Plan Section 1115 Demonstration 2013 Annual Report and Interim Evaluation. Indiana Office of Medicaid Policy and Planning. October 2014. Survey of Non-Group Health Insurance Enrollees, Wave 3, conducted February 9–March 26, 2015; the Kaiser Family Foundation. Retrieved May 19, 2016 from http://kff.org/health-reform/poll-finding/survey-of-non-group-health-insurance-enrollees-wave-3/

[7] Basic members are able to rollover funds to reduce future contributions only if they receive a qualifying preventive service. Plus members are able to rollover their share of leftover funds whether or not they receive qualifying services, and are able to double the amount of the rollover if they receive a qualifying preventive service.

When looking at all members enrolled during the first demonstration year, those that enrolled in HIP Plus were approximately 42 percent more likely to utilize preventive care services than HIP Basic members. The analysis of risk scores also reveals that chronic conditions are more prevalent in HIP Plus than HIP Basic members. Members with chronic conditions in either HIP Plus or HIP Basic were more likely to use preventive and primary care services than were healthier members. Medically frail members (a benefit category related to screening for illness/disability) also exhibited a relatively high likelihood of obtaining preventive care (82 percent) in comparison to the overall HIP 2.0 population.

Goal 4: Promote Private Market Coverage and Family Coverage Options to Reduce Network and Provider Fragmentation within Families

HIP Link is intended to assist HIP-eligible workers to be able to afford employer-sponsored coverage, if it is available to them. In the first year, the state developed supports for employer participation including an approval process for employer participation and employer health plan reviews. The first year has been a pilot test of the process, and enrollment data is not available for evaluation.

Goal 5: Provide HIP Members with Opportunities to Seek Job Training and Stable Employment to Reduce Dependence on Public Assistance

The Gateway to Work program is intended to assist low-income adults to secure new or better employment. Marketing began in May 2015 and a targeted mailing to HIP 2.0 members was sent in January 2016. The Gateway to Work call center has received 3,277 inquiries to date. There have been over 500 individual counselling sessions with job seekers held to date.

Introduction & Background

The purpose of this report – ***Indiana Healthy Indiana Plan 2.0 Interim Evaluation*** – is to evaluate the progress made in the first year of a three-year demonstration period that runs February 1, 2015 through January 31, 2018, as required by the Centers for Medicare & Medicaid Services (CMS).[8]

CMS granted the original HIP 1115 Waiver Demonstration in 2007 with enrollment beginning in 2008. On January 27, 2015, CMS approved a new waiver, "HIP 2.0," which took effect on February 1, 2015. The Special Terms and Conditions (STCs) for Indiana's 1115 Demonstration require that Indiana submit an Interim Evaluation Report by June 30, 2016, and a Final Evaluation Report within 60 days after the expiration of the demonstration. Indiana Family and Social Services Administration (FSSA) hired the Lewin Group as an independent evaluator to conduct the HIP 2.0 evaluation.

Indiana utilized the original 1115 Waiver to expand Medicaid coverage to otherwise ineligible populations, while testing a new program structure. The original expansion initiative, HIP 1.0, offered low-income Indiana residents a High Deductible Health Plan (HDHP) paired with the Personal Wellness and Responsibility (POWER) Account, which operates similarly to a Health Savings Account (HSA). As the nation's first HDHP with HSA model for Medicaid recipients, the aim was to encourage members to be more active purchasers of their healthcare services.

Upon enactment of the Patient Protection and Affordable Care Act (ACA), Indiana opted to renew its 1115 Waiver and create the HIP 2.0 program, aiming to cover all non-disabled adults between the ages of 19 and 64 with income at or below 138 percent of the federal poverty level (FPL). With this change, the state also opened HIP enrollment to Section 1931 parents and caretaker relatives and low-income 19 and 20 year olds who were previously eligible for Hoosier Healthwise (HHW), the state's more traditional Medicaid managed care program covering pregnant women and children. Section 1931 parents and caretaker relatives and low-income 19 and 20 year olds enrolled in HHW as of January 2015 were transitioned into HIP 2.0 when the program began in February 2015.

HIP 2.0 maintains the consumer-driven principles of the original program while expanding its eligibility criteria and building out its structure. Specifically, the waiver goals are:

1. Reduce the number of uninsured low-income Indiana residents and increase access to healthcare services
2. Promote value-based decision-making and personal health responsibility
3. Promote disease prevention and health promotion to achieve better health outcomes
4. Promote private market coverage and family coverage options to reduce network and provider fragmentation within families

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[8] HIP 2.0 Special Terms and Conditions, Section XIII. Evaluation, paragraph 9, pg.50. Retrieved April 2, 2016 from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-ca.pdf.

5. Provide HIP members with opportunities to seek job training and stable employment to reduce dependence on public assistance
6. Assure state fiscal responsibility and efficient management of the program (not included in this report; to be evaluated by the state)

HIP 2.0 is administered by Indiana's Family and Social Services Administration (FSSA). Under CMS' requirements for the HIP 2.0 program, FSSA is required to provide the public an opportunity to comment on the program within six months of the demonstration's implementation.[9] To fulfill this requirement, FSSA held a Medicaid Advisory Committee (MAC) meeting on July 9, 2015. The meeting summarized the innovation driving HIP 2.0, program highlights, rollout events, and goals for the future. Below, we summarize comments made during the meeting, based on meeting notes provided by FSSA.

In attendance was Matt Brooks (Chair of Indiana's Medicaid Advisory Committee), Joe Moser (Director of the Indiana Medicaid Program), as well as representatives from various organizations, including: Indiana Hospital Association, Insurance Interests, Indiana State Department of Health, Indiana Minority Health Coalition, National Alliance on Mental Illness, Indiana University Health, Indiana Rural Health Association, Indiana Primary Health Care Association, Covering Kids and Families, Franciscan Alliance, Open Door Health Policies, Anthem, Managed Health Services (MHS), and MDwise.

The majority of comments were positive. Participants identified the consumer outreach efforts, marketing strategies, commercials, and bulletin systems which provided alerts and information about the program, that contributed to a successful program roll-out. Participants commended the "unique features," including helping members attain and sustain financial sustainability, access case management, enroll through Presumptive Eligibility (PE), and get support from navigators.

In addition, participants noted increased consumer satisfaction, increased access to care, and reduction of gaps in coverage. They recognized an increased level of involvement and engagement among consumers in HIP 2.0, citing the ease with which they are able to make POWER Account contributions, the click-rates of people looking at benefit options online, excitement about vision and dental coverage, and not having to make co-payments.

Criticisms focused on the internal program "complexities," but participants noted that the launch of the program was smooth despite these complexities. Recommendations on areas for future improvement included: (1) case management and consumer management, which are likely to become more complex post-enrollment when individuals need payment and resolution assistance; (2) presumptive eligibility enrollment training; (3) the number of assisters, particularly in-person, which may be increasingly important for future participants; and (4) data availability and analysis necessary to understand shifts and trends.

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[9] Per section III, paragraph 10 of the STCs, "Within six months of the demonstration's implementation, and annually thereafter, the state shall afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. […] The state must also include the summary in its annual report."

Program Overview

HIP 2.0, a three-year demonstration implemented under an 1115(a) waiver, began accepting applications on January 27, 2015 for coverage beginning February 1, 2015. HIP 2.0 offers coverage through two plans with different benefit packages and cost sharing arrangements to encourage members to take an active role in their personal health management.

HIP 2.0 provides coverage through a High Deductible Health Plan (HDHP), administered by a Managed Care Entity (MCE), paired with a Personal Wellness and Responsibility (POWER) Account, which operates similarly to an HSA. Under HIP 2.0, members who consistently make required contributions to their POWER Account, called POWER Account Contributions (PACs), are enrolled in HIP Plus – a plan that includes enhanced benefits such as dental and vision coverage.[10] Members with income under 100 percent of the FPL who do not make PACs are placed in the HIP Basic plan, a more limited benefit plan that does not include coverage for dental services, vision services, bariatric surgery or temporomandibular joint (TMJ) treatment.

HIP Basic, unlike HIP Plus, requires co-payments for most services and is available to individuals with income of less than 100 percent of FPL. If an individual with income above 100 percent of the FPL never makes a PAC, he/she is not enrolled in HIP 2.0. Individuals with income above 100 percent of the FPL who make at least one PAC, but subsequently stop making required PACs are disenrolled and cannot re-enroll for six months.[11]

Both HIP Plus and HIP Basic members use their POWER Accounts to pay for covered services. POWER Accounts are funded up to a ceiling of $2,500. For members who are required to make a PAC, i.e. Plus members, this amount is a combination of member and state contributions. Members contribute two percent of their household income or at least one dollar, while the state contributes the difference.

POWER Accounts are used to pay for the first $2,500 of covered services. Services thereafter are covered by the member's MCE. Members may rollover a portion of unused funds from the account (depending on how much the member contributed to the account) to the next benefit year to reduce future contributions.

HIP 2.0 also maintains a traditional Medicaid benefits package, referred to as the "State plan," for some of HIP's more vulnerable populations, described in the HIP 2.0 Special Populations section below. Members in the State plan are subject to the same cost-sharing incentives as Regular plan members, e.g. POWER Account Contributions are required for Plus members and Basic members pay co-payments for most services.[12] However, all State plan members, regardless of whether they are enrolled in Basic or Plus, are eligible for enhanced coverage, including dental and vision benefits. ***Table 1*** summarizes the eligible populations, benefit packages and cost-sharing requirements for the Regular and State, Plus and Basic plans.

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[10] Native American and pregnant women are exempt from POWER Account contributions.

[11] Certain populations are exempt from disenrollment even if their income is above 100 percent FPL: medically frail and Transitional Medical Assistance (TMA) participants, and individuals experiencing a qualifying event.

[12] Pregnant women and Native Americans are exempt from cost-sharing, as described in ***Table 2*** below.

Table 1: Summary of HIP 2.0 Benefits

Plan	Eligible Population	Description
Regular Plus	Non-disabled adults, aged 19 – 64; income ≤ 138% of the FPL	▪ Benefits: Meets minimum coverage standards and includes vision and dental ▪ Cost-sharing: Must make PAC, no co-payment for services except non-emergency use of the ED
Regular Basic	Non-disabled adults, aged 19 – 64; income ≤ 100% of the FPL	▪ Benefits: Meet minimum coverage standards, no vision or dental coverage ▪ Cost-sharing: No POWER Account contribution required, co-payments for all services (except qualifying preventive, family planning, and emergency services) and prescriptions
State Plus	▪ Medically frail ▪ Transitional Medical Assistance (TMA) participants ▪ Section 1931 low-income parents and caretakers ▪ Low-income 19 – 20 year olds	▪ Benefits: Traditional Medicaid benefits including vision, dental and non-emergency medical transportation (NEMT) ▪ Cost-sharing: Must make PAC, no co-payment for services except non-emergency use of the ED
State Basic	▪ Medically frail ▪ Transitional Medical Assistance (TMA) participants ▪ Section 1931 low-income parents and caretakers ▪ Low-income 19 – 20 year olds	▪ Benefits: Traditional Medicaid benefits. including vision, dental and NEMT ▪ Cost-sharing: No POWER Account contribution required, co-payments for all services (except qualifying preventive, family planning, and emergency services) and prescriptions

Note: Medically frail individuals with income above 100 percent of the FPL who do not make a PAC are enrolled in a special State plan called HIP Plus State plan with co-pays.

HIP 2.0 Special Populations

HIP 2.0 is available to non-disabled Indiana residents, 19 to 64 years old, with income up to 138 percent of the FPL and without other insurance. Within this general population are five special populations eligible for traditional Medicaid benefits. Most of these populations were eligible for Medicaid prior to the expansion of HIP and thus maintain their traditional Medicaid benefits through the State plan, as described above. A breakdown of each of these populations is included in ***Table 2.***

Table 2: HIP 2.0 Special Populations: Description and Benefits

Population	Description	Benefits
Medically Frail	Members with serious physical, mental, and behavioral health conditions	State plan; exempt from disenrollment for failure to pay PAC (members below 100 percent FPL who fail to make a PAC are transitioned to HIP Basic, members above 100 percent FPL who fail to make a PAC are transitioned into a HIP Basic plan with co-pays)
Transitional Medical Assistance (TMA) Participants	Low-income parents/caretaker relatives between 19 to 185 percent of the FPL who would lose Medicaid coverage due to increased earnings, but who, under Transitional Medical Assistance, continue to receive Medicaid services for up to 1 year if they comply with income reporting requirements. Note that during the first 6 months the income cap of 185 percent does not apply.	State plan; exempt from disenrollment for failure to pay PAC (members who fail to make a PAC are transitioned to HIP Basic)
Section 1931 Low-income Parents and Caretaker Relatives	Members with income below 19 percent of the FPL who assume primary responsibility for a dependent child	State plan
Low-income 19- 20- Year-Olds	Members with income below 19 percent of the FPL who live in the home of a parent or caretaker relative	State plan
Native Americans	American Indian/Alaska Natives (AI/AN)	▪ Can opt-out of HIP 2.0 into traditional Indiana Medicaid fee-for-service (FFS) ▪ Those who opt-in are exempt from all cost-sharing and enrolled in HIP Plus automatically (without making PAC)
Pregnant Women	Pregnant women during their pregnancy and up to 60 days post-partum	▪ Exempt from all cost-sharing and eligible for additional benefits, including vision, dental, NEMT, and chiropractic services ▪ Can opt to move to HIP's maternity plan

Note: Section 1931 Low-income Parents and Caretaker Relatives and Low-income 19 and 20- Year-Olds are by definition exempt from disenrollment for failure to pay PAC because their incomes must be below 19 percent FPL, i.e. below 100 percent FPL. Native Americans and Pregnant Women are also exempt from disenrollment for failure to pay PAC by default because they are exempt from cost sharing. Native Americans and pregnant women may also be eligible for the State plan if they also fall into one of the State plan eligibility categories.

Comparison of Plus and Basic Policies

Several key distinctions between policies in HIP Plus and HIP Basic are shown in ***Table 3***. These policies could affect members' behavior and, therefore, inform questions throughout this evaluation.

Table 3: Comparison of HIP Plus and HIP Basic Policies

Policy	HIP Basic	HIP Plus
Benefits		
Medical benefits	Does not include coverage for vision services, dental services, bariatric surgery and temporomandibular joint (TMJ) treatment; allows for 60 treatments for physical, speech, occupational, respiratory, or cardiac therapy	Includes coverage for vision services, dental services, bariatric surgery and temporomandibular joint (TMJ) treatment; allows for 75 treatments for physical, speech, occupational, respiratory, or cardiac therapy
Pharmacy benefits	Cannot receive medications by mail order; all drugs have 30 day supply limit	Can receive medications by mail order; maintenance drugs have a 90 day supply limit; non-maintenance drugs have a 30 day supply limit
POWER Accounts		
POWER Accounts	Members use POWER Account to pay for the first $2,500 incurred in claims; receive monthly statements detailing account activity	Members use POWER Account to pay for the first $2,500 incurred in claims; receive monthly statements detailing account activity
POWER Account Contributions	Members do not make contributions	Members make a monthly/annual contribution based on their income (not to exceed two percent of the member's gross annual household income)
POWER Account Rollover (i.e. reduction to future contributions)	Only eligible to rollover leftover funds to reduce future contributions if member received a qualifying preventive service[13]	Member's share of leftover funds is automatically rolled over as a credit to reduce future contributions; rollover amount is doubled if the member received a qualifying preventive service
Preventive Services		
Rewards for receiving qualifying preventive services	Rolled over funds can be used to reduce future contributions by up to 50% *if receiving at least 1 qualifying service*	Can double rollover amount to reduce future contributions *if receiving at least 1 qualifying service*
Preventive service utilization (for qualifying services)[14]	Exempt from PAC funds and member co-payments	Exempt from PAC funds and member co-payments
Co-payments		
Co-pays (excluding non-emergency ED co-pays)	$4 (Outpatient services, preferred drugs) $8 (Non-preferred drugs) $75 (Inpatient services)	None
Co-pays for non-emergency ED use	$8 first visit; $25 for all subsequent visits (within 12 month benefit period)	$8 first visit; $25 for all subsequent visits (within 12 month benefit period)

Note: Members across all three programs may receive additional incentives from their MCE for receiving preventive services. The State and Regular plans have different benefit packages for Plus and Basic members; see ***Table 1***.

[13] Because rollover translates to a reduction to future contributions, only Basic members who move to Plus can benefit from rollover because if they remain in Basic, they will not have any contributions in Year 2.

[14] See Goal 3 for a definition of 'qualifying' preventive services.

As explained in ***Table 3***, there are a number of policies that may incentivize HIP Plus members to make varying decisions about their use of services and the management of their POWER Account. HIP Plus members contribute to their POWER Accounts and use their contributions (as well as state contributions) to pay for services. The contribution is an attempt to establish more active management and awareness by members of the resources available for their healthcare.

Plus members are also automatically eligible to rollover their share of unused funds to reduce future contributions. For example, if $1,000 is leftover, the required contribution would be reduced in the future by the member's share of the $1,000.[15] Moreover, if members receive preventive services recommended by their health plan, then the reduction to required future contributions is doubled. This provides an explicit incentive to use preventive care, and an implicit incentive to spend POWER Account funds efficiently.

Depending on the balance in the account, the rollover amount can significantly reduce or even eliminate required contributions in future plan years. For example, if a member has $1,400 leftover in her POWER Account from Year 1, and contributed 4.8 percent of the POWER Account (i.e. her PAC was $10 a month or $120 annually, so 120 ÷ 2,500 = .048) her rollover amount would be equal to $67.20 (.048 x 1,400 = 67.2). If this member received preventive services, the rollover amount would be equal to $134.40 (67.2 x 2= 134.4). If the member's required annual contribution for the new plan year continues to be $10 a month, or $120 annually, the member would not need to make a required contribution in Year 2 because her rollover amount ($134.40) from Year 1 would exceed the amount of his annual contribution in Year 2 ($120).

HIP Basic members do not contribute to their POWER Accounts, so they may have fewer incentives than HIP Plus members to be cost-conscious with POWER Account funds. Instead, they have co-pays for each service received, including doctor visits and prescription drugs.[16] Hence, they face a cost at the point of care, as opposed to Plus members. Although they do not contribute to the POWER Account, Basic members also pay for services using their POWER Accounts. Their use of the POWER Account funds to pay for services, plus the co-pays they pay, could encourage some cost-consciousness.

In addition, if Basic members have funds left over in their POWER Account and have received recommended preventive services they can reduce their future contributions if they enroll in HIP Plus in the next year. The reduction can be up to half of their required contribution amount. For example, if three quarters of a member's POWER Account is leftover after 12 months and the member received recommended preventive services, then the member can get up to a 50 percent reduction in the cost of enrolling in HIP Plus. In addition, Basic members do not make co-pays for preventive care and family planning services, which could further incentivize preventive care use for Basic members.

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[15] The member's share of the POWER Account is the percentage of the POWER Account that the member (rather than the state) contributed, plus any balance rolled over from previous terms.

[16] Members cannot use POWER Account funds to pay co-pays.

Data Sources and Analytic Approach

Data Sources

The data sources used for this evaluation include:

Census and Coverage Data

Two nationally-representative, federal surveys were used to provide estimates of the number of people potentially eligible for HIP 2.0 members in Indiana, as well as the number of uninsured. They are: (1) the American Community Survey (ACS),[17] sponsored jointly by the U.S. Census Bureau and the U.S. Department of Commerce.; and (2), the Current Population Survey, Annual Social and Economic Supplement (CPS-ASEC),[18] which is sponsored jointly by the U.S. Census Bureau and the U.S. Bureau of Labor Statistics (BLS). Both surveys collect and produce information on demographic, social, economic, and health insurance coverage characteristics of the U.S. population each year. The ACS provides a more consistent measure of health insurance coverage pre- and post-2013. However, at the time of this evaluation, the CPS-ASEC had more recent data (relative to the ACS) available to estimate Indiana's population; with an estimate as of March 2015. Therefore, CPS-ASEC was used to approximate the potential number of Indiana residents who could have been eligible for HIP 2.0, and ACS was used for data on uninsured populations.

Enrollment and Claims Data from FSSA

HIP 2.0 member enrollment and claims information was obtained from the Enterprise Data Warehouse (EDW), which is maintained by FSSA Division of Healthcare Strategies & Technology. The EDW is an enterprise-wide normalized repository of membership, provider, utilization, and financial data. Member enrollment is initially processed through the Indiana Client Eligibility System (ICES). Data are fed from ICES to the state's Medicaid Management Information System (MMIS) and eventually to the EDW. Except for dental and pharmacy claims, all providers submit claims to the member's selected MCE. Each individual MCE submits claim information to the MMIS, which feeds into the EDW. Additionally, the EDW also collects information associated with dental and pharmacy claims from each MCE and each dental or pharmacy benefit manager when one exists. Estimates using eligibility data and other information from ICES, including data used to estimate the number of disenrolled members, were developed using data from the Social Services Data Warehouse (SSDW).

Enrollment Data

Member enrollment data is used to understand the size and sociodemographic composition of the HIP 2.0 enrollee population. HIP 2.0 fully eligible members were identified based on four recipient aid category codes: RB (regular basic), RP (regular plus), SB (state basic) and SP (state plus). Membership data identifies and measures key enrollment metrics such as monthly and annual counts by a variety of socioeconomic factors such as income, age, gender and the length

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[17] United State Census Bureau. American Community Survey. Retrieved June 1, 2016 from https://www.census.gov/programs-surveys/acs/.

[18] United State Census Bureau. Current Population Survey. Retrieved June 1, 2016 from http://www.census.gov/cps/.

of time individuals are enrolled in the program. Analyses regarding presumptively eligible (PE) and conditionally eligible individuals utilized different data, capturing information only for the specific population cohort. Analyses on the number of members disenrolled for failure to pay PAC utilize data on whether members made a PAC and when members were enrolled (from the EDW), combined with SSDW data identifying members who were closed out of the program. Data used in this report are from an extract as of May 2016.

Claims Data

Claims and encounter records are used to assess healthcare utilization patterns of all HIP 2.0 members. The data file provided by Indiana FSSA included all services incurred during the HIP 2.0 demonstration year 1 (DY1) timeframe (February 2015 through January 2016) and paid through April 2016. Additional data tables were provided that included all the header-level diagnoses and procedures on a claim by diagnosis (or procedure) position for members having utilization, which provided a source for secondary diagnosis and procedure codes. The secondary code data tables were used along with the detailed claims file to identify members having specific conditions of interest for this report.

Managed Care Entity Data

The three managed care entities (MCEs) in HIP – Anthem, Managed Health Service (MHS), and MDwise – also provided a variety of data for use in this evaluation. The data included information on each MCE's provider network (whether the MCE met network accessibility standards), waiver and exemptions for members disenrolled for failure to pay PAC, disease management program participation, and Fast Track payment data.

Current Member, Leaver and Never-Member Survey Data

Current HIP 2.0 members, HIP 2.0 leavers, and never-members were surveyed in December 2015 and January 2016. Surveys were created through an iterative process that included Lewin, FSSA, and CMS. Copies of all of the surveys are included in ***Appendices A-F***. The surveys cover a range of topics that address aspects such as access to care, affordability, and member understanding of the program.

Current Member Survey

A survey was administered to members that were currently enrolled in HIP 2.0 as of winter 2015. As such, survey respondents had up to 10 months of program experience on which to base their responses. Separate member surveys were administered to Plus and Basic members to accommodate differences in benefit designs. The survey design and collection process used a quota-based sample to approximate the universe of HIP 2.0[19] members in the HIP Plus and HIP Basic plans. ***Appendix G*** provides more detail on the sample size determination. Lewin also used a survey weight adjustment technique called raking to adjust the sampling weights by age, gender, and FPL so that responses better reflect the core demographics in the state. Details on the weighting process can be found in ***Appendix H***. ***Table 4*** describes the final distribution of

[19] The sample was selected based on the HIP 2.0 population at a point in time in August 2015. References to universe of HIP 2.0 beneficiaries for any sample projections refer to this point in time population.

survey respondents by plan (HIP Plus vs. HIP Basic) and compares the distribution to the actual number of members in HIP 2.0 (at the time the survey sample was generated).

Table 4: Summary of Current Member Sample Sizes

Surveyed HIP 2.0 Population	Total Number of Members	Number of Completed Responses
All Members	**264,018**	**600**
Plus Members	183,021	420
HIP Basic Members	80,997	180

Note: Data reflects the universe of HIP 2.0 members as of August 2015 when the survey sample was generated.

Leaver Survey

The leaver survey included individuals who were: 1) members with income over 100 percent of the FPL who were disenrolled from the program for non-payment of the POWER Account contribution; or 2) previously enrolled members that left the program for any reason (e.g., moved out of state or received coverage through Medicare). Data from this group was weighted by reason for leaving (disenrolled for failure to pay PAC, or other reasons). ***Table 5*** describes the final distribution of survey respondents by reasons for leaving and compares the distribution to the actual number of members in HIP 2.0. A similar weighting technique was used for the leaver survey as for the current member survey (see ***Appendix H*** for more details).

Table 5: Summary of Leaver Sample Sizes

Surveyed HIP 2.0 Leaver Population	Total Number of Members	Number of Completed Responses
Leavers – Disenrolled for failure to pay PAC	890	75
Leavers - Other	8,569	55

Note: Data reflects the universe of HIP 2.0 leavers as of August 2015, when the survey sample was generated.

Never-Member Survey

Two versions of the never-member survey were distributed. One was distributed among individuals who met the following criteria (as determined by eligibility data):

- not currently enrolled in HIP who applied for HIP coverage but did not make their first POWER Account Contribution (PAC) and
- who have incomes over 100 percent of the FPL.

The other survey was distributed to individuals who began but did not complete the HIP 2.0 presumptive eligibility (PE) process. Never-member survey data was not weighted due to limited demographic information for these individuals.

Table 6 describes the final distribution of never-member survey respondents and compares the distribution to the number of never-members available in our sample. This population was

difficult to contact resulting in a low response rate. Only one response was collected among individuals who did not become HIP members because they did not make their first POWER Account contribution. Fifty responses were collected from individuals who completed the PE process but did not complete a full application.

Table 6: Summary of Never-Member Sample Sizes

Surveyed Never-Member Population	Total Number of Never-members in Sample	Number of Completed Responses
Conditionally approved but did not make POWER Account contribution in first month (income at or above 100% FPL)	121	1
Completed presumptive eligibility (PE) process but did not complete full application	5,190	50

Provider Survey Data

HIP providers were also surveyed on their perceptions of HIP 2.0 including overall impressions of HIP, missed appointments, the presumptive eligibility process, and collection of co-payments. The survey collected responses from 225 providers, including respondents from Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), hospitals, and physician practices in Indiana. Similar to the current member survey, questions were identified through an iterative process that included Lewin, FSSA, and CMS. A copy of the provider survey is available in ***Appendix F*** and detail on the sampling for the provider survey is available in ***Appendix G***.

Analytic Approach

The analysis in this report is based upon the flow model outlined for the evaluation that was approved by CMS in the Final Evaluation Plan.[20] For each goal to be evaluated, there was at least one hypothesis identified related to the impact of the HIP 2.0 program. The flow model details the specific research questions, measures and methods for each of the hypotheses. However, as the availability of data was explored, limitations were found in what analyses could be conducted at this time. Consequently, other approaches were also examined and are noted in the report. In some cases, a more comprehensive analysis has been deferred until the Final Evaluation Report when more data becomes available.

This evaluation is presented in five sections, each corresponding to one of the five goals of the HIP 2.0 program.[21] Each section begins with an overview of each hypothesis included in the specific goal and related research questions from the approved Final Evaluation Plan for that goal. Contextual background is provided to assist in interpreting the results, followed by the results for each research question.

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[20] Healthy Indiana Plan 2.0 Final Evaluation Plan. (2015, December 28). Retrieved June 15, 2016 from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-final-eval-dsgn-122815.pdf

[21] There is a sixth, financial goal, which is outside the scope of this report.

Goal 1: Reduce the Number of Uninsured Low-income Indiana Residents and Increase Access to Healthcare Services

One of the principal objectives of the HIP 2.0 program is to reduce the number of uninsured Indiana residents with income up to 138 percent of the FPL and expand access to healthcare for this group. To evaluate the success of this goal, five separate hypotheses were analyzed:

1. HIP will reduce the number of uninsured Indiana residents with income under 138 percent of the FPL over the course of the demonstration (HIP 2.0 Waiver, Section 5 and STCs, Section XIII, Paragraph 3i).
2. HIP will increase access to healthcare services among the target population (HIP 2.0 Waiver, Section 5 and STCs, Section XIII, Paragraph 3ii).
3. (i) POWER Account contributions for individuals in the HIP Plus plan are affordable and do not create a barrier to healthcare access (STCs, Section XIII, Paragraph 3v).

   (ii) Few individuals will experience a disenrollment period because the policy will deter nonpayment of POWER Account contributions policy for HIP Plus beneficiaries (STCs, Section XIII, Paragraph 3vi).
4. Presumptive eligibility (PE) and Fast Track prepayments will provide the necessary coverage so as not to have gaps in healthcare coverage (STCs, Section XIII, Paragraph 3vii).
5. Waiver of non-emergency transportation to the non-pregnant and non-medically frail population does not pose a barrier to accessing care (STCs, Section XIII, Paragraph 3ix).

As with the other goals, these hypotheses were framed in the STCs and the Final Evaluation Plan that was submitted on December 28, 2015, and subsequently approved by CMS.

Hypothesis 1.1: HIP Will Reduce the Number of Uninsured Indiana Residents with Income Under 138 Percent of the FPL Over the Course of the Demonstration.

One of the principal objectives of the HIP 2.0 program is to decrease the rate of uninsured, low-income individuals in Indiana by providing additional coverage options. Therefore, the first hypothesis associated with Goal 1 is:

- HIP will reduce the number of uninsured Indiana residents with income under 138 percent of the FPL over the course of the demonstration.

There are four research questions associated with this hypothesis:

1. How many Indiana residents with income under 138 percent of the FPL have any insurance relative to the total Indiana resident population and how many have Medicaid/HIP coverage?
2. Are there sociodemographic differences in the health insurance coverage/HIP coverage among Indiana residents with income under 138 percent of the FPL?
3. What proportion of Indiana residents with income under 138 percent of the FPL have had HIP 2.0 coverage at some point over the course of the year?
4. Why do members leave HIP and how are they accessing care after leaving HIP?

The first three questions aim to understand the coverage of HIP 2.0 enrollment during the first year of the demonstration, and how coverage differs by socioeconomic group. The ultimate objective is to examine whether HIP 2.0 has succeeded in lowering the number of uninsured Indiana residents at or below 138 percent of the FPL. The final question under this hypothesis examines the reasons individuals leave the program and how they access healthcare post-HIP.

Research Question 1.1.1: How many Indiana residents with income under 138 percent of the FPL have any insurance relative to the total Indiana resident population and how many have Medicaid/HIP coverage?

Information on insurance coverage rates is released by the Federal government approximately nine months after the end of the calendar year for which it is collected.[22] Hence, insurance coverage data for 2015 will be released in the Fall of 2016, too late to be used in this report. In order to provide context for HIP 2.0 enrollment estimates provided in this report, estimates of the uninsured prior to the implementation of HIP 2.0 were used. According to the most recently available data of the American Community Survey (ACS), approximately 34.6 percent of the Indiana population with incomes up to 138 percent of the FPL did not have any insurance in 2014. ***Exhibit 1.1.1*** shows the trend in uninsurance rates from 2008 through 2014 for the population that would be potentially HIP 2.0 eligible (i.e., those between 19 to 64 years old and with incomes up to 138 percent of the FPL) and for the overall Indiana population.

Prior to 2008, according to Current Population Survey (CPS) estimates,[23] individuals 19 to 64 years old and with incomes up to 138 percent of the FPL had an uninsurance rate around 42.4 percent in 2005, which fell to about 36.5 percent in 2006 before rising again to 41.5 percent in 2007. Using estimates from ACS in ***Exhibit 1.1.1,*** the uninsurance rates from 2008 through 2010 continued to increase, likely due to external factors such as the national economic recession and high unemployment rates. From 2011, the rate of uninsurance began declining.

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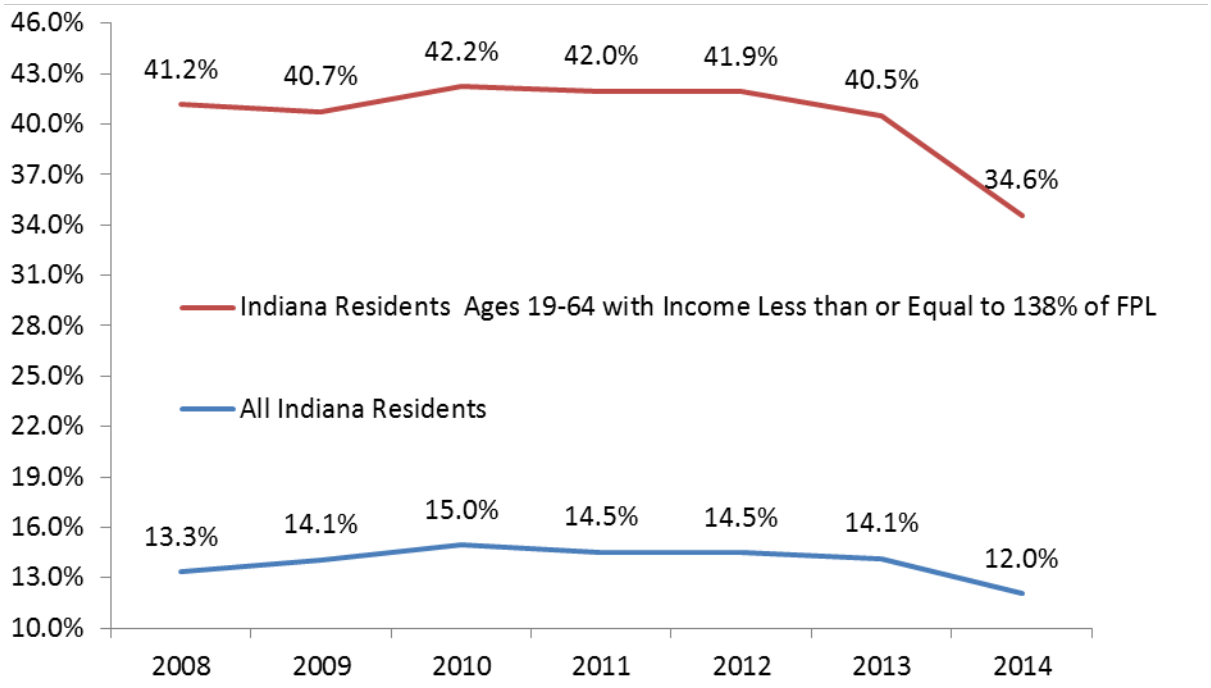
[22] Background on the federal surveys are provided at: http://www.census.gov/programs-surveys/cps.html (United State Census Bureau, Current Population Survey) and http://www.census.gov/hhes/www/hlthins/data/index.html (Annual Social and Economic Supplement to the Current Population Survey). An example of the lag in survey results is presented in: United State Census Bureau, Current Population Survey. (September 16, 2015). "Income, Poverty and Health Insurance Coverage in the United States: 2014." Retrieved June 3, 2016 from http://www.census.gov/newsroom/press-releases/2015/cb15-157.html.

[23] ACS did not provide data on health insurance coverage prior to 2008. The three-year average uninsurance rate from CPS for all Indiana residents during 2005 through 2007 was approximately 12 percent. However, the ACS uninsured rate is a measure of the percentage of people who were uninsured at the time of the interview. The CPS uninsured rate, on the other hand, represents the percentage of people who had no health insurance coverage at any time during the previous calendar year.

Exhibit 1.1.1: Rates of Uninsurance in Indiana



Source: American Community Survey data, 2008 through 2014.

As additional context, the Current Population Survey, Annual Social and Economic Supplement (CPS-ASEC) shows that there were 3,778,814 Indiana residents between the ages of 19 and 64 in 2015. Of these, 791,430 (21 percent) had incomes less than or equal to 138 percent of FPL. The 791,430 includes individuals who are both insured and uninsured. As part of the waiver application (and using older ACS data), Milliman estimated that nearly 559,000 Indiana residents would be eligible for HIP 2.0 (taking into account that certain residents in the eligible age and income categories would already have some form of health insurance coverage).[24]

The total Medicaid enrollment from FSSA Monthly Enrollment Report for January 2016 amounts to 1,343,176. This includes HIP 2.0, Hoosier Care Connect, Hoosier Healthwise, and Traditional Medicaid Fee-For-Service. Thus, roughly 21 percent of all Indiana residents have some form of Medicaid.[25]

HIP 2.0 Enrollment

Enrollment in HIP 2.0 has gradually increased over the first year of the program. Based on enrollment data provided by FSSA, as of January 2016, there were 345,656 HIP 2.0 enrollees. ***Table 1.1.1*** presents a detailed account of HIP 2.0 enrollment by primary plan types (Plus and Basic) and aid categories (State and Regular Basic or Plus), as well as by family income. Nearly 89 percent of HIP 2.0 enrollees in January 2016 had a family income at or below the federal

[24] The Milliman report uses the ACS. Milliman. 2014. *1115 Waiver – Healthy Indiana Plan Expansion Proposal*.
[25] For more detail on the FSSA monthly Medicaid enrollment data, please see ***Appendix J***.

poverty level. About 65 percent of enrollees were in the Plus plan, and among individuals with incomes under the federal poverty level, Plus membership accounted for approximately 62 percent of enrollment. Looking at the entire demonstration year, Plus membership was higher: 69 percent of the 407,746 ever-enrolled individuals were in Plus. Members with incomes under the federal poverty level who do not make contributions to their POWER Account default into the Basic program, which does not require any member contributions to the POWER Account, without any discontinuity in coverage. By making the POWER Account contributions, they remain eligible for Plus and its enhanced benefits.

Table 1.1.1: HIP 2.0 Enrollment as of January 2016

Percent FPL	Basic				Plus				Total HIP Enrollment
	State	Regular	Basic Total	Basic Enrollment as a Percent of Total HIP Enrollment for the Income Cohort	State	Regular	Plus Total	Plus Enrollment as a Percent of Total HIP Enrollment for the Income Cohort	
0%-50%	56,072	35,165	91,237	40.0%	64,150	72,571	136,721	60.0%	**227,958**
51%-100%	4,839	19,968	24,807	30.9%	9,185	46,332	55,517	69.1%	**80,324**
101%-138%	1,424	2,603	4,027	11.9%	4,922	24,829	29,751	88.1%	**33,778**
>138%*	1,264	53	1,317	36.6%	1,926	353	2,279	63.4%	**3,596**
Total*	**63,599**	**57,789**	**121,388**	**35.1%**	**80,183**	**144,085**	**224,268**	**64.9%**	**345,656**

Source: Enrollment data from FSSA. *Individuals over 138 percent of the FPL may continue on the program due to participation in the Transitional Medical Assistance (TMA) program or appeal status.

There may be as many as 30,000 additional members who are conditionally enrolled in any given month. These are members who are eligible for the program but have not started coverage because they are within the 60-day payment period and have not yet made a PAC payment.[26] Based on the enrollment data for the first year of the program, it appears that approximately two-thirds of the conditionally enrolled members eventually fully enroll in HIP by the end of the 60-day payment period.

There are differences between the state-reported number of enrolled individuals below 25 percent of the poverty level and estimates of the total number of Indiana residents under 25 percent of the poverty level using national survey data. According to the state, current *monthly* Modified Adjusted Gross Income (MAGI) is used as the basis for determining income eligibility for potential enrollees. MAGI is based on taxable components of income. In contrast, surveys such as the CPS-ASEC use *annual* estimates of income that can also incorporate non-taxable income sources (e.g., worker's compensation, Veterans' payments, Supplemental Security

[26] Members below 100 percent of the FPL who do not make a PAC are automatically enrolled in Basic following the expiration of the 60-day payment period.

Income, public assistance or welfare payments, and child support).[27] These differences may explain in part why state enrollment figures are higher in the population below 25 percent of the FPL, compared to projections based on national survey data.[28]

Transfer from Existing Medicaid Programs

One goal of HIP 2.0 is to reduce the number of uninsured Indiana residents. This section deconstructs HIP 2.0 enrollment into transfers from existing Medicaid programs versus enrollees who were presumably previously uninsured. A segment of HIP 2.0 members transitioned into HIP 2.0 from previously existing Medicaid programs, including:

1. HIP 1.0 enrollees;
2. Section 1931 low-income parents and caretaker relatives, enrolled in HHW – a program separate from HIP 1.0; and
3. Section 1931 19 and 20 year-olds, also enrolled in HHW.[29]

Table 1.1.2: Transition from Other Medicaid Programs to HIP 2.0

Enrollment Count As Of	Total Enrollment in HIP 2.0	Non-Conversion HIP 2.0 Members	Proportion of HIP 2.0 Members that were Not Converted from other Medicaid Programs	Members Previously Enrolled in HIP 1.0	Proportion of HIP 2.0 Members Previously Enrolled in HIP 1.0	Members Previously Enrolled in HHW	Proportion of HIP 2.0 Members Previously Enrolled in HHW
Feb 2015	143,079	4,676	3.3%	58,295	40.7%	80,108	56.0%
Jul 2015	272,276	133,797	49.1%	58,311	21.4%	80,168	29.4%
Jan 2016	345,656	207,133	59.9%	58,328	16.9%	80,195	23.2%

Source: Enrollment data from FSSA. These counts do not include members previously receiving family planning services.

As can be seen in ***Table 1.1.2***, at the initiation of HIP 2.0 in February 2015, nearly 97 percent of its enrollees were previously insured through HHW or HIP 1.0. By the end of the first demonstration year (January 2016), HIP 2.0 enrollment had grown by over 200,000 members, with about 40 percent of the HIP 2.0 enrollees previously insured through HHW or HIP 1.0.

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[27] CPS ASEC reports data on income by sources; however, the total family income variable that includes non-taxable sources of income is routinely combined with the poverty cutoff variable available in the data to estimate the number of people in different income levels.

[28] Among the available national surveys, the Survey of Income and Program Participation (SIPP) is recommended for use with the Standardized MAGI Conversion Methodology. See "Data Sources for Modified Adjusted Gross Income (MAGI) Conversions"; ASPE Issue Brief, February 2013. Retrieved June 20, 2016 from https://aspe.hhs.gov/basic-report/data-sources-modified-adjusted-gross-income-magi-conversions

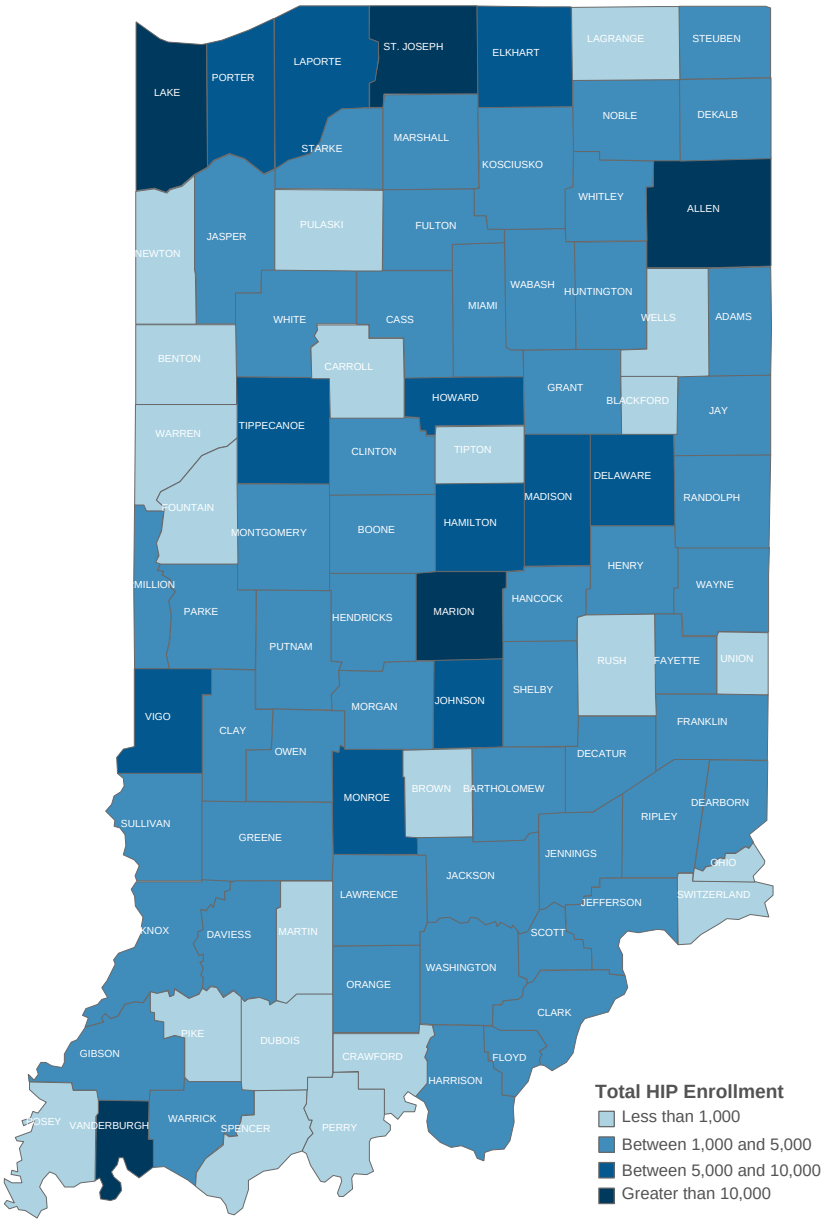
[29] In addition, individuals receiving family planning services were eligible for HIP 2.0.

Thus, HIP 2.0 has attracted Indiana residents with incomes up to 138 percent of the FPL who were not previously enrolled in other Medicaid programs.

HIP 2.0 Enrollment by County

Exhibit 1.1.2 displays a map of Indiana reflecting HIP 2.0 enrollment as of January 2016 for each county in Indiana. County membership ranges from 203 members to 67,371 members. The four counties with the highest enrollment (and overall population) are Marion County (67,371 members), Lake County (32,744), Allen County (19,263), and St. Joseph County (14,355).

Exhibit 1.1.2: HIP 2.0 Enrollment as of January 2016 by County



Source: Enrollment data from FSSA.

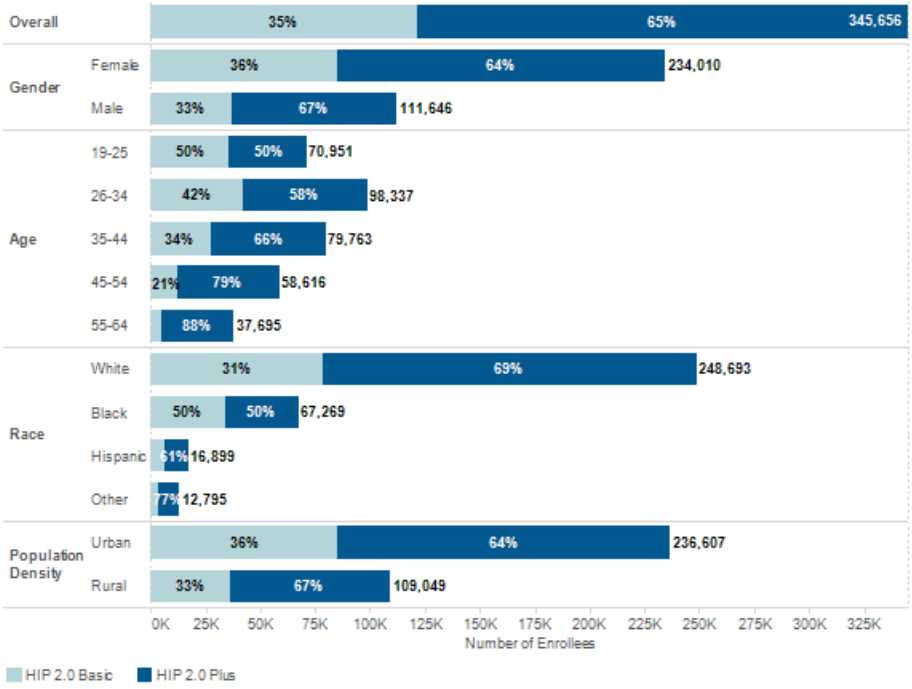
Research Question 1.1.2: Are there socio-demographic differences in the health insurance coverage/HIP coverage among Indiana residents with income under 138 percent of the FPL?

Sociodemographic Differences in HIP 2.0 Enrollment

Though the Final Evaluation Plan called for an analysis of Indiana health insurance status by sociodemographic characteristics, census data that includes the time of HIP 2.0 activity will not be released until Fall 2016. Hence, this research question will be evaluated during the final evaluation cycle.

In this report, HIP 2.0 enrollment as of January 2016 was examined across several sociodemographic characteristics, such as gender, race and ethnicity, age, or population density, to determine if there are any specific cohorts who would select HIP Plus over HIP Basic. As can be seen in ***Exhibit 1.1.3*** below, the overall greater share of HIP 2.0 enrollment in the Plus plan relative to the Basic plan was generally consistent across all demographic groups.[30]

Exhibit 1.1.3: HIP 2.0 Enrollment as of January 2016 by Sociodemographic Groups[31]



Source: Enrollment data from FSSA.

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30 For additional detail on county-level data by race, gender and Aid Category, see: Healthy Indiana Plan Demonstration Project Number: 11-W-00296/5 Annual Report (Reporting Period February 1, 2015-January 31, 2016); State of Indiana; Submitted April 29, 2016. Retrieved May 16, 2016 from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-annl-rpt-feb-jan-2016-04292016.pdf

31 The HIP 2.0 enrollment data shows a small number of HIP enrollment at ages less than 19 and greater than 64. They are not reflected in the enrollment counts by age group, but are included in the counts shown for the other sociodemographic classifications.

Research Question 1.1.3: What proportion of Indiana residents with income under 138 percent of the FPL have had HIP 2.0 coverage at some point over the course of the year?

In the first demonstration year, 407,746 individuals enrolled in HIP 2.0. According to CPS ASEC 2015,[32] there are an estimated 791,430 Indiana residents ages 19 to 64 with family income at or below 138 percent of the FPL. To estimate the population eligible for HIP, those individuals who are eligible for other insurance coverage such as Medicare and other Medicaid programs (aside from HIP 2.0) are set aside for purposes of this evaluation. For the waiver application, Milliman estimated that nearly 559,000 Indiana residents would be eligible for HIP (taking into account that certain residents in the eligible age and income categories would have coverage through other sources).[33] Using Milliman's estimation, roughly 73 percent of the eligible Indiana residents between 19 and 64 years old with family income at or below 138 percent of the FPL may have had HIP 2.0 coverage at some point over the demonstration year.

Research Question 1.1.4: Why do members leave HIP and how are they accessing care after leaving HIP?

As of the end of the first year of the demonstration, there were 61,572 total closures – i.e., members who left the HIP 2.0 program – including individuals who moved to another (non-HIP 2.0) Medicaid category or moved out of the Medicaid program altogether. About 16 percent of these were served in another Medicaid program. The closures amounted to about 15 percent of 407,746 unique ever-enrolled individuals.

FSSA reports **t**he most common reason for closure is that income exceeds program eligibility standards.[34] Other top reasons for closure included failing to comply with redetermination and failing to provide required supporting documentation.

In order to shed light on the reasons individuals leave HIP, results from the *leaver survey* were analyzed. The respondents for this survey included members who left the program for any reason (such as moving out of state), and members who had income over 100 percent of the FPL and left the program for non-payment of their POWER Account contribution. The sample of previous members included 130 individuals. Of these respondents, 14 were previous HIP Basic members, and 116 were previous HIP Plus members (see ***Appendix C*** for more details on the *leaver survey*).

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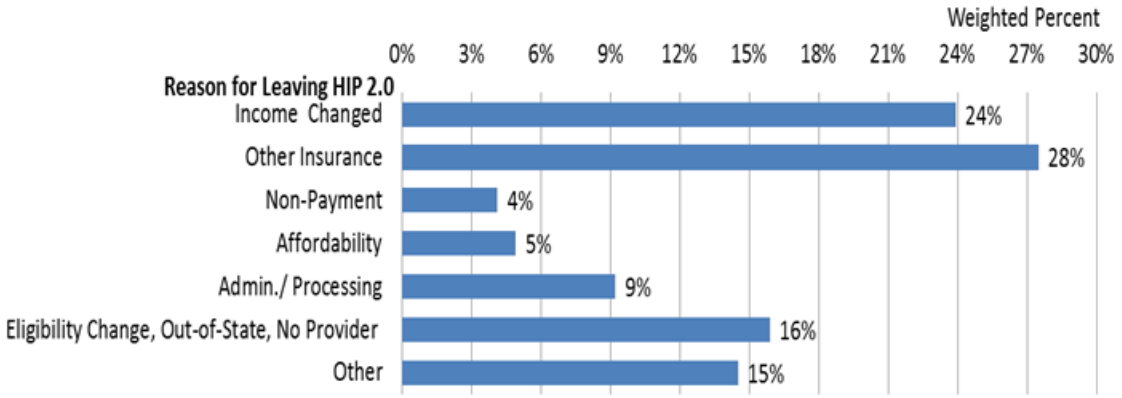
[32] United State Census Bureau. Current Population Survey. Retrieved April 1, 2016 from https://www.census.gov/cps/data/

[33] Note that the Milliman report based their estimates off the ACS. Milliman. 2014. *1115 Waiver – Healthy Indiana Plan Expansion Proposal*.

[34] Healthy Indiana Plan Demonstration Project Number: 11-W-00296/5 Annual Report (Reporting Period February 1, 2015-January 31, 2016); State of Indiana; Submitted April 29, 2016. Retrieved May 16, 2016 from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-annl-rpt-feb-jan-2016-04292016.pdf

Exhibit 1.1.4: Reason for Leaving HIP 2.0
Surveyed Sample of Previous HIP 2.0 Members



Source: Leaver survey. "Other Insurance" includes individuals reporting that they acquired Medicare coverage, insurance from other source, Medicaid, or Veteran's benefits. "Affordability" is indicative of responses that noted lack of money and cannot afford. The category "Other" encapsulates responses for miscellaneous/unrelated, don't know/no reason, not enrolled in HIP, items not covered, incomplete paperwork, and pregnancy.

As depicted in ***Exhibit 1.1.4***, the top two reasons cited for leaving HIP 2.0 were: (1) respondents had insurance through an alternate source (28 percent; n=42) and (2) there was a change in their income levels (24 percent; n=27). A change in income most likely results in the individuals no longer being eligible for HIP 2.0. According to survey respondents, affordability accounted for five percent (n=13) and non-payment another four percent (n=10) of exits. However, the sample size for this survey is small and may not be generalizable to the entire population.

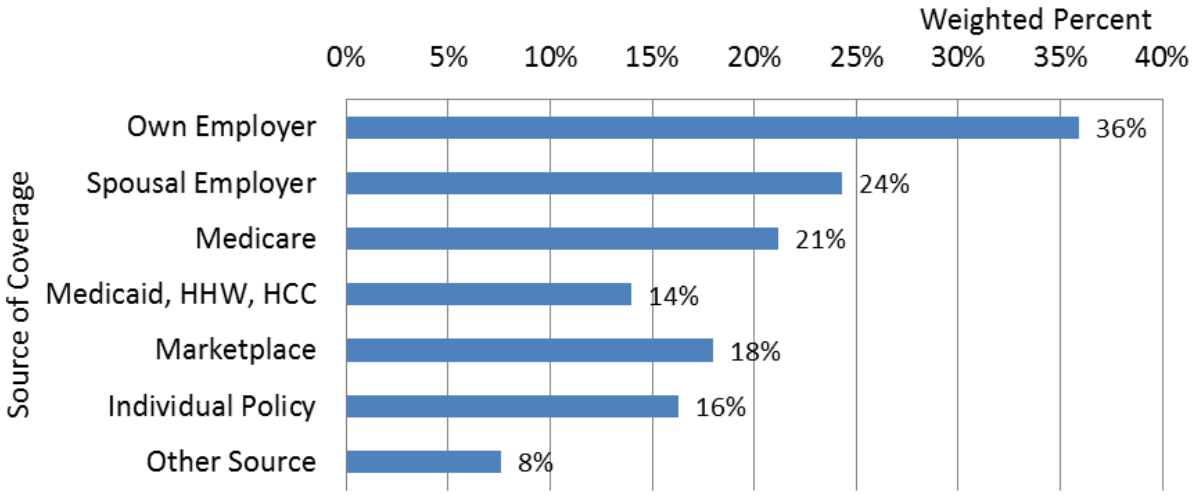
Access to Care after Leaving HIP 2.0

The survey also asked whether respondents had health insurance coverage after they had left the program. Approximately 55 percent of the respondents (n=71) responded that they did.[35]

The members who responded that they had health insurance after leaving HIP 2.0 were additionally asked about the source of their coverage. Respondents were able to report single or multiple sources of coverage. ***Exhibit 1.1.5*** depicts information on the source of coverage for these individuals. Based on survey data, own or spousal employer is a key source of insurance coverage for individuals that left HIP. Former HIP 2.0 members also acquired coverage through other Medicaid programs, Medicare, or the Marketplace (i.e., the health insurance exchange).

[35] Three Plus members responded *Don't Know* to this survey question.

Exhibit 1.1.5: Source of Health Insurance Coverage after Leaving HIP 2.0



Source: Leaver survey.[36] HCC = Hoosier Care Connect. HHW = Hoosier Healthwise.

Hypothesis 1.2: HIP Will Increase Access to Healthcare Services Among the Target Population.

HIP 2.0 retains a number of program elements introduced to the HIP 1.0 program to increase access to healthcare services. For instance, HIP 2.0 maintains the reimbursement rates for providers under HIP 2.0 at the level of Medicare reimbursement rates or 130 percent of Medicaid reimbursement rates where a Medicare rate does not exist. [37,38] HIP 2.0 offers benefits such as maternity coverage without any cost sharing for all pregnant women, as well as dental and vision coverage, bariatric surgery and temporomandibular joint (TMJ) treatment for Regular Plus members, services that were already available to State plan members. Under HIP 2.0, transportation, vision, dental and chiropractic services are also available for pregnant women in the HIP Basic plan.[39]

There are four research questions associated with this hypothesis that are designed to assess the effectiveness of HIP 2.0 in expanding and ensuring access to healthcare services:

1. How do member perceptions of access to healthcare change before and after enrolling in HIP?
2. How does perceived access to care differ between HIP members and individuals who are eligible but have not applied and/or enrolled in HIP?

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[36] There was one *Don't know* response for each of the questions on own employer plan, individual policy, Medicare, and Medicaid. There were two *Don't Know* responses for the question on spousal employer plan.

[37] Exception: Low Income Parent/Caretaker aid category members will be reimbursed based on the Medicaid Fee Schedule.

[38] "IHCP Bulletin: Indiana Health Coverage Programs"; January 27, 2015. Retrieved June 17, 2016 from http://provider.indianamedicaid.com/ihcp/Bulletins/BT201503.pdf

[39] "Healthy Indiana Plan 2.0: Introduction, Plan options, Cost sharing, and Benefits." FSSA.

3. How does access to care differ between HIP 2.0 and HHW members?
4. Are there geographic areas in Indiana where HIP members lack access to primary or specialty care?

Research Question 1.2.1: How do member perceptions of access to healthcare change before and after fully enrolling in HIP?

Research Question 1.2.2: How does perceived access to care differ between HIP members and individuals who are eligible but have not applied and/or enrolled in HIP?

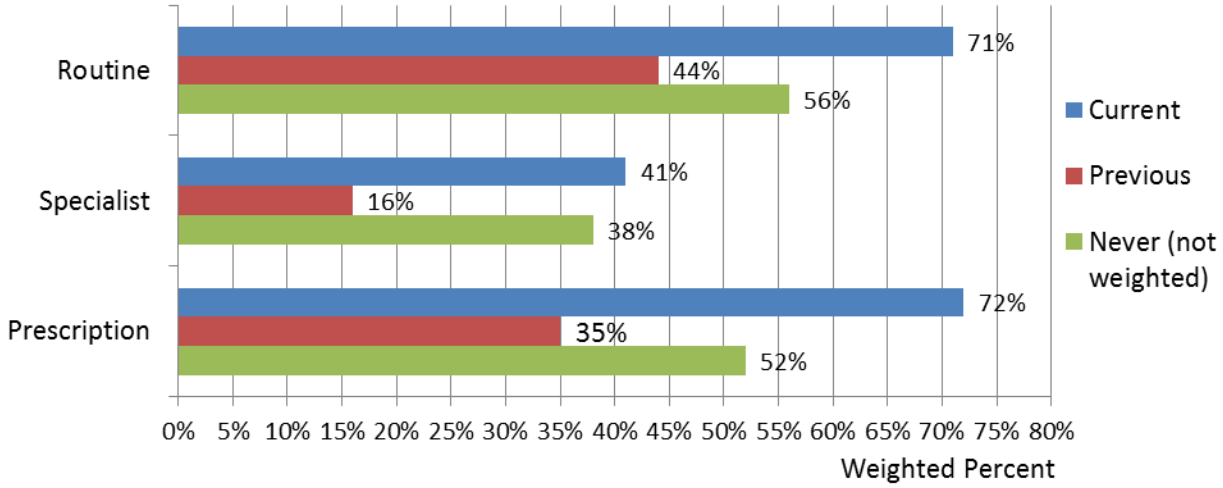
These questions focus on HIP 2.0 members' perception of access to healthcare services. The surveys and evaluation were completed after the start of the program, so it was not possible to survey perception of access prior to members enrolling in the program. Instead, the questions regarding access to care that were asked of the three groups under three distinct surveys, namely, the *current member survey*, the *never-member survey*, and the *leaver survey* were used (Details on the survey design are available in ***Appendix G*** and on the survey questions in ***Appendices A through E***).

Each of these three surveys asked respondents whether, in the past six months, individuals:

1. Made any appointment for a routine check-up at a doctor's office or clinic,
2. Made any appointment to see a specialist, and
3. Acquired any prescription refill.

For each of these three questions, a follow-up question was asked to learn whether necessary services could be accessed as soon as needed during the previous six months. The responses to the first three questions across the three different surveys are depicted in ***Exhibit 1.2.1***.

Exhibit 1.2.1: Proportion of Survey Respondents who Utilized Routine Care, Specialty Care and Prescription Drugs in the Past 6 Months

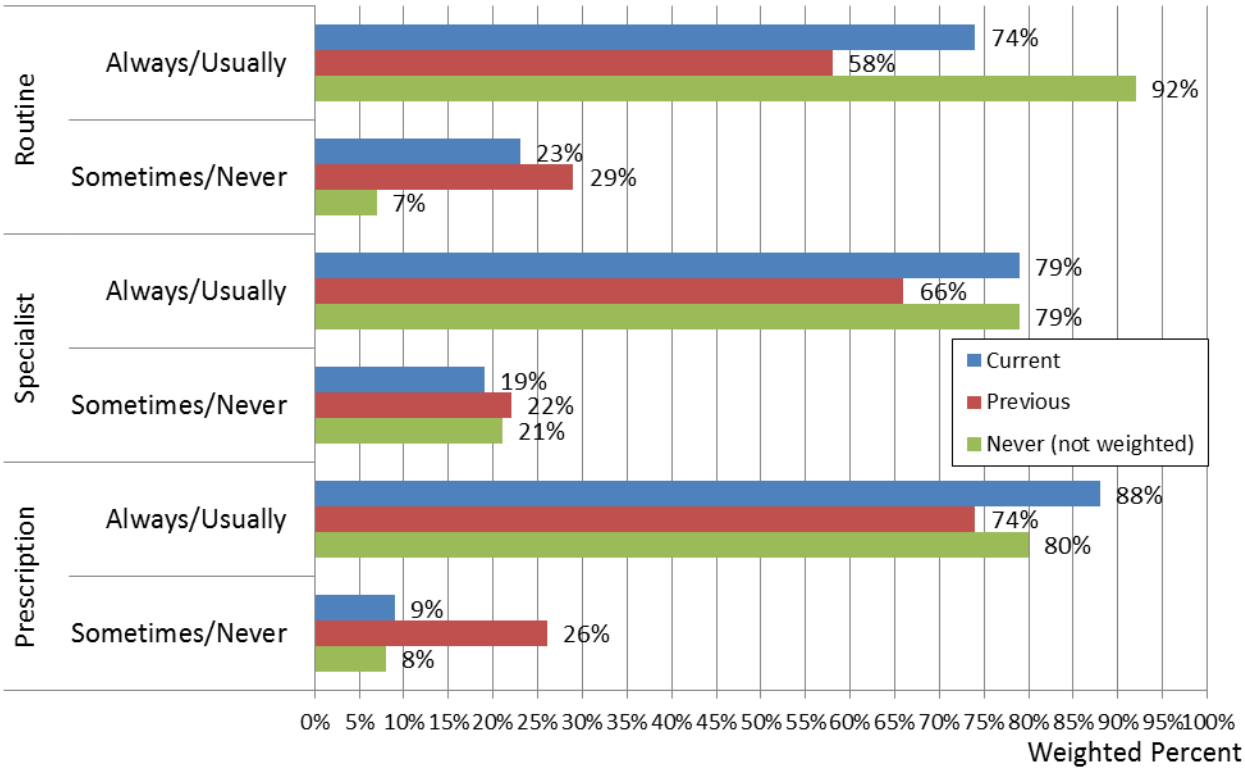


Source: Current member, leaver and never-member survey. Percentages are based on weighted responses, except for never-members.

Current members were more likely than leavers to access healthcare services (for all three domains of care) in the six months prior to being surveyed. Never-members were more likely to use care than leavers across all three domains (routine care, specialist care and prescription drugs).

The responses to the three follow-up questions on access are depicted in ***Exhibit 1.2.2***. A majority of respondents in every surveyed population revealed that they always could access the necessary care as soon as needed; though the percentages are substantially higher for current members, as well as for never-members, than for leavers. Never-members report accessing routine and specialist care as soon as needed with higher likelihood than current members.

Exhibit 1.2.2: Proportion of Survey Respondents who Access Care as Soon as Needed



Source: Current member, leaver and never-member survey. Percentages are based on weighted responses, except for never-members.

According to the national Consumer Assessment of Healthcare Providers and Systems (CAHPS) Database, in 2015, 79 percent of respondents (33,106 responses out of 41,941 total responses) to the Adult Medicaid CAHPS survey[40] said they always or usually acquired routine

[40] The sample consists of data from thirty-six states, including directly from sixteen state Medicaid agencies. There were 61,369 total respondents to the adult Medicaid survey in 2015. Responses to the CAHPS Health Plan database are voluntarily submitted by health plans or state Medicaid agencies; the only requirement is that submitters comply with standard data submission specifications developed by the Agency for Healthcare Research and Quality (AHRQ) for the CAHPS database.

appointments at a doctor's office or clinic as soon as needed and 80 percent (19,430 responses out of 24,527 total responses) said they always or usually acquired appointments with specialists as soon as needed.[41] These national baselines are very close to the 74 percent of current HIP 2.0 members who indicated they always or usually could access routine care as soon as needed and the 79 percent of current members who said they always or usually could access specialists as soon as needed.

Self-Reported Satisfaction with HIP 2.0

The survey of current HIP members included questions about satisfaction with HIP. Overall, 58 percent of members reported that they were very satisfied with HIP, while an additional 22 percent said they were somewhat satisfied (***Table 1.2.1***). Plus members were more likely to be very or somewhat satisfied with their experience with HIP than Basic members (86 percent of Plus members, compared to 71 percent of Basic members). Furthermore, 93 percent of surveyed members reported that they would choose to re-enroll in HIP if they left but then became eligible again. Under HIP 1.0, 94.7 percent of members were either very or somewhat satisfied with their overall experience in HIP. In addition, approximately 98 percent of the surveyed HIP 1.0 members noted that they would choose to re-enroll if they left HIP 1.0. Note that the members surveyed under HIP 1.0 likely had more program experience compared to HIP 2.0 members surveyed because the HIP 1.0 member survey was administered in 2013, five years into the HIP 1.0 demonstration, whereas the HIP 2.0 member survey was administered about 10 months into the first HIP 2.0 demonstration year. Also, to remain enrolled, HIP 1.0 members were required to pay POWER Account contributions.[42]

Table 1.2.1: Satisfaction with HIP 2.0

Level of Satisfaction	Overall		HIP Plus		HIP Basic	
	Responses	Weighted %	Responses	Weighted %	Responses	Weighted %
Overall Experience with HIP in Past Six Months						
Very Satisfied	356	58%	286	66%	70	39%
Somewhat Satisfied	131	22%	74	18%	57	32%
Neither	30	6%	16	4%	14	9%
Somewhat Dissatisfied	40	7%	25	6%	15	8%
Very Dissatisfied	22	4%	9	2%	13	8%
Don't Know	21	3%	10	3%	11	4%
Would Try to Re-Enroll in HIP if Left HIP but Became Eligible Again						
Yes	566	93%	399	95%	167	91%
No	14	3%	9	3%	5	4%
Don't Know	20	4%	12	3%	8	5%

Source: Current member survey.

[41] National CAHPS baselines were generated using the AHRQs online CAHPS database. Retrieved May 16, 2016 from https://www.cahpsdatabase.ahrq.gov/cahpsidb/

[42] Healthy Indiana Plan Section 1115 Demonstration 2013 Annual Report and Interim Evaluation. Indiana Office of Medicaid Policy and Planning. October 2014.

Research Question 1.2.3: How does access to care differ between HIP 2.0 and HHW members?

HIP 2.0 policies have been designed to promote increased access to healthcare services for all beneficiaries. To identify the program's success in this goal, the differences in access to care between HIP 2.0 and Hoosier Healthwise (HHW) members were examined. Specifically, the number of primary medical providers, as well as the number of providers accepting new members, available to HIP 2.0 members and HHW members was compared.

Primary Medical Providers

The number of primary medical providers (PMPs) in HIP 2.0 and HHW are presented in ***Table 1.2.2***. The state enrolls Medicaid providers through the Indiana Health Coverage Program (IHCP) and the MCEs contract with these enrolled providers for the HIP program and HHW. There are three MCEs – Anthem, MDwise, and Managed Health Services (MHS). All three MCEs participate in HIP and HHW. Providers may contract with one, two or all three MCEs for both HIP and HHW. Two of the MCEs require providers to enroll in both HIP and HHW; hence, it is unclear why there are so many more providers in HIP. This could be an error in data provided for this evaluation. There are more providers in HIP 2.0 and a higher provider-to-member ratio largely due to lower enrollment in HIP 2.0 compared to HHW.

Table 1.2.2: Primary Medical Providers (PMPs) in HIP 2.0 and Hoosier Healthwise (HHW) (As of December 1, 2015)

Provider Description	HIP	HHW
Primary Medical Providers	6,945	5,013
Primary Medical Providers who are Accepting New Patients	6,411	4,180
Number of Enrollees	336,124[43]	599,366[44]
Primary Medical Providers per 1000 Enrollee	20.7	8.4

Source: FSSA: "Healthy Indiana Plan: Provider Payment Report, December 29, 2015."

Additional access measures will be gathered from member responses to the CAHPS surveys conducted annually by the MCEs. The data from these surveys are expected to be made available in August 2016. CAHPS data will be used in the final evaluation of HIP 2.0.

Research Question 1.2.4: Are there geographic areas in Indiana where HIP members lack access to primary or specialty care?

Exhibit 1.2.3 describes the HIP 2.0 goals in regards to provider network adequacy. All three MCEs are required to maintain adequate provider networks for all services, including dental, vision, and pharmacy.

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[43] HIP 2.0 enrollment as of December 2015. Source: Enrollment data from FSSA.

[44] HHW enrollment as of December 2015. Source: FSSA Medicaid Monthly Enrollment Report. Retrieved April 15, 2016 from http://in.gov/fssa/ompp/4881.htm

Exhibit 1.2.3: 2015 Healthy Indiana Plan Network Adequacy Initiatives

Objective	Methodology	Goal
1. **Primary and Specialty Care** HIP members shall have access to primary care within a maximum of 30 miles of the member's residence and at least two providers of each specialty type within 60 miles of member's residence.	The MCE must ensure that each member has an ongoing source of primary care appropriate to the member's needs.	90% of all HIP members shall have access to primary care within a minimum of 30 miles of member's residence and at least two providers of each specialty type within 60 miles of member's residence.
2. **Dental and Vision** HIP members shall have access to dental and vision care within a maximum of 60 miles of the member's residence.	The MCE must ensure that each member has an ongoing source of dental and vision care appropriate to the member's needs.	90% of all HIP members shall have access to dental and vision care within a minimum of 60 miles of member's residence.

Source: FSSA: "Indiana Medicaid Managed Care Quality Strategy Plan 2015."

As part of assessing the adequacy of provider network access for HIP 2.0, metrics describing HIP 2.0 members' proximity to providers as specified in the goals above (***Exhibit 1.2.3***) were examined using data furnished by the MCEs.

Primary Medical Providers (PMPs)

All HIP 2.0 members are required to select a PMP. Those who do not select a PMP are auto-assigned to a provider. All three MCEs are required to evaluate whether their network meets the standard of access for PMPs on a quarterly basis using GeoAccess. Requirements for access specifically identify that there is a PMP within 30 miles of all members' homes. During demonstration year one, all three MCEs met the standards for PMPs, and nearly all their enrollees were reported to have a PMP within 30 miles of their residence.

Specialty Care Providers

Network adequacy goals for HIP 2.0 stipulate that members should have access to two specialists of each specialty type within 60 miles of their homes. Anthem, MDwise and MHS appear to meet accessibility standards for most categories of specialists.

Anthem reported network adequacy data for 30 specialist types in its most recently available quarterly report.[45] ***Table 1.2.3*** depicts for Anthem's specialist network: the number of providers in each specialty, average distance of the two nearest providers from member residences for each type of specialty, and an indicator to display whether or not the network standard for the specialist type is satisfied. As can be seen in the table below, Anthem met the standard for all specialties reported. However, for a number of specialist categories, Anthem provides access measures in its quarterly network accessibility report in terms of one specialist provider within

[45] Source: QR-HIP NA4 - Network GeoAccess Assessment: Managed Care Accessibility Analysis - Healthy Indiana Plan (HIP), Indiana. April 17, 2015.

90 miles of member's residence instead of the requirement of two specialists within 60 miles (these specialties are denoted with an asterisk in ***Table 1.2.3***).[46]

Table 1.2.3: Anthem Specialist Network for HIP 2.0 Members

Specialty Types	Number of Providers	Average Distance to the Two Nearest Providers	Meet Criteria of having 90% of Members with Access to Two Providers within 60 Miles
Anesthesiology	966	5.8	✓
Cardiovascular Disease	605	4.5	✓
Dermatology	89	10.3	✓*
Endocrinology	107	10.4	✓
Gastroenterology	262	8.3	✓
General Surgery	575	5.2	✓
Hematology	134	8.5	✓
Infectious Disease	106	11.9	✓*
Nephrology	200	7.3	✓
Neurological Surgery	92	13.2	✓*
Neurology	252	7.3	✓
Obstetrics and Gynecology	631	4.7	✓
Occupational Therapist	175	9.4	✓
Oncology	242	6.4	✓
Ophthalmology	313	7.2	✓
Optometrist	386	5.0	✓
Orthopedic Surgery	490	5.4	✓
Otolaryngology	273	6.1	✓
Pain Medicine	93	9.0	✓*
Pathology	267	8.2	✓*
Physical Therapist	576	6.4	✓
Psychiatry	357	4.8	✓
Pulmonary Disease	250	7.4	✓
Radiation Oncology	137	6.6	✓*
Radiology, Vascular, and Interventional	972	4.7	✓
Rheumatology	77	11.0	✓*
Speech Pathology	76	19.2	✓
Surgery – Oral and Maxillofacial	81	-	✓**
Thoracic Surgery	108	9.5	✓*
Urology	225	6.0	✓

Source: MCE data. *Reported for one provider within 90 miles. ** Reported for one provider within 60 miles.

MHS reported data for 26 specialist types in its most recent quarterly report on network adequacy,[47] which are presented in ***Table 1.2.4*** below. The table shows the number of providers

[46] There was an error in Anthem's report for the specialty "Surgery - Oral & Maxillofacial." In email correspondence shared by the state, Anthem indicated that they meet the standard of *one* provider within 60 miles of a member's residence for this specialty and provided updated estimates.

[47] Source: MHS-NA4 HIP Specialist 2016-01-29.

in each specialty, average distance of the nearest provider from member residences for each type of specialty,[48] and an indicator to display whether or not the network standard for the specialist type is satisfied. MHS failed to meet the network standard requirements in three of its 26 reported specialist categories, namely Hematology, Pain Medicine, and Pathology. There are 59 counties where fewer than 90 percent of members have access to two Hematologists, 47 of which are designated as Medically Underserved Areas (MUA) by the Health Resources and Services Administration (HRSA).[49] Forty-five counties do not have an adequate number of Pain Medicine Specialists, 35 of those are entirely or partially MUAs. Twenty-three counties do not meet the standard for Pathologists; 20 of those are fully or partially MUAs.

Table 1.2.4: MHS Specialist Network for HIP 2.0 Members

Specialty Types	Number of Providers	Average Distance to the Nearest Provider	Meet Criteria of having 90% of Members with Access to Two Providers within 60 Miles
Anesthesiology	460	9.0	✓
Cardiology	803	7.0	✓
Cardiothoracic Surgeons	49	15.7	✓
Dermatology	73	19.3	✓
Endocrinology	102	12.1	✓
Gastroenterology	263	10.8	✓
General Surgery	490	6.2	✓
Hematology	10	38.2	×
Infectious Disease Specialists	98	15.2	✓
Medical Oncology	245	10.6	✓
Nephrology	175	11.8	✓
Neurological Surgery	63	17.8	✓
Neurology	233	9.3	✓
Obstetrics and Gynecology	633	6.3	✓
Occupational Therapist	107	12.9	✓
Ophthalmology	140	12.7	✓
Orthopedic Surgery	405	6.5	✓
Otolaryngology	194	9.9	✓
Pain Medicine	13	32.0	×
Pathology	126	20.0	×
Physical Therapists	314	8.7	✓
Pulmonary Disease	241	10.2	✓
Radiology	126	12.9	✓
Rheumatology	62	14.3	✓

[48] Note that Anthem reported the average distance of the *two* nearest providers for each specialty type.

[49] Health Resources and Services Administration (HRSA) Data Warehouse MUA Find. Retrieved May 23, 2016 from: http://datawarehouse.hrsa.gov/tools/analyzers/muafind.aspx

Specialty Types	Number of Providers	Average Distance to the Nearest Provider	Meet Criteria of having 90% of Members with Access to Two Providers within 60 Miles
Speech Therapists	54	19.7	✓
Urology	227	10.1	✓

Source: MCE data.

MDwise provided data for provider NPIs along with their specialty type and each provider's zip code within their specialist network.[50] ***Table 1.2.5*** depicts the number of providers in each specialty, average distance of the nearest provider from member residences for each type of specialty,[51] and an indicator to display whether or not the network standard for the specialist type is satisfied. As shown in the table, MDwise meets the network adequacy standard for all the specialist types made available except for Proctology. Thirty-one counties do not meet the standard for Proctologists; 26 of those are fully or partially MUAs.

Table 1.2.5: MDwise Specialist Network for HIP 2.0 Members

Specialty Types	Number of Providers	Average Distance to the Nearest Provider	Meet Criteria of having 90% of Members with Access to Two Providers within 60 Miles
Allergist	83	6.4	✓
Anesthesiology	1044	4.3	✓
Cardiology	674	3.5	✓
Cardiovascular Surgery	179	7.4	✓
Dermatology	104	8.1	✓
Gastroenterology	316	5.8	✓
General Surgery	573	3.9	✓
Nephrology	230	5.4	✓
Neurological Surgery	119	11.4	✓
Neurology	318	5.2	✓
Obstetrics/ Gynecology	807	3.2	✓
Oncology	396	4.8	✓
Ophthalmology	307	5.4	✓
Orthopedic Surgery	614	3.7	✓
Otology, Laryngology, Rhinology	222	4.7	✓
Pathology	300	8.8	✓
Physical Medicine and Rehabilitation	144	6.1	✓
Plastic Surgery	57	12.9	✓

[50] For MDwise, we calculate the distances and percentage estimate for their specialist network, whereas for Anthem and MHS, we present the distance and percentage estimates as reported in their GeoAccess reports for their respective specialist network. Our distance calculations are 'as the crow flies' and use the 'spherical law of cosines' formula, which gives results for all distances with precision down to a few meters or +/-0.002 miles (see http://www.movable-type.co.uk/scripts/latlong.html).

[51] Note that Anthem reported the average distance of the *two* nearest providers for each specialty type.

Specialty Types	Number of Providers	Average Distance to the Nearest Provider	Meet Criteria of having 90% of Members with Access to Two Providers within 60 Miles
Proctology	17	22.3	×
Psychiatry	121	10.8	✓
Pulmonary Disease	277	5.5	✓
Radiology	964	4.5	✓
Thoracic Surgery	101	10.2	✓
Urology	214	5.1	✓

Source: Lewin analysis of MCE data.

Anthem and MDwise both reported that they do not use their commercial networks if there is a shortfall of providers in HIP. However, contractually, the MCEs are required to arrange for medically necessary services for each member and may do so by arranging out of network care or arranging for transport to an in-network provider.

Vision and Dental Services Providers

Tables 1.2.6 shows that all three MCEs satisfy the network access requirement of at least 90 percent of members having access to at least one vision and at least one dental provider within 60 miles of their homes.

Table 1.2.6: Dental and Vision Networks for Providers for HIP 2.0 Members[52]

Dental/Vision	Number of Providers	Average Distance to the Nearest Provider	Meet Criteria of 90% of Members Having Access to One Provider within 60 Miles
Anthem			
Dental Services Providers*	1,650	5.3	✓
Vision Services Provider	1458	4.5	✓
MDwise			
General Dentists	851	2.8	✓
Specialists	161	7.3	✓
Oral Surgeons	81	9.0	✓
Vision Services Provider	603	3.4	✓
MHS			
Dental Services Providers	731	3.2	✓
Vision Services Provider	419	4.0	✓

Source: MCE data. *For Anthem, dental providers include General Dentistry, Pediatric Dentistry, and Oral Surgery.

[52] For Anthem's vision and dental services as well as MDwise's dental services, we present the distance and percentage estimates from MCE provided reports for their respective network. For MDwise's vision services network and MHS's vision and dental services networks, we present Lewin's calculations based on data provided by MDwise and MHS. Our distance calculations are 'as the crow flies' and use the 'spherical law of cosines' formula, which gives results for all distances with precision down to a few meters or +/-0.002 miles (see http://www.movable-type.co.uk/scripts/latlong.html).

The MCEs routinely review network gaps and develop provider recruitment plans to identify providers that can fill these needs and outreach to them. These can be new providers or current non-participating providers. The plans also work closely with hospitals to identify new service lines they may offer to include in existing contracts. Through medical and case management, the MCEs assist providers and members in seeking and approving referrals for services in which access gaps exist. Indeed, as mentioned previously, the survey findings suggest that a majority of respondents could access necessary care as soon as needed. Thus, overall, it appears that HIP members are accessing needed care within the available provider network.

Hypothesis 1.3:

1. **POWER Account Contributions for Individuals in the HIP Plus Plan are Affordable and do not Create a Barrier to Healthcare Access.**
2. **Few Individuals will Experience a Six-Month Disenrollment Period because the Policy will Deter Non-payment of POWER Account Contributions for HIP Plus Beneficiaries.**

POWER Accounts, designed after health savings accounts, play a key role in the HIP 2.0 program, and are intended to pay for the first $2,500 of covered services. The objective of this hypothesis is to assess whether POWER Account contributions are affordable and whether HIP 2.0 policies encourage beneficiaries to maintain required contributions.

There are eight research questions associated with this hypothesis:

1. How many members will be impacted by employers and not-for-profit organizations paying all or part of their POWER Account contributions?
2. How do HIP 2.0 enrollees perceive the affordability of the PAC and non-payment penalties?
3. Was the six-month disenrollment period a deterrent for individuals over 100% FPL to miss a PAC?
4. How many individuals were never fully enrolled in HIP due to non-payment of the PAC?
5. How many individuals lost HIP Plus coverage due to non-payment of the PAC?
6. How many individuals requested a waiver from the six-month disenrollment period?
7. How are individuals accessing healthcare if they are disenrolled due to non-payment of the PAC?
8. Do POWER Account contributions present a barrier to initial enrollment in the HIP program?

Designed to incentivize and empower individuals to manage their healthcare expenses, POWER Accounts cover the first $2,500 of covered services for HIP Plus members. Members are required to make a monthly or annual contribution towards their POWER Account to maintain Plus coverage, indexed to two percent of their household income with a minimum of a one dollar contribution and capped at $100/month. Individuals with income more than the federal poverty level are not eligible for HIP Basic; if an individual with income above 100 percent of

the FPL never makes a PAC, he/she is never enrolled in HIP 2.0. Individuals with income above 100 percent of FPL who make at least one PAC but subsequently stop making PAC are disenrolled from HIP 2.0 for six months. Individuals with income below 100 percent of the FPL are transferred from HIP Plus to HIP Basic rather than being disenrolled from the program if PACs are not made.

In HIP 1.0, there was a similar policy in place that disenrolled individuals for 12 months if they did not make a PAC, however the original policy did not distinguish between individuals' with incomes over or under 100 percent of the FPL. HIP 2.0 decreased the exclusion period for individuals with incomes over 100 percent of the FPL from 12 months under HIP 1.0 to six months and replaced the disenrollment of members below poverty with the policy to shift them into a program with less co-payments and benefits.[53] Individuals who submit a new application during their HIP disenrollment period will have their eligibility considered for other Medicaid categories but will not be eligible for HIP. Disenrollment periods do not apply to individuals who are medically frail or receiving TMA, or to individuals who apply for a waiver from the six-month disenrollment period due to a qualifying event (e.g., obtaining and subsequently losing private insurance coverage; experiencing a loss of income after disqualification due to increased income; taking up residence in another state and returning later; being a victim of domestic violence; or residing in a county subject to a disaster declaration made in accordance with IC 10-14-3-12 at the time of member termination for non-payment or at any time in the 60 calendar days prior to the date of member termination for non-payment).[54]

As of January 2016, there were 224,268 HIP Plus members among a total of 345,656 HIP 2.0 enrollees. Even though individuals with family income under 100 percent of the FPL automatically qualify for HIP Basic, roughly 86 percent of HIP Plus members had income less than 100 percent of the FPL. During year one of HIP 2.0, a large majority of HIP enrollees maintained their Plus membership from their initial month of enrollment until the end of the demonstration year; hence, maintaining their PAC payments during this time.

Exhibit 1.3.1 displays the percentage of HIP Plus members with incomes by FPL based on January 2016 enrollment data. As displayed in the figure, more than half of HIP Plus membership was comprised of members with income less than 23 percent of the FPL, while about 14 percent of the HIP Plus members had an income above 100 percent of the FPL.

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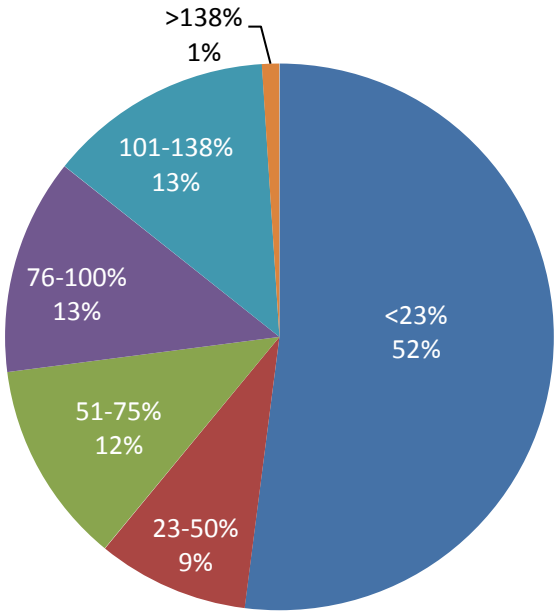
[53] "Healthy Indiana Plan POWER Account Contributions and Copayments Infrastructure Operational Protocol". (February 26, 2015). Retrieved April 18, 2016 from: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-Pwr-acct-co-pay-prtcl-02262015.pdf

[54] Medically frail individuals above 100 percent of the FPL who fail to make a PAC are transferred to the Basic plan with co-pays. TMA participants who fail to make a PAC are transitioned to the Basic plan.

Exhibit 1.3.1: Plus Plan Membership as of January 2016 by Federal Poverty Level



Source: Enrollment data from FSSA. Note: Individuals with income above 138 percent of the FPL are not eligible for the program, with the exception of Transitional Medical Assistance participants or members with appeal status.

The next few sections address perceptions of POWER Accounts and their affordability along with their impact on Plus plan enrollment.

Research Question 1.3.1: How many members will be impacted by employers and not-for-profit organizations paying all or part of their POWER Account contributions?

Power Account Contributions from Third Parties

HIP 2.0 enrollees can have all or a portion of their required POWER Account Contribution (PAC) paid by employers or not-for-profit organizations. ***Tables 1.3.1*** and ***1.3.2*** present information from FSSA,[55] on the number of POWER Accounts with contributions from employers and non-for-profit organizations, respectively, and the amount of contributions.

[55] Healthy Indiana Plan Demonstration Project Number: 11-W-00296/5 Annual Report (Reporting Period February 1, 2015-January 31, 2016); State of Indiana; Submitted April 29, 2016. Retrieved May 16, 2016 from: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-annl-rpt-feb-jan-2016-04292016.pdf

Table 1.3.1: Employer Power Account Contributions (February 1, 2015 – January 31, 2016)

	YTD Total
Number of Employers Participating	124
Number of Members on Whose Behalf an Employer Makes a Contribution	131
Total Amount of Employer Contributions	$5,563.69
Average Amount of Employer Contributions	$42.47

Source: FSSA: HIP 2.0 Annual Report.[56]

As of the end of the first year of the program, 124 employers contributed on behalf of 131 HIP 2.0 members.

Table 1.3.2: Non-Profit Organization Contributions (February 1, 2015 – January 31, 2016)

	YTD Total
Number of Non-Profit Organizations Participating	75
Number of Members on Whose Behalf a Non-Profit Makes a Contribution	1244
Total Amount of Non-Profit Contributions	$17,482.29
Average Amount of Non-Profit Contributions	$14.05

Source: FSSA: HIP 2.0 Annual Report.[57]

As of the end of the first demonstration year, 75 non-profit organizations contributed on behalf of 1,244 members. Altogether, less than one percent of the HIP 2.0 population required to contribute is relying on a non-profit organization or employer for assistance with their PAC.

While the MCEs are tracking POWER Account contributions made by employers and non-profit organizations on behalf of HIP 2.0 enrollees, the HIP 2.0 surveys shed additional light on the question of third party contributions to POWER Accounts.

For instance, Plus members who responded that they made a monthly or annual PAC to remain in HIP were further asked whether they received any help with the cost of monthly or annual HIP payment from someone else such as a family member, friend, employer, healthcare provider or charity. Approximately 70 percent of all respondents indicated they made PAC on

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[56] Healthy Indiana Plan Demonstration Project Number: 11-W-00296/5 Annual Report (Reporting Period February 1, 2015-January 31, 2016); State of Indiana; Submitted April 29, 2016. Retrieved May 16, 2016 from: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-annl-rpt-feb-jan-2016-04292016.pdf

[57] Ibid.

their own, while about 30 percent of respondents noted that they received help. Almost all of the individuals receiving help had income less than or equal to 100 percent of the FPL.[58]

In a series of follow-up questions, those who reported receiving help paying for their HIP contribution (n=119) were asked about the source(s) of their help. Individuals could indicate more than one source. ***Table 1.3.3*** shows the member responses:

Table 1.3.3: Help with Cost of POWER Account Contribution

Source of Assistance	Weighted Proportion (Number of Members)
Family Member	86% (101)
Friend	25% (31)

Source: Current member survey. Other options for which there were three or fewer responses included a charity or religious organization, a healthcare provider such as a doctor's office or hospital, their employer, and any other source(s).

As can been seen above, of those who noted receiving help with PAC payments, 86 percent received help from a family member, while 25 percent received help from a friend.

Research Question 1.3.2: How do HIP 2.0 enrollees perceive the affordability of the PAC and non-payment penalties?

Based on enrollment data, more than 90 percent of HIP Plus enrollees maintained their PACs through the duration of their enrollment. However, to understand perceptions of affordability, additional data from the *current member survey* was used. HIP Plus members (n=420) were asked to report how frequently they make their POWER Account contributions and the average amount of these contributions. As shown in ***Table 1.3.4,*** 61 percent of Plus members with income up to the federal poverty level reported paying their PAC monthly, whereas 36 percent indicated annually. Approximately 86 percent of members with income over 100 percent of the FPL reported paying their PAC monthly and 11 percent paid annually.

Table 1.3.4: Frequency of Making PAC by Income

	Frequency of Making PAC			
	Monthly	Annually	Not Made a PAC	Don't Know/Refuse
All HIP Plus Members				
Member Response	258	147	5	10
Weighted Proportion	64%	32%	1%	3%
Less than or Equal to 100 Percent of the FPL				
Member Response	199	139	4	9
Weighted Proportion	61%	36%	1%	3%

[58] Fifteen members who responded *No pay* (5), *Don't know* (9) and *Refused* (1) to an earlier survey question on whether they made a monthly/annual payment to be in HIP were skipped from being asked this question. Of the 405 surveyed HIP Plus members who were asked the question, two respondents selected *don't know* for a weighted one percent of responses.

	Frequency of Making PAC			
	Monthly	Annually	Not Made a PAC	Don't Know/Refuse
Greater than 100 Percent of the FPL				
Member Response	59	8	1	1
Weighted Proportion	86%	11%	2%	2%

Source: Current member survey. Percentages may not add to 100 due to rounding.

In a follow-up question, individuals were asked about the amount they pay towards their POWER Accounts each month if they mentioned paying a monthly PAC. Otherwise, they were asked about how much they contributed to their annual PAC for the year. Of the 239 respondents who noted making a monthly PAC the average contribution indicated was $15.89 per month.[59] For the 141 respondents that mentioned making an annual PAC and provided an annual PAC amount, the average self-reported amount was $32.33.[60] For individuals with income less than or equal to 100 percent of the FPL, the average monthly and annual self-reported PACs were roughly $13.17 and $21.78, respectively. The corresponding monthly amount for those with income above 100 percent of the FPL was $28.48.

Table 1.3.5: Average Self-Reported PAC by Income and Frequency of Contribution

Average POWER Account Contribution[61]	
For those Making Monthly Contribution	For those Making Annual Contribution
All HIP Plus Members	
$15.89 (N=239)	$32.33 (N=141)
Less than or Equal to 100 Percent of the FPL	
$13.17 (N=184)	$21.78 (N=134)
Greater than 100 Percent of the FPL	
$28.48 (N=55)	$266.94* (N=7)

Source: Current member survey. *Sample size too small for the reported average to be reliable.

HIP Plus members were asked a series of questions to ascertain whether these monthly and annual PAC payment amounts were affordable and manageable, as well as to gauge their comfort level in paying the PAC. For instance, individuals were asked how often they were concerned about having enough money to pay their PACs during the previous six months.[62]

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[59] There were 19 *don't know* responses. Fifteen members who responded *No pay* (5), *Don't know* (9) and *Refused* (1) to an earlier survey question on whether they made a monthly/annual payment to be in HIP were skipped from being asked this question.

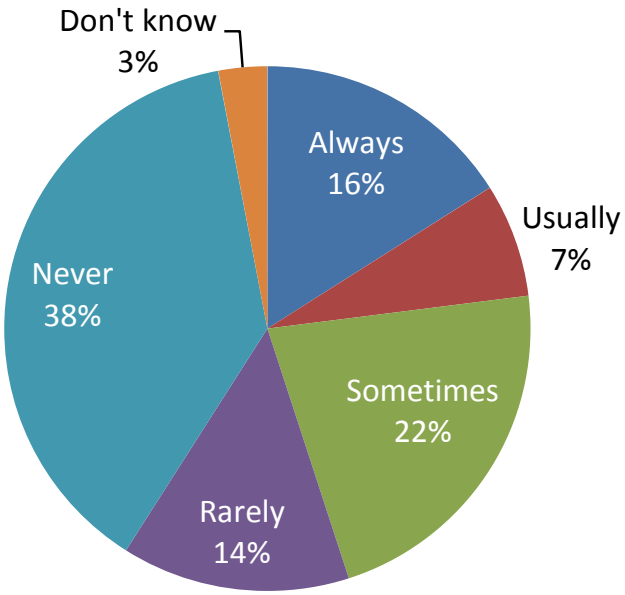
[60] There were six *don't know* responses. Also, the 15 members who responded *No pay* (5), *Don't know* (9) and *Refused* (1) to a previous survey question on whether they made a monthly/annual payment to be in HIP were skipped from being asked this question.

[61] Weighted averages reported.

[62] Fifteen members who responded *No pay* (5), *Don't know* (9) and *Refused* (1) to whether they made a monthly/annual payment to be in HIP were skipped from being asked this question. Also, there were 11 *don't know* responses to this specific question.

Approximately 38 percent (n=165) of HIP Plus members noted that they *never* worried, in contrast to about 16 percent (n=58) of respondents who mentioned they worried *always* (see ***Exhibit 1.3.2***). Worrying *sometimes* was indicated by 22 percent of the weighted responses (n=93). Overall, over half (52 percent) of the members *never* or *rarely* worried about POWER Account contributions.

Exhibit 1.3.2: Worries about Ability to Pay the POWER Account Contribution



Source: Current Plus member survey data. Weighted proportion reported.

As depicted in ***Table 1.3.6***, of those who always or usually worried about PAC, about 50 percent reported that they were very satisfied with their overall experience with HIP 2.0 in the past six months. In contrast, 73 percent of those who rarely or never worried reported to be very satisfied.

Table 1.3.6: Worry about PAC Payment and Overall Satisfaction with HIP

Overall Experience with HIP in Past Six Months	Worry About PAC									
	Always/Usually		Sometimes		Rarely/Never		Don't Know		Total	
	Responses	Weighted %	Responses	Weighted %	Responses	Weighted %	Responses	Weighted %	Responses	Weighted %
Very Satisfied	42	50%	68	68%	161	73%	9	77%	280	67%
Other levels of Satisfaction	36	45%	24	29%	53	24%	2	23%	115	30%
Don't Know	4	5%	1	3%	5	2%	0	--	10	3%
Total	82	22%	93	22%	219	53%	11	3%	405	100%

Source: Current member survey.

Willingness to Pay a (Higher) Monthly Contribution

To further explore members' perception on affordability of PAC, the survey asked HIP Plus and HIP Basic members two additional questions. Basic members were asked if they would be willing to stay enrolled in HIP if they had to contribute $5 and $10 each month. HIP Plus members were asked if they would remain in HIP if they had to pay $5 and $10 *more* each month.

Table 1.3.7: Willingness to Pay More

HIP Plus[63]				HIP Basic[64]			
Yes	Weighted Proportion	No	Weighted Proportion	Yes	Weighted Proportion	No	Weighted Proportion
Continue to Stay Enrolled if Required to Pay $5 More							
326	80%	36	10%	161	87%	12	9%
Continue to Stay Enrolled if Required to Pay $10 More							
222	59%	87	23%	127	79%	20	13%

Source: Current member survey.

As shown in ***Table 1.3.7***, the majority of HIP 2.0 members were willing to pay more each month to remain enrolled in HIP 2.0. Among those who were already making monthly contributions (i.e., HIP Plus members), about 80 percent were willing to pay $5 more each month and 59 percent were willing to pay $10 more each month to remain enrolled in HIP 2.0. Among those members who were not making monthly contributions (i.e., Basic members), 87 percent reported that they would be willing to pay $5 each month for HIP coverage, while 79 percent said they would be willing to pay $10 each month. Thus, Basic members were more likely to be willing to pay the additional amounts than the Plus members (although they currently do not make any PACs). The willingness to pay for individuals at different income levels was also explored and no differences based on income level were seen.

Research Question 1.3.3: Was the disenrollment period a deterrent for individuals over 100% FPL to miss a PAC?

HIP Plus members were asked whether they were aware that if they did not make payments they would either lose some benefits and would have to make co-payments for all services (if below the poverty level) or could be disenrolled from HIP and not allowed to return for six

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63 Among surveyed Plus members, there were 40 *Don't Know* and 3 *Refused* responses to the survey question on $5, for a weighted 10 percent of responses. Fifteen members who responded *No pay* (5), *Don't know* (9) and *Refused* (1) to whether they made a monthly/annual payment to be in HIP were skipped from being asked this question. For the question on $10, there were 57 *Don't Know* and 3 *Refused* responses for a weighted 17 percent of responses. Additionally, the question was not asked to 51 Plus members who either were skipped being asked the $5 question (15), or responded *No* (36) on the $5 question, accounting for 14 percent of weighted responses.

64 Among surveyed Basic members, there were 6 *Don't Know* and 1 *Refused* response to the survey question on $5, for a weighted four percent of responses. For the question on $10, there were 14 *Don't Know* responses for a weighted eight percent of responses. Additionally, the question was not asked to 19 Basic members who responded *No* (12), *Don't Know* (6) or *Refused* (1) on the $5 question, representing a weighted 13 percent of responses.

months (if above the poverty level). Members were asked the question based on the policy applicable for their income level. ***Table 1.3.8*** depicts the survey responses:

Table 1.3.8: HIP 2.0 Member Knowledge of Disenrollment Period

Response	Total	Below 100% FPL		Above 100% FPL	
	Member Responses	Member Responses	Weighted Proportion	Member Responses	Weighted Proportion
Yes, aware	339	275	78%	64	97%
No, not aware	78	73	21%	5	3%
Don't know	3	3	1%	-	-

Source: Current member survey.

Approximately, 78 percent of the surveyed members with income below 100 percent of the FPL and 97 percent of those with income above 100 percent of the FPL noted that they were aware of the policy. Thus, it is quite plausible that this relatively large degree of awareness incentivizes HIP Plus members to pay their PAC consistently.

Research Question 1.3.4: How many individuals were never fully enrolled in HIP due to non-payment of the PAC?

Individuals with income above the federal poverty level who do not pay their first POWER Account contribution within 60 days of receiving a bill from their MCE are never enrolled in HIP 2.0. These individuals are not subject to a six-month disenrollment period because they did not pay their first PAC. At this time, data is not yet available for this group and the question will be addressed in the final evaluation.

Research Question 1.3.5: How many individuals lost HIP Plus coverage due to non-payment of the PAC?

Over the first year of the demonstration, 2,677 individuals were disenrolled from HIP and not allowed to return for six months for failing to make a POWER Account contribution. This represents 5.9 percent of the 45,607 ever-enrolled members with income above the federal poverty level who could be disenrolled for a non-payment of PAC. The 45,607 count excludes anyone who was exempt from disenrollment for failure to pay PAC (e.g., medically frail, TMA, Native American, and pregnant women).

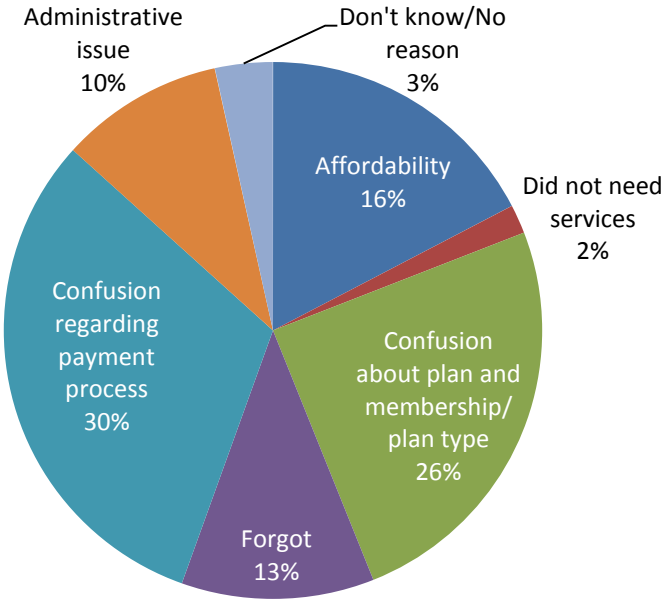
At the same time, there were another 21,445 members who transitioned from HIP Plus to HIP Basic due to non-payment of PAC. This is approximately 8.2 percent of the 262,579 members ever enrolled in Plus with income at or below the federal poverty level, and anyone who was medically frail or TMA with income above the poverty level. TMA participants and medically frail individuals are eligible for the Basic plan even if they have incomes above 100 percent of the FPL. Thus, the denominator count of 262,579 captures anyone who would have been eligible to transition from Plus to Basic had they not made a PAC.[65]

[65] Pregnant or Native American members are not included in the denominator since they could remain in Plus even without making a PAC.

Based on these calculations, it appears that approximately 92 percent of individuals with income below poverty and nearly 94 percent of individuals with income above poverty have maintained their PAC payment during the first year of the program.[66]

To understand why members failed to pay PACs, the *Basic member survey* included a question asking respondents why they never made or stopped making payments. There were 173 HIP Basic members asked the question. As seen in ***Exhibit 1.3.3***, approximately 84 percent cited reasons other than affordability for not making a PAC. For instance, about 30 percent (n=54) of the respondents mentioned that they did not know that a payment was required, or that an *advance* payment was required, and did not know how to pay. Another 26 percent of members (n=43) cited confusion about membership and plan type as a reason for non-payment of PAC. Among these members, a lack of understanding about whether they were HIP Plus or HIP Basic members was among the reasons cited. The remaining 16 percent of respondents (n=30) noted affordability as the reason for non-payment.

Exhibit 1.3.3: Reasons for Non-Payment of PAC



Source: Current member survey. Weighted proportions reported.

Research Question 1.3.6: How many individuals requested a waiver from the six-month disenrollment period?

Most members with income above the federal poverty level who do not make a POWER Account contribution are disenrolled from HIP and are not allowed to return for six months. However, there are certain populations that are exempt from disenrollment regardless of income: 1) medically frail and 2) Transitional Medical Assistance recipients. Individuals may

[66] In the state's Annual Report submitted to CMS, 4,486 members with income above 100 percent of the FPL were reported to be disenrolled from the HIP program for failure to pay PAC. The counts presented in this report differ from the state's estimates due to refinements in the methodology.

apply for a waiver of the six-month disenrollment period if they have experienced a qualifying event. Individuals with a satisfying qualifying event include members who:

- Obtained and subsequently lost private insurance coverage;
- Had a loss of income after disqualification due to increased income;
- Took up residence in another state and later returned;
- Were a victim of domestic violence; or
- Were residing in a county subject to a disaster declaration made in accordance with IC 10-14-3-12 at the time the member was terminated for non-payment or at any time in the sixty (60) calendar days prior to date of member termination for non-payment.

Two of these three groups, the medically frail members and the members experiencing qualifying life events, are re-enrolled in HIP Plus prior to the expiration of the six-month disenrollment period provided their request for a waiver of disenrollment for failure to pay a PAC is granted and they resume making POWER Account contributions. As can be seen in ***Table 1.3.9***, the majority of medically frail members or members experiencing a qualifying life event who applied for a waiver or exemption from disenrollment were granted one.

Table 1.3.9: Number of Disenrollment Waivers and Exemptions February 1, 2015 – January 31, 2016

HIP Members Applied for Waiver/Exemption	Granted Waiver/Exemption	Denied	Pending
176	166	6	4

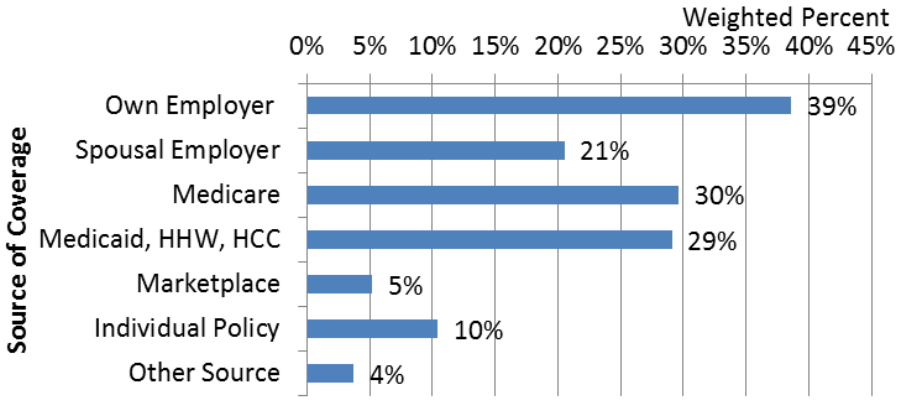
Source: MCE data.

The Transitional Medical Assistance recipients who fail to make a PAC are transferred to HIP Basic.

Research Question 1.3.7: How are individuals accessing healthcare if they are disenrolled due to non-payment of the PAC?

The member sample included 75 former HIP Plus members who were disenrolled from HIP for failure to pay a PAC. Among those, 56 percent of respondents had acquired other coverage. Respondents could indicate more than one source. About 39 percent (n=17) of those that secured coverage after being disenrolled from HIP acquired it through their employers, while about 21 percent (n=8) of these individuals reported obtaining coverage through spousal employment. A notable fraction also reported getting insurance through other Medicaid programs as well as through Medicare (see ***Exhibit 1.3.4***).

Exhibit 1.3.4: Source of Health Insurance Coverage after Disenrollment for Failure to Pay PAC



Source: Leaver survey.[67] HCC = Hoosier Care Connect. HHW = Hoosier Healthwise.

Research Question 1.3.8: Do POWER Account contributions present a barrier to initial enrollment in the HIP program?

As previously discussed, a greater proportion of individuals both above and below the poverty level enroll in HIP Plus than in HIP Basic. Thus, it appears that POWER Account contributions do not constitute a barrier to enrollment in the HIP program.

Hypothesis 1.4: Presumptive Eligibility (PE) and Fast Track Prepayments Will Provide the Necessary Coverage so as Not to have Gaps in Healthcare Coverage.

There are several HIP 2.0 policies that could affect whether HIP members experience gaps in coverage: the waiver of retroactive coverage, presumptive eligibility (PE) and Fast Track payments. Hypothesis Four is focused on examining the effect of these policies on gaps in health coverage.

There are seven research questions associated with this hypothesis:

1. How does the waiver of retroactive coverage impact uncompensated care costs?
2. What is the number of PE applications vs. traditional applications?
3. How many PE members go to HIP Basic vs. HIP Plus?
4. What are provider perceptions of PE effectiveness?
5. What proportion of members elected to make Fast Track prepayments to expedite enrollment in HIP?
6. How does utilization of services differ between those who utilize the Fast Track payment option and those who do not?

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[67] There was one *Don't know* response for each of the questions on own employer plan, spousal employer plan, and individual policy.

7. How many members are taking advantage of other policies that help prevent gaps in coverage, e.g. ex-parte determinations and prepopulated renewal forms?

To respond to the first research question, an analysis of the effect of the retroactive coverage waiver was completed. In the five subsequent research questions, HIP 2.0 policies aimed at *reducing* gaps in coverage are examined: PE in research questions two through four and Fast Track payments in research questions five and six. Each of these policies are described in detail below.

Presumptive Eligibility for HIP

PE allows qualified healthcare providers to screen for eligibility based on gross income and temporarily enroll individuals meeting thresholds in coverage. Individuals determined eligible through PE receive immediate access to healthcare coverage. The coverage lasts up to 60 days during which time individuals are expected to submit a full application. In the past, PE has been limited to select eligibility groups, such as pregnant women and children. The Affordable Care Act (ACA) required that PE be extended to adults, and expanded the role of hospitals in determining eligibility presumptively.

In 2014, Indiana opened enrollment for acute care hospitals interested in becoming 'Qualified Providers' – providers qualified to make PE determinations.[68] Indiana also introduced a new aid category – 'HPE Adult' – that allows hospitals and certain providers to determine *adults* PE for HIP (PE was previously limited to pregnant women, infants, children, low-income parents and caretakers, former foster children, and individuals seeking family planning services). Individuals are only eligible for one PE period in a 12-month span. Individuals who are conditionally approved for HIP (i.e. members who have been determined eligible for HIP but have not made their first PAC) are not eligible for PE.

To assess whether an individual is presumptively eligible, designees from qualified PE entities work with individuals to complete an electronic Hospital Presumptive Eligibility (HPE) application that includes questions about the applicant's identity, family size, and household income. Applicant responses are self-attested and providers are not permitted to ask for supporting documentation to verify the applicants' eligibility.[69] Enrollment is available 24 hours a day, seven days a week and there is a real-time response as to whether the individual is eligible. If determined eligible, HPE coverage begins the day that the provider determined the individual presumptively eligible.

Under HIP 2.0, HPE individuals receive HIP Basic coverage through an MCE. Members can choose an MCE or are automatically assigned to one. The PE Basic plan covers all benefits that

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[68] Enrollment opened for free-standing psychiatric hospitals, federally qualified health centers, rural health centers, community mental health centers, and local county health departments on April 1, 2015. See Presumptive Eligibility Web inter Change Training. (February 2015.) Available from http://provider.indianamedicaid.com/media/136435/presumptive%20eligibility%20web%20interchange%20training.pdf

[69] Hospital Presumptive Eligibility Qualified Provider Manual. (2016, February 1). Retrieved February 22, 2016, from http://provider.indianamedicaid.com/ihcp/manuals/Hospital Presumptive Eligibility Qualified Provider Manual.pdf

the Basic plan covers; like non-PE HIP Basic, it does not cover dental or vision and requires co-pays for most services. HPE members do not have POWER Accounts.

Once an individual is assigned to an MCE, he/she is sent an invoice and is given the opportunity to make a Fast Track payment (described below) that would apply to their full Indiana Health Coverage Programs (IHCP) application. An HPE adult has until the end of the second month after approval for HPE to submit his/her full HIP application. After submitting an application, the individual continues to receive HPE coverage until an eligibility determination is made. If the application is denied, coverage ends the day after the denial is processed. If approved, PE coverage ends when HIP coverage begins, without a gap in coverage. For members who make a PAC, HIP Plus coverage begins the first of the month following the month in which the PAC was made, or the month in which the individual is found eligible, whichever is later. For individuals below 100 percent of the FPL who do not make a PAC, HIP Basic coverage begins the first of the month following the expiration of their payment period. Individuals above 100 percent of the FPL who do not make a PAC do not have continued coverage.

Fast Track Payments

Under HIP 2.0, HIP Plus coverage begins the first day of the month in which an individual makes their POWER Account contribution. If an individual's income is above 100 percent of the FPL and does not make a POWER Account contribution within the 60-day deadline, the individual is not enrolled in coverage.[70] If the individual's income is below 100 percent of the FPL and does not make a PAC, he/she is placed into HIP Basic coverage, effective the first of the month in which the 60-day payment period ends.

For example, assume an individual receives her bill from her MCE on March 15, 2015. If she makes a PAC any day before March 31, 2015, her coverage will be effective March 1, 2015. If she does not make a payment within 60 days of March 15, 2015 (by May 15, 2015), and is under 100 percent of the FPL, her Basic coverage will begin May 1, 2015. If she does not make a payment within 60 days of March 15, 2015 (by May 15, 2015), and is above 100 percent of the FPL, she does not receive coverage.[71]

In April 2015, HIP 2.0 established a way for eligible HIP members to speed up this process – called *Fast Track payments* – which enables members to expedite the start of their coverage. Fast Track allows individuals to make a $10 payment at the time of application, after applying, or while the application is being processed.

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[70] The "60 day clock" starts the day the members receives a bill from his/her MCE. Also, if the individual *previously made* a PAC payment and is above 100 percent of the FPL, and fails to make a PAC, he/she will be disenrolled from HIP for six months. In other words, individuals above 100 percent of the FPL who *make a payment and then stop making payments* are disenrolled, whereas individuals above 100 percent of the FPL who *never make a payment* are not subject to disenrollment because they never effectuate their coverage.

[71] Individuals who do not make their first PAC payment are not subject to the disenrollment period but must reapply to gain coverage.

Individuals can make the optional payment online via credit card during the application process. Individuals who do not apply online (or choose not to make a Fast Track payment when applying), are sent a Fast Track invoice from the MCE they selected.

The $10 payment is applied towards the member's first POWER Account contribution. If the individual is not found eligible for HIP, the state will refund the payment. If a member makes a Fast Track payment and is determined eligible for HIP, his/her HIP Plus coverage begins the first of the month in which he/she made the Fast Track payment. If the member's POWER Account contribution amount is less than $10 per month, the $10 payment is applied to their first coverage month, with the remaining amount applied to future months.

Passive Verification Renewal Process

HIP 2.0 members must have their eligibility reassessed and their coverage renewed on an annual basis. In accordance with the ACA and accompanying federal regulations, Indiana introduced a simpler process for Medicaid renewals that uses electronic data sources for verification rather than relying on the member to provide verification. Under the new procedures, redeterminations for certain eligibility categories (called 'Assistance Groups') are conducted through an automated batch process. The batch process runs during the first week of the month to process the eligibility categories that are due for redetermination in the following month.

The state then determines if the selected members qualify for automated redetermination. To qualify for automated redetermination, enough income and other data must exist for the state to be able to make a renewal determination. The members who are verified as eligible through automated redetermination will be renewed, and will be mailed a renewal notice. Members who are not verified as eligible or did not qualify for automated redetermination will retain their current redetermination date, and will be mailed a redetermination packet with a pre-populated re-enrollment form that the member must complete and return to remain enrolled in HIP. Once a member returns the form, the Division of Family Resources (DFR) will review his/her information and make a new eligibility determination.[72]

Because HIP eligibility lasts for one year (unless a verified income change occurs), there are no HIP redeterminations to report for the first demonstration year.[73] Indiana began running the batch process described above in November 2015 for the first round of redeterminations for individuals whose eligibility ended on January 31, 2016. The results of this first round of redeterminations and subsequent rounds will be included in the Final Evaluation Report.

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[72] DFR also assesses eligibility for other Medicaid eligibility categories. Source: Healthy Indiana Plan 2.0: Enrollment, Redetermination, and Conversion. Retrieved March 2, 2016, from http://www.in.gov/idoi/files/HIP_2_0_Training_-_Enrollment_Redetermination_and_Conversion_-_1_21_15.pdf

[73] For individuals who transitioned into HIP, their annual benefit period restarted with the beginning of HIP 2.0 in February 2015.

Research Question 1.4.1: How does the waiver of retroactive coverage impact uncompensated care costs?

As described above, HIP 2.0 does not provide retroactive coverage for most HIP members, with the exception of a limited program for certain Section 1931 parents and caretaker relatives. Section 1931 HIP members are eligible for retroactive coverage if they meet the following criteria:

- Are new applicants, were not covered through HIP or Medicaid within the past two years,[74] or experienced a qualifying life event;
- Did not gain coverage through presumptive eligibility;
- Received medical care within the 90 days prior to the effective date of eligibility; and
- Submitted for reimbursement within 90 days of the individual's receipt of the bill for such care.

Costs for this population *receiving* retroactive coverage are reported separately by the state, in the 'Prior Claims Payment Program Report,' submitted to CMS on October 27, 2015.[75] This report, focuses on costs for the HIP population *not receiving* retroactive coverage.

Provider Perceptions Concerning Cost of Uncompensated Care

Uncompensated care refers to care provided for which no payment was received from the patient or from an insurer. It is comprised of two categories:

1. **Charity Care:** care that hospitals or doctors provide at no cost because the patient meets certain criteria, e.g. low-income, few assets; and
2. **Bad Debt:** bills that a provider is unable to obtain reimbursement for because a patient is either unable or unwilling to pay.

To understand provider perceptions of the cost of uncompensated care under HIP 2.0, the provider survey – administered in December 2015 and January 2016 – asked a series of questions about these two components of uncompensated care. Specifically, the survey, included in ***Appendix F***, asked providers whether, since HIP 2.0 started in February 2015, they had seen a decline in a) the number of patients without insurance; b) the number of requests for charity care cases that the practice receives; and c) the instances of bad debt. It is important to note that the survey question does not specifically refer to changes brought about by HIP 2.0, but rather changes occurring *since HIP 2.0 started*. For this reason, provider perceptions of changes in charity care/ bad debt could reflect other, concurrent developments in the Indiana healthcare system unrelated to HIP 2.0.

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[74] Members residing in a domestic violence shelter or in a state declared disaster area are not subject to the two year stipulation. Source: MHS Member Handbook. Retrieved June 2, 2016 from http://www.mhsindiana.com/files/2013/03/HHW-HIP-Member-Handbook-July-2015-EN.pdf

[75] Prior Claims Payment Program Report. (2015, October 27). Retrieved June 6, 2016 from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-prior-claims-pymt-rpt-10272015.pdf.

Table 1.4.1 and ***Table 1.4.2*** below, report the results for charity cases and instances of bad debt. For both charity cases and instances of bad debt, 16 percent of providers reported an increase, with the majority of providers reporting either a decline or no change.

Table 1.4.1: Provider responses regarding change in requests for charity cases

	Number	Proportion
Decline in number of charity care requests	88	39%
No change in number of charity cases	81	36%
Increase in number of charity cases	37	16%
Don't know	19	8%
Total respondents	225	100%

Source: Provider survey.

Table 1.4.2: Provider responses regarding change in instances of bad debt

Does missing an appointment impact preventive care	Number	Proportion
Decline in instances of bad debt	60	27%
No change in instances of bad debt	100	44%
Increase in instances of bad debt	35	16%
Don't know	30	13%
Total respondents	225	100%

Source: Provider survey.

Research Question 1.4.2: What is the number of Presumptive Eligibility applications vs. traditional applications?

As described above, to help eligible HIP enrollees get access to coverage quicker, Indiana made two major changes to presumptive eligibility policies:

1. Indiana increased the number of *entities* eligible to *make* PE determinations.
2. Indiana increased the categories of *members* eligible to *receive* PE determinations by expanding PE eligibility to adults. (PE was previously limited to pregnant women, infants, children, low-income parents and caretakers, former foster children, and individuals seeking family planning services.)

To evaluate the reach of these policy changes, data on both the *entities* eligible to make PE determinations and the *members* applying for and enrolling in HIP after having PE coverage were examined.

Number of Entities Participating in PE

Providers must enroll through the state to become 'qualified providers' – entities eligible to make presumptive eligibility determinations. There are three categories of PE, each of which has a different process for determination and enrollment:

1. Presumptive Eligibility for Pregnant Women (PEPW);
2. Hospital Presumptive Eligibility (HPE); and
3. Presumptive Eligibility (PE).

The first category is available to pregnant women only, whereas HPE and PE are available for adults 19 to 64 years old (i.e. potential HIP enrollees), low-income parents and caretakers (also potential HIP enrollees), pregnant women, infants, children, former foster children, and individuals seeking family planning services. Only certain facilities, including acute care psychiatric hospitals for category 2 and Federally Qualified Health Centers, Rural Health Clinics, Community Mental Health Centers, and Local county health departments for category 3, can make HPE and PE determinations.[76]

In ***Table 1.4.3***, the total number of entities participating in PE and the total number of potentially qualifying PE providers are shown. The table only includes providers participating in HPE and PE, i.e. provider types that can make PE determinations for potential HIP members (it does not include PEPW providers). In total, 208 unique providers had made a PE eligibility determination as of April 30, 2016. This represents about 62 percent of potentially qualifying providers. The majority (113) of participating PE providers are acute care hospitals. Given the high cost and high volume at hospitals, this is not surprising.

Table 1.4.3: Number of Presumptive Eligibility providers, by Specialty Type

Provider Prime Specialty	Number of Potentially Qualifying Providers	Number of Providers Making PE Determinations
Acute Care Hospital	113	125
Community Mental Health Center	21	25
Federally Qualified Health Center	22	26
Psychiatric Hospital	20	41
Rural Health Clinic	22	67
County Health Department	10	49
Total	208	333

Source: Data provided by FSSA.

Percent of All Applications Coming through PE

Individuals who are determined presumptively eligible for HIP must formally apply to Medicaid in order to continue receiving coverage after the end of the presumptive eligibility period. To estimate the impact of presumptive eligibility on Medicaid enrollment, in ***Table 1.4.4*** we report the total number of PE members, the percentage of members who subsequently completed a full Medicaid application, and the percentage approved for full coverage. This data was prepared by FSSA for the time period: February 2015 through January 2016.

In total, 111,224 individuals had a PE benefit segment during the first demonstration year. Of these, 85,552 individuals (77 percent) completed a full Medicaid application. Of members who completed a full Medicaid application, 26,606 (32 percent) were approved for and enrolled in

[76] See Presumptive Eligibility. Retrieved February 22, 2016, from http://provider.indianamedicaid.com/about-indiana-medicaid/member-programs/special-programs/qualified-provider-presumptive-eligibility-(pe).aspx

full Medicaid coverage. Medicaid determinations for PE members represent about 8 percent of determinations on all applications.[77]

Table 1.4.4: Presumptive Eligibility Applications and Enrollment

	Total number of PE members	Total number of PE members who submitted a full Medicaid application	Percent of PE members who submit a Medicaid application	Total number of PE members with a Medicaid determination	Total number of Medicaid determinations	PE determinations as a percent of all determinations	Total number of PE members who enrolled in full Medicaid coverage
Total	111,224	85,552	76.9%	82,532	983,087	8.4%	26,606

Source: Data provided by FSSA.

Research Question 1.4.3: How many PE members go to HIP Basic vs. HIP Plus?

Due to data issues, we are unable to report on the number of PE members who ultimately enrolled in HIP, by enrollment in HIP Plus and Basic. We plan to report on this in the Final Evaluation Report.

Length of PE Period Before Making PAC, by FPL

At the time of this evaluation, we are unable to report on the length of time before Plus members make a PAC. It will be evaluated in the Final Evaluation Report.

Research Question 1.4.4: What are provider perceptions of PE effectiveness?

The provider survey included five questions related to presumptive eligibility. The first two questions asked providers whether they were qualified to make PE determinations, and for what category: Presumptive Eligibility for Pregnant Women (PEPW); Hospital Presumptive Eligibility (Hospital PE); or Presumptive Eligibility (PE). Providers who make PE determinations were also asked about their experiences of the program, covering:

1. Perceptions of the effectiveness of the PE process;
2. Whether they track how many people who signed up for Presumptive Eligibility coverage went on to complete an application; and
3. What they would say the success rate of their PE members getting full HIP coverage.

Of the 225 providers surveyed, 115 reported being eligible to make PE determinations. Of these, 90 reported being able to make HPE or PE determinations. Of these 90 providers, 87 percent reported that the PE process is either very effective or somewhat effective at eliminating gaps in healthcare coverage. Thirty-two percent reported that they track whether members complete a

[77] These counts reflect the number of PE members with a Medicaid *determination* as a percentage of total Medicaid determinations, rather than the number of PE members with a Medicaid *application* as a percentage of total Medicaid applications to remain consistent with the state's methodology for tracking PE applications on a monthly basis.

full Medicaid application and 56 percent report that they believed the success rate of their PE members getting full Medicaid coverage is over 50 percent.

Research Question 1.4.5: What proportion of members elected to make Fast Track prepayments to expedite enrollment in HIP?

HIP 2.0 established Fast Track payments in April 2015 as a way for eligible HIP members to expedite the start of their coverage. Members who made a Fast Track payment are able to make payments much earlier than members who do not: Fast Track payments can be made as early as the point of application, but regular PACs cannot be made until a member receives his/her bill from the MCE, which could take weeks. If a member makes a Fast Track payment and is determined eligible for HIP, his/her HIP Plus coverage begins the first of the month in which he/she made the Fast Track payment.

To answer this research question, we examine data on the number of members taking advantage of the Fast Track payment option, for all HIP members and HIP members initially determined eligible through presumptive eligibility. In the final evaluation, we also plan to compare the length of time to coverage for HIP members who made a Fast Track payment versus those who did not. This data was unavailable for this evaluation.

Number of Individuals Making Fast Track Payments, by FPL

Table 1.4.5 describes the number of members whom the MCEs reported made Fast Track payments, by FPL. In total, the MCEs report 30,856 unique members made a Fast Track payment, which represents eight percent of total HIP 2.0 ever-enrolled members during the year, and 11 percent of Plus members.

Excluding all members who started coverage on or before April 2015 (prior to the start of Fast Track), members making Fast Track payments represent 18 percent of all ever-enrolled members and 26 percent of ever-enrolled Plus members from May 2015 through January 2016.

Table 1.4.5: Members who made a Fast Track payment, by FPL

Income Level	Total Number of Members Making Fast Track Payments
All Income Levels	30,856
Less than or equal to 100% FPL	27,106
Greater than 100% FPL	3,750

Source: MCE data.

Number of PE Individuals Making Fast Track Payments

PE individuals are also eligible to make Fast Track payments. All PE adult members receive a letter with an invoice for $10 from their MCE to facilitate the Fast Track process. After payment for this invoice is submitted, and official eligibility approved, the individual's HIP enrollment

begins on the *first day of the month following the PE period*.[78] The Fast Track option is especially important for PE individuals because it allows members to begin HIP coverage sooner. Enrollment data on the number of PE individuals making Fast Track payments is presented below. There were 6,365 members with a PE period who made a Fast Track payment. This represents 22 percent of all previously-PE members and 40 percent of all previously-PE *Plus* members. These rates are higher than Fast Track payment rates described above for non-PE members, which suggests that PE members may be taking advantage of the Fast Track policy to gain coverage sooner. Members with income above 100 percent of the FPL are particularly likely to make a Fast Track payment; about 60 percent of previously-PE members make a Fast Track payment.

Table 1.4.6: PE Individuals who made a Fast Track payment

Income Level	Total Number of Members Making Fast Track Payments
All Income Levels	6,365
Less than or equal to 100% FPL	5,615
Greater than 100% FPL	750

Source: MCE data.

Research Question 1.4.6: How does utilization of services differ between those who utilize the Fast Track payment option and those who do not?

Members making Fast Track payments gain coverage sooner than they would have had they not made a payment. Most of these members might not have had any healthcare coverage during this period had they not made a Fast Track payment. For this reason, utilization in the first period of enrollment for Fast Track members is of interest; Fast Track members might not have had access to coverage for these services if the Fast Track policy did not exist. Utilization among Fast Track members in their first months of coverage may suggest that Fast Track policies help remediate coverage gaps, improving access to needed care. Higher utilization compared to non-Fast Track members could also suggest that members in need of care understand and utilize the policy to get coverage faster.

The table below shows utilization by service category for members making Fast Track payments (n=30,856) compared to those who do not (n= 376,890). This includes data on primary care, specialty care and emergency care.[79] Members making Fast Track payments are using care in their first month of enrollment, but at lower levels than members who do not make Fast Track payments. In other words, Fast Track members are not using more care in their first month of enrollment than members who do not make Fast Track payments.

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[78] Indiana Medicaid for Providers; Hospital Presumptive Eligibility Process. Retrieved June 2, 2016 from http://provider.indianamedicaid.com/about-indiana-medicaid/member-programs/special-programs/qualified-provider-presumptive-eligibility-%28pe%29/hospital-presumptive-eligiblity-%28hpe%29.aspx.

[79] See ***Appendix K*** for definitions of primary and specialty care for this report.

Table 1.4.7: Rates of Service utilization per 1,000 member years in first month of enrollment (primary care vs. specialty care vs. emergency care), by Fast Track utilization and income

Income Level	Primary		Specialty		Emergency	
	Fast Track	Not Fast Track	Fast Track	Not Fast Track	Fast Track	Not Fast Track
All	44.0	55.7	136.9	140.9	70.75	81.47
Less than or equal to 100% FPL	43.7	55.9	141.5	142.3	72.90	83.01
Greater than 100% FPL	46.4	51.9	103.2	116.3	55.20	53.97

Source: MCE data, enrollment and claims data from FSSA.

Research Question 1.4.7: How many members are taking advantage of other policies that prevent gaps in coverage, e.g. ex-parte determinations and prepopulated renewal forms?

As mentioned previously, because HIP eligibility lasts for one year (unless an income change occurs), there are no HIP redeterminations to report for the first demonstration year.[80] Indiana began running the batch process described above in November 2015 for the first round of redeterminations for individuals whose eligibility ended on January 31, 2016. Results of this first round of redeterminations and on subsequent rounds will be analyzed in the Final Evaluation Report.

Hypothesis 1.5: Waiver of NEMT to the Non-pregnant and Non-medically Frail Population Does Not Pose a Barrier to Accessing Care

Indiana submitted an evaluation of the Indiana HIP 2.0 non-emergency medical transportation (NEMT) waiver to CMS on February 29, 2016.[81] Member and provider surveys developed for this evaluation were the primary sources of data for this analysis. Key findings from the report are highlighted below.

- Very few members surveyed, with or without NEMT coverage, indicated that they rely on medical/insurance-covered transportation to get to medical appointments. Over 90 percent report using their car or someone else's car (such as a friend's, neighbor's, or family member's) and either driving themselves or having someone else drive them.
- Transportation was reported as a reason for missing an appointment in the six months prior to being surveyed by approximately six percent of members *without* state-provided NEMT.
- Transportation was reported to be a reason for missing appointments by 10 percent of members *with* state-provided NEMT.

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[80] For individuals who transitioned into HIP, their annual benefit periods restarted with the beginning of HIP 2.0 in February 2015.

[81] The Lewin Group. *Indiana HIP 2.0: Evaluation of Non-Emergency Medical Transportation (NEMT) Waiver*. February 2016. Retrieved from Medicaid website: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-eval-nonemerg-med-transport-02262016.pdf

- The populations with and without state-provided NEMT are not readily comparable due to large differences in demographics and healthcare needs.
- A subset of the population without state-provided NEMT did have NEMT benefits provided through their MCE, which appear very similar to those offered through the state. Given the similar proportions of members without state-provided NEMT who report transportation as a reason for missing an appointment for both those with MCE-provided NEMT (six percent) and those without any NEMT benefits (seven percent), having MCE-provided NEMT does not appear to influence whether members missed appointments for transportation-related reasons when compared to members who did not have access to NEMT. These findings also suggest that similar levels of transportation problems can occur for populations regardless of whether NEMT benefits are available.
- There were statistically significant differences in the proportion of members that identified transportation as a reason for missing an appointment across income levels, and this pattern held for both members with and without state-provided NEMT. This is driven by differences between members below 25 percent of the FPL (10 percent and 12 percent in the populations without and with state-provided NEMT) and those between 25 percent and 100 percent of the FPL (three percent and four percent, respectively), indicating that those with the fewest resources are generally more likely to face access to care issues. Complicating the interpretation though is the similar proportions of members above 100 percent of the FPL (who are predominantly covered by HIP Plus) and below 25 percent of the FPL that reported missing an appointment regardless of the reason, with or without state-provided NEMT.
- However, one quarter of members with the lowest poverty levels who were receiving state-provided NEMT had higher proportions of reporting various reasons, beyond just transportation problems, for missing appointments.
- There was no evidence of significant differences in the proportion of all members surveyed without state-provided NEMT who missed appointments or reported transportation as a reason for missed appointments by rural/urban location, availability of public transportation, age, or gender. However, the sample sizes were relatively small at the levels of these subgroups, which may have limited the ability to capture statistically significant differences.
- Results of a provider survey pointed to transportation as the most common perceived reason that members missed appointments. This was a view shared across provider types and regions. Provider survey respondents also viewed missed appointments as impactful on patients' preventive care and overall quality of care, expressing concerns for detrimental effects. It is important to note that the provider survey respondents were not asked to limit their views to HIP 2.0 members, and the vast majority of respondents of the provider survey were administrative staff, rather than clinical staff, raising questions about their ability to evaluate clinical issues.

In sum, the *current member survey* shows a relatively small number of HIP 2.0 members missed appointments due to transportation-related issues. In addition, members without NEMT benefits did not appear to be substantially more likely to report transportation problems relative to those with MCE-provided or state-provided NEMT benefits.

Summary

A fundamental objective of HIP 2.0 is to provide low-income adults with health insurance coverage in order to reduce the number of uninsured in Indiana. In the first year, 407,746 Indiana residents were enrolled in HIP 2.0 for at least one month. This amounts to nearly three-fourths of the actuarial projections of the number of Indiana residents potentially eligible for HIP 2.0 during the first demonstration year.

By the end of the first demonstration year, there were approximately 61,500 members (representing about 15 percent of ever-enrolled members) who left HIP 2.0—either leaving Medicaid altogether or shifting to another Medicaid program. The primary reasons for disenrollment were a change in income or having secured insurance from another source. In addition, approximately 16 percent of "leavers" used services in another Medicaid program.

In terms of access to providers, current members reported having a greater likelihood of accessing routine care, specialist care and prescription drugs, compared to leavers and never-members. The current members were equally satisfied with their speed of access to care as nationally-reported numbers in Medicaid CAHPS reports. With respect to provider network adequacy, all three MCEs satisfied the network standards for PMPs, dental and vision services, and within specialist types, the MCEs met the access requirements for most.

HIP 2.0 also aims to ensure that the PACs are affordable for their members, while acting to incentivize them to manage their healthcare expenses. It appears that PACs are being maintained by the majority of members. Over the first year, non-payment of PAC resulted in about eight percent of members below poverty moving from HIP Plus to HIP Basic. About six percent of individuals required to make a PAC and with income above poverty were disenrolled for failing to make a POWER Account contribution.

Survey respondents were asked about whether they worried about making PACs. Over half (52 percent) of the members *never* or *rarely* worried about POWER Account contributions, whereas 16 percent *always* worried about being able to afford their PAC payment and another 29 percent worried *usually* or *sometimes*. Almost 90 percent of Basic members and about 80 percent of Plus members reported that they would be willing to pay $5 more a month for their health insurance. The majority of those would be willing to pay $10 more a month. Thus, even though a segment of surveyed members reported worrying about making PAC payments, overall perceptions of affordability of PAC were more favorable than not.

According to survey data, over 80 percent of HIP Basic members cited reasons other than affordability for not making a PAC. The primary reasons given for not making a required PAC payment were confusion about the payment process and the plan types.

Certain HIP 2.0 eligibility policies, such as PE and Fast Track payments are meant to reduce coverage gaps, while the waiver of retroactive coverage could potentially increase coverage

gaps. The net effect of these policy changes on gaps in coverage is difficult to measure with existing data. However, some providers are able to detect a decrease in the number of requests for charity care and in instances of bad debt. Also, providers who were engaged in presumptive eligibility determinations were finding that the PE process was either very effective or somewhat effective at eliminating gaps in healthcare coverage. In total, 208 unique providers had made a PE eligibility determination as of April 30, 2016, representing about 62 percent of potentially qualifying providers.

Finally, a sizable number of members were using the option of making Fast Track payments to start their coverage faster. In total, 30,856 unique members made a Fast Track payment as of January 31, 2016, which represents 18 percent of all ever-enrolled members during the time period when the fast-track payment option was available, and 26 percent of ever-enrolled Plus members during this timeframe. Fast Track payment rates are especially high among former PE members.

Overall, a majority of survey respondents (80 percent) were either very satisfied or somewhat satisfied with their experience with HIP. Plus members were more likely to be very or somewhat satisfied than Basic members (86 percent of Plus members, compared to 71 percent of Basic members).[82] Further, 93 percent of surveyed members reported that they would choose to re-enroll in HIP if they left but then became eligible again.

[82] Under HIP 1.0, 94.7 percent of members were either very or somewhat satisfied with their overall experience in HIP. Note that the members surveyed under HIP 1.0 likely had more program experience compared to HIP 2.0 members surveyed. Also, to remain enrolled, HIP 1.0 members were required to pay POWER Account contributions. Source: Healthy Indiana Plan Section 1115 Demonstration 2013 Annual Report and Interim Evaluation. Indiana Office of Medicaid Policy and Planning. October 2014.

Goal 2: Promote Value-Based Decision Making and Personal Health Responsibility

One of the principle goals of the HIP 2.0 program is to promote personal responsibility for positive health behaviors and healthcare spending. To evaluate the success of this goal, the following hypotheses were analyzed:

1. HIP policies will encourage member compliance with required contributions and provide incentives to actively manage Personal Wellness and Responsibility (POWER) Account funds (HIP 2.0 Waiver, Section 5); HIP policies surrounding rollover and preventive care will encourage beneficiaries' compliance with required contributions and provide incentives to actively manage POWER Account funds (STCs, Section XIII, Paragraph 3viii).
2. HIP Plus members will exhibit more cost-conscious healthcare consumption behavior than: a) HIP Basic members; and b) traditional Hoosier Healthwise members in the areas of primary, specialty, and pharmacy service utilization without harming beneficiary health (HIP 2.0 Waiver, Section 5 and STCs, Section XIII, Paragraph 3iv).
3. HIP's (i) graduated co-payments required for non-emergency use of the emergency department (ED), (ii) ED prior authorization process, and (iii) efforts to expand access to other urgent care settings will together effectively deter inappropriate ED utilization without harming beneficiary health (HIP 2.0 Waiver, Section 5).
    - The graduated co-payment structure for non-emergency use of the emergency department will decrease inappropriate ED utilization without harming beneficiary health (STCs, Section XIII, Paragraph 3x).
    - The prior authorization process for hospital emergency department use and efforts to expand access to other urgent care settings will decrease inappropriate ED utilization without harming beneficiary health (STCs, Section XIII, Paragraph 3xi).

As with the other goals, these hypotheses are based on evaluation requirements in the STCs and in the Final Evaluation Plan approved by CMS.

Hypothesis 2.1: HIP Policies Will Encourage Member Compliance with Required Contributions and Provide Incentives to Actively Manage POWER Account Funds; HIP Policies Surrounding Rollover and Preventive Care will Encourage Beneficiaries' Compliance with Required Contributions and Provide Incentives to Actively Manage POWER Account Funds.

A principal focus in the design of the HIP program has been to support more consumer involvement in healthcare choices by offering its members a High Deductible Health Plan (HDHP) paired with a Personal Wellness and Responsibility (POWER) Account. This section examines whether awareness about the POWER Account and the policies surrounding it influences POWER Account management as well as members' healthcare utilization.

Specifically, six research questions are related to this hypothesis:

1. What proportion of members make POWER Account payments on time? What proportion of members move from HIP Plus to HIP Basic due to non-payment?
2. How many members are subject to collection due to non-payment of PAC?

3. Are providers complying with HIP policies, e.g. charging co-payments to HIP Basic members?
4. Are members actively managing their POWER Accounts?
5. Are there differences in utilization and POWER Account management among members related to health status, (e.g., diabetes, or other chronic diseases)?
6. Are there differences in utilization and POWER Account management between individuals paying a PAC and those who do not? How are these variables impacted by member income level?

These questions were evaluated using enrollment and claims data as well as data collected from member and provider surveys. At this time, data are not yet available on PAC debt or rollover, as members are not eligible for rollover until they have been in the program for a full year. Many members were only enrolled for a few months during the first demonstration year. Also, MCEs typically need several months to fully process claims and other administrative information necessary in determining rollover eligibility. The Final Evaluation Report will be able to assess the effectiveness of the policies surrounding the POWER Account and rollover in active management of the POWER Accounts.

Policies to Encourage Member Compliance with Required Contributions (PAC) and Incentives to Actively Manage POWER Account Funds

HIP 2.0 policies include a strong incentive for member compliance with PAC for individuals with income over 100 percent of the FPL. Those who fail to make a POWER Account contribution are subject to a six-month disenrollment period from coverage after a 60-day non-payment grace period elapses. However, for individuals below 100 percent of the FPL, those who fail to make a PAC are moved from the HIP Plus plan to the HIP Basic plan after the 60-day grace period, rather than being disenrolled from HIP 2.0 altogether. However, disenrollment for failure to pay a PAC is not applicable to individuals who are medically frail or receiving TMA, or to individuals who apply for a waiver from the six-month disenrollment period due to a qualifying event (e.g., obtaining and subsequently losing private insurance coverage; experiencing a loss of income after disqualification due to increased income; taking up residence in another state and returning later; being a victim of domestic violence; or residing in a county subject to a disaster declaration made in accordance with IC 10-14-3-12 at the time the member was terminated for non-payment or at any time in the sixty calendar days prior to date of member termination for non-payment).[83]

To incentivize members to continue making their PAC and remain in HIP Plus, HIP Plus has several advantages over HIP Basic: an enhanced benefit package, no co-payments (except for non-emergency use of the Emergency Department) and additional rollover rewards for receiving preventive care. Refer to ***Table 3*** of the Program Overview section for more details on benefits and incentives within Basic and Plus.

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[83] Medically frail individuals above 100 percent FPL who fail to make a PAC are transferred to a Basic plan with copays. TMA participants who fail to make a PAC are transitioned to the Basic plan.

Rollover rewards are of particular importance: both Basic and Plus members are potentially eligible to rollover their portion of unused funds to reduce future contributions in subsequent years. The potential to reduce future required contributions may encourage all members to manage their PAC funds. This aspect of the program will be expanded on in the Final Evaluation Report. Nonetheless, the efficacy of HIP 2.0 policies in POWER Account management and healthcare utilization was assessed within the scope of available data and information for this interim report.

Research Question 2.1.1: What proportion of members make POWER Account payments on time? What proportion of members move from HIP Plus to HIP Basic due to non-payment?

As discussed in Goal 1, during the first demonstration year, there were 281,471 unique members enrolled for at least one month in HIP Plus. This amounts to about 70 percent of all ever-enrolled members.

About 21,445 of these individuals transitioned from Plus to Basic during the year, representing approximately 8.2 percent of the 262,579 individuals who would have been eligible to transition from Plus to Basic, had they not made a PAC.

There were also 2,677 HIP Plus members who were disenrolled from the program during the first year due to non-payment of PAC. This represents approximately six percent of the 45,607 individuals with income above the federal poverty level who could be disenrolled for a non-payment of PAC.[84] Thus, it appears that over 90 percent of members, whether above or below poverty, make their required PAC payments to stay in Plus. (See Goal One, Hypothesis Three, Research Question Five for additional detail on the estimates of members who left Plus due to PAC non-payment.)

Research Question 2.1.2: How many members are subject to collection due to non-payment of PAC?

Analysis of this question will be included in the Final Evaluation Report.

Research Question 2.1.3: Are providers complying with HIP policies, e.g. charging co-payments to HIP Basic members?

As noted previously, Basic members are required to make a co-payment each time they receive a healthcare service, such as going to the doctor, filling a prescription, or staying in the hospital. These payments may range from $4 to $8 per doctor visit or prescription filled, and may be as high as $75 per hospital stay.

To assess provider compliance with HIP policies on charging co-payments to HIP Basic members, data collected from a survey of HIP providers were analyzed. Providers were asked to report on a series of questions to gain an understanding about co-payment collection rates and co-payment collection policies in general, as well as to estimate metrics such as the percent

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[84] The 45,607 count excludes anyone who was exempt from disenrollment for failure to pay PAC, e.g., medically frail, TMA, Native American, and pregnant women.

of HIP patients for which providers report regularly collecting co-payments (See ***Appendix F*** for more details on the provider survey including specific survey questions).

Provider Knowledge and Compliance with HIP 2.0 Co-payment Policies

In order to assess provider knowledge and compliance with HIP 2.0 co-payment policies, providers were first asked whether they knew how to identify if HIP patients were required to pay co-payments. Approximately 88 percent or 198 of the 225 surveyed providers responded affirmatively.[85] The 198 providers who responded that they knew how to find out if a patient was required to pay a co-payment were also asked about the typical way they found out that information. Providers could select multiple options. A majority (n=164) stated that they used the Eligibility Verification System (EVS) and 54 mentioned other sources such as asking the patient, checking the patient's insurance card, looking up the explanation of benefits, and using the web portal.

Providers were subsequently asked if they were charging co-payments to HIP members. Approximately 84 percent responded affirmatively.[86] Providers who reported charging co-payments (n=188) were then asked *when* they were made. Approximately 80 percent (n=151) reported that HIP patients made co-payments at the point of service, while the remainder reported that HIP patients were billed for their co-payments. Providers who reported billing patients (n=37) were next asked, "Do you pursue collections on unpaid co-pays?" About 78 percent of the respondents noted that they pursued collections always or at least sometimes.[87]

Providers who reported charging co-payments to HIP members (n=188) were additionally asked: "For those HIP members who are required to pay co-payments, what percentage of them are making their co-payments to you?" Of the providers charging co-payments to HIP members, about 9 percent of providers said that all their patients made their required co-payments (see ***Table 2.1.1***). An additional 43 percent of providers (n=81) reported that over half made their required co-payments. About a third of providers reported that (n=65) that less than half of their patients made their required co-payments.

Table 2.1.1: Percentage of HIP Members Making their Co-payments, as Reported by Surveyed Providers

Percentage of HIP Members Making their Co-payments, as Reported by Surveyed Providers	Provider Responses	Weighted Proportion
Less than 25% of members	38	20%
25-49% of members	27	14%
50-74% of members	41	22%
75-99% of members	40	21%
100% of members	16	9%
Don't Know	26	14%

Source: Provider survey.

[85] One provider responded *Don't Know*.
[86] Four providers, representing 2 percent of the surveyed sample of the provider population, responded *Don't Know*.
[87] There were 37 provider survey respondents to this question; 22 responded always, 7 responded sometimes, 7 responded never and 1 responded *Don't Know*.

Research Question 2.1.4: Are members actively managing their POWER Accounts?

Members use their POWER Account funds to pay for covered services until they meet their deductible ($2,500).[88] Members are responsible for making a small contribution to the account each month (equal to approximately two percent of annual family income) based on their income and family size. The state contributes the remainder up to the $2,500 deductible. Members receive monthly statements detailing account activity and how much money remains in their POWER Account.

The MCEs are adjudicating POWER Account balances and rollover beginning in June 2016 for the first year of the HIP 2.0 program. Once data become available, future reports will include estimates of the percentage of HIP Plus members that have a POWER Account balance at the end of their 12-month benefit period, as well as the average of those POWER Account balances. As these data are not yet available, to assess whether members actively manage their POWER Accounts, data from the surveys conducted on a sample of the Plus and Basic members was used. A total of 600 HIP 2.0 members were surveyed, 420 of whom were Plus members and 180 Basic members. Members were asked to report on whether they had heard of the POWER Account, whether they had a POWER Account, and how often they checked the balance of their POWER Account.

Knowledge and Awareness of POWER Account

First, HIP 2.0 members were asked if they had ever heard of the "Healthy Indiana Plan POWER Account." The majority of respondents – 60 percent – reported hearing of the HIP POWER Account.[89] There were differences by Plus and Basic status, with those that are required to make PACs (i.e. Plus members) reporting a higher awareness of the POWER Account. Approximately 66 percent of HIP Plus members reported hearing of the HIP POWER Account, as opposed to 46 percent of HIP Basic members (see ***Table 2.1.2***). Under HIP 1.0, 77 percent of respondents reported hearing about the POWER Account.[90] However, the survey for HIP 1.0 was conducted when the program was more mature. At the time of the HIP 2.0 survey, many members had only been in the program for a few months.

HIP 2.0 members who reported hearing of the POWER Account were asked whether they had a POWER Account. Approximately 72 percent of HIP Plus members and 76 percent of HIP Basic members who reported hearing of the HIP POWER Account also reported having one (see ***Table 2.1.2***).[91]

HIP 2.0 members who reported having a POWER Account were additionally asked how often they checked the balance on their accounts. Among members who reported having a POWER Account, 40 percent of HIP Plus and 30 percent of HIP Basic members reported checking their

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88 After a member meets his/her deductible, the member's MCE pays for all covered services.

89 Four Basic and 19 Plus members representing 3 percent of the weighted HIP 2.0 member population responded *Don't Know*.

90 To remain enrolled, HIP 1.0 members were required to pay POWER Account contributions. Healthy Indiana Plan Section 1115 Demonstration 2013 Annual Report and Interim Evaluation. Indiana Office of Medicaid Policy and Planning. October 2014.

91 Ten Basic and 50 Plus members for an overall weighted 10 percent responded *Don't Know*.

POWER Account balance monthly. Another 42 percent of Plus members and 37 percent of Basic members reported never checking their POWER Account balance (see ***Table 2.1.2***).[92] Few respondents selected each of the other response categories: weekly, a few times a month, every few months, and yearly.[93]

Table 2.1.2: HIP 2.0 Members' Knowledge and Awareness of the POWER Account

	HIP Plus		HIP Basic	
	Member Responses	Weighted Proportion	Member Responses	Weighted Proportion
Heard about HIP POWER Account	281	66%	87	46%
Have a POWER Account	204	72%	63	76%
Frequency of Checking POWER Account Balance				
Weekly/A Few Times a Month*	5	2%	2	3%
Monthly	75	40%	18*	30%
Every Few Months*	19	9%	13	24%
Once a Year*	4	2%	5*	6%
Never	91	42%	25	37%

Source. Current member survey. *The sample sizes are too small for the reported percentages to be reliable.

Knowledge and Awareness of HIP Policies on Preventive Care and Rollover

Three questions tested members' awareness of policies related to rollover and preventive care. First, the members were asked if they thought that the costs for preventive services such as cancer screenings would be deducted from their POWER Account. Slightly over half of both Plus and Basic members thought that the cost would be deducted from their accounts (see ***Table 2.1.3***). Moreover, a substantial number of respondents in both plans – 160 Plus (39 percent) and 74 (40 percent) Basic members – responded *Don't Know*. Thus, survey data suggest that a large majority of HIP 2.0 members may not be aware of the HIP 2.0 policy that would allow them to get no-cost preventive care. However, as noted previously, members did not have much experience with HIP 2.0 at the time the survey was administered. In addition, a majority of members enrolled for at least 12 months are obtaining preventive care services (see Goal 3 discussion).

Lack of awareness of preventive care coverage is not unique to HIP 2.0. In similar questions asked of HIP 1.0 members on annual exams and cancer screenings, slightly more than 70 percent reported not knowing the policy accurately.[94] Similarly, a recent survey conducted on those purchasing their own health insurance in the non-group market also finds a lack of

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92 The 42 percent of HIP Plus members that report never checking POWER Account balance is somewhat higher than the percentage reported under HIP 1.0, where about 21 percent of respondents mentioned never checking their POWER Account balance.

93 In response to the frequency with which members check their POWER Accounts, 10 Plus members answered *Don't Know* for a weighted 2 percent of the population having a POWER Account.

94 Healthy Indiana Plan Section 1115 Demonstration 2013 Annual Report and Interim Evaluation. Indiana Office of Medicaid Policy and Planning. October 2014.

awareness about new rules for coverage regarding preventive services. [95] Fewer than half (47 percent) knew that preventive services were covered completely by their plans, and among those in high-deductible plans, awareness was even lower: 41 percent knew that preventive services were covered with no cost-sharing.

Table 2.1.3: HIP 2.0 Members' Knowledge on Policies on Preventive Care and POWER Account Rollover

Question	HIP Plus		HIP Basic	
	Member Responses (Yes/True)	Weighted Proportion	Member Responses (Yes/True)	Weighted Proportion
If you were to get preventive services such as a cancer screening, do you think the cost would be deducted from your POWER Account if you have enough money available in the account?	224	52%	94	51%
If you get preventive services suggested by your plan every year and have money left in your POWER Account, part of that money will be rolled over to your account for next year.	270	65%	95	57%
(***Basic members***) If you do not get the preventive care that your health plan recommends during the year and you have money left over in your POWER Account, you will not be able to reduce your monthly contributions if you move to HIP Plus.			70	35%
(***Plus members***) If you do not get the preventive care that your health plan recommends during the year and you have money left over in your POWER Account the amount that is rolled over will not be doubled.	215	52%		

Source: Current member survey.

Another policy related question asked members whether they thought it was true that if they obtained preventive services suggested by their plan every year and had money left in their POWER Account, part of that money would be rolled over to their account for next year. Sixty-five percent of Plus members and 57 percent of the Basic members thought that it was true (see ***Table 2.1.3***). Sizable segments[96] of both groups of members also responded they *didn't know* whether it was a true or false statement. This may not be surprising since rollover has not yet been experienced by HIP 2.0 members.

The last policy question also addressed the link between rollover, preventive care and reducing future POWER Account contributions. Basic members were asked if they thought it was true that if they did not get the preventive care that their health plan recommended during the year and they had money left over in their POWER Account, they would not be able to reduce their

[95] Survey of Non-Group Health Insurance Enrollees, Wave 3, conducted February 9–March 26, 2015; the Kaiser Family Foundation. Retrieved May 19, 2016 from http://kff.org/health-reform/poll-finding/survey-of-non-group-health-insurance-enrollees-wave-3/

[96] Sixty-seven Plus members (15 percent) and 40 Basic members (21 percent) responded *Don't Know.*

monthly contributions if they moved to HIP Plus. A corollary question to Plus members asked if they thought it was true that if they did not receive the preventive care recommended by their plan and had money left over in their POWER Account, the amount that would be rolled over would not be doubled. Fifty-two percent of Plus members and 35 percent of Basic members thought that the applicable provision was true (see ***Table 2.1.3***). Once again, there was a sizable response of *Don't Know* in both membership groups.[97]

Nonetheless, HIP Plus plan members surveyed reflect greater awareness about policies on preventive services and their relationship to rollover and future POWER Account contributions in comparison to that of members under HIP 1.0, in which approximately one-quarter reported that getting preventive services would qualify them for a rollover.[98] This is particularly notable because some HIP Plus respondents, specifically respondents who did *not* transition from HIP 1.0, may have never experienced rollover because the member survey was administered 10 months after the start of HIP 2.0, but rollover occurs after 12 months of enrollment.[99] In comparison, as noted previously, the HIP 1.0 member survey was administered approximately five years after HIP 1.0 began, so HIP 1.0 survey respondents may have been more likely to have experienced rollover prior to being surveyed.

Research Question 2.1.5: Are there differences in utilization and POWER Account management among members related to health status (e.g., diabetes, or other chronic diseases)?

Research Question 2.1.6: Are there differences in utilization and POWER Account management between individuals paying a PAC and those who do not? How are these variables impacted by member income level?

The final two research questions associated with Hypothesis 1 under Goal 2 will be addressed together. Since the POWER Account balances are not adjudicated by the MCEs until after four months from the end of the benefit period, during this evaluation cycle, data is not yet available to address how POWER Account management and rollover are directly correlated with income, health, or healthcare utilization. However, it is of interest to examine whether utilization is associated with making a POWER Account contribution (proxied by membership in Plus[100]) and income level, controlling for members' health conditions.

In order to analyze the healthcare utilization behavior among members with different income and health status, as well as members that differ in plan type, HIP 2.0 members were broken down into four distinct groups of HIP 2.0 members:

1. Exclusively Plus members with income greater than 100 percent of the FPL;
2. Exclusively Plus members with income up to 100 percent of the FPL;
3. Exclusively Basic members with income up to 100 percent of the FPL; and

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97 90 Plus members (21 percent) and 58 Basic members (33 percent) responded *Don't Know.*

98 Healthy Indiana Plan Section 1115 Demonstration 2013 Annual Report and Interim Evaluation. Indiana Office of Medicaid Policy and Planning. October 2014.

99 Plus members who transitioned from HIP 1.0 may have experienced rollover *during their enrollment in HIP 1.0.*

100 Everyone in the Plus plan is required to pay a PAC to maintain membership, except for pregnant women and Native Americans.

4. Plus to Basic switchers with income up to 100 percent of the FPL. [101]

The *exclusive* concept is used to focus on members that stay in the specific plan type for the entire period of their enrollment; and are assumed to maintain the same income level. The aim is to help to isolate the effects of plan type and income on utilization patterns. While this section largely focuses on "exclusively" enrolled members, the discussion in Goal 3 reviews utilization statistics for the overall population of HIP 2.0 members in the first demonstration year.

For each of these four groups, four categories of health status were identified, represented by the number of each member's physical and/or behavioral chronic disease conditions. Specifically, the four health status categories we use are:

1. At least one physical health condition;
2. At least one behavioral health condition;
3. At least one physical health and at least one behavioral health condition; or
4. More than two physical health or behavioral health conditions.

The analysis focused on seven physical health conditions: diabetes, congestive heart failure, coronary artery disease, asthma, chronic obstructive pulmonary disease, chronic kidney disease, and rheumatoid arthritis. Behavioral health is also represented by seven conditions: autism, depression, schizophrenia, bipolar disorder, other severe and persistent mental illness, attention deficit hyperactivity disorder, and substance abuse. These specific physical and behavioral health conditions are of particular interest since these are typically regarded as high priority conditions for Medicaid programs, and the MCEs offer disease management programs for most of these conditions.

In addition, the extent utilization differs across the four groups of members based on their medical frailty status was explored.[102]

To assess if healthcare utilization varies by income and POWER Account contribution, accounting for health status, five aspects of utilization among the four HIP membership groups were compared, including:

1. Use of at least one preventive service (***Table 2.1.5***);
2. Use of primary care services (***Table 2.1.6***);
3. Use of specialty care services (***Table 2.1.7***);
4. Use of emergency department services (***Table 2.1.8***); and
5. Use of prescription drugs (***Table 2.1.9***).

Table 2.1.4 displays the prevalence of health conditions and medical frailty for the four groups of HIP 2.0 members defined above. According to the claims data, exclusive Plus members with

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[101] HIP members' overall utilization is described under Goal 3.

[102] Individuals are considered medically frail in the analysis if they were indicated to be medically frail during any month of their enrollment during the first demonstration year.

income up to 100 percent of the FPL were most likely to have chronic conditions – whether physical or behavioral – among the four groups. Medical frailty is also most prevalent among this group.

Members who switched from Plus to Basic also had a higher likelihood to be sicker, as well as medically frail, than their exclusive Basic counterparts, although less than the exclusive Plus members at the same income level (i.e., with income up to the poverty level). Exclusive Plus members with income greater than 100 percent of the FPL were less likely to have health conditions, or to be medically frail, than the exclusive Plus members with lower income.

Table 2.1.4: Disease Prevalence and Medical Frailty across Membership Status

Health Status	"Exclusive" Plus >100% of FPL (N = 17,685)		"Exclusive" Plus <=100% of FPL (N = 185,890)		Plus to Basic Switcher (<=100% of FPL) (N = 17,812)		"Exclusive" Basic <=100% of FPL (N = 118,267)	
	Unique Members with Disease							
	Count	Percent	Count	Percent	Count	Percent	Count	Percent
At least one **PH condition**	2,156	12.2%	27,272	14.7%	1,561	8.8%	5,877	5.0%
At least one **BH condition**	1,241	7.0%	28,749	15.5%	2,293	12.9%	12,556	10.6%
At least one PH **and** at least one BH condition	203	1.1%	5,197	2.8%	291	1.6%	1,182	1.0%
More than **two BH or PH conditions**	60	0.3%	1,331	0.7%	93	0.5%	406	0.3%
	Unique Members with Medical Frailty							
Medically Frail	1313	7.4%	26, 548	14.3%	1,733	9.7%	9,830	8.3%

Source: Claims data from FSSA. Notes: BH = Behavioral Health, PH = Physical Health.

1. Seven physical health conditions, namely, Diabetes, Congestive Heart Failure, Coronary Artery Disease, Asthma, Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease, and Rheumatoid Arthritis are included in this category.

2. Seven behavioral health conditions, namely, Autism, Depression, Schizophrenia, Bipolar Disorder, Other Severe and Persistent Mental Illness, Attention Deficit Hyperactivity Disorder, and Substance Abuse are included in this category.

Tables 2.1.5 through ***2.1.9*** summarize utilization behavior across the five domains listed above for each of the enrollment groups of interest. For each of the groups, utilization is based on whether members had physical and/or behavioral health conditions.

How Does Making a POWER Account Contribution Relate to Utilization?

Focusing on the utilization patterns of individuals with income up to 100 percent of the FPL, but across three different groups of members, namely the exclusive Plus, the exclusive Basic, and the Plus to Basic switchers, may shed light into the motivation behind making a POWER Account contribution, and maintaining Plus membership.

Exclusive Plus members with income up to 100 percent of the FPL are most likely to use preventive care regardless of the status of behavioral or physician health conditions; exclusive Basic members up to 100 percent of the FPL are least likely (see ***Table 2.1.5***). This may be related to the stronger incentives to use preventive care under the Plus program.[103]

Primary care, specialty care, and prescription drug use are generally higher for the exclusive Plus members with income up to 100 percent of the FPL regardless of the status of behavioral or physical health conditions. Exclusive Basic members are generally the lowest utilizers of care, with the exception of emergency services. As noted previously, the exclusive Basic members are also least likely to have health conditions or be medically frail. As additional claims data becomes available for future analyses, the relationship between primary care and ER use will be further examined. More detail on avoidable ER use in the HIP 2.0 population is also provided in Goal 2, Hypothesis 2, Research Question One.

Utilization across Different Income Groups

It is of interest to examine the healthcare utilization pattern of Plus members across the two different income categories, since that may help understand the extent Plus membership could be a product of policy (individuals with income greater than 100 percent of the FPL can only enroll in Plus), or a choice shaped by potential healthcare needs (as members below poverty may be able to shift into Basic). In general, utilization of services tends to be lower among Plus members with higher income relative to their lesser income counterparts within similar health condition cohorts. ***Table 2.1.4*** reflects that the likelihood of potentially needing healthcare is greater for the Plus members in the lower income group. Thus it is plausible that individuals with income up to the federal poverty level who choose to enroll in the Plus plan do so to take advantage of the benefits in Plus.

How does Utilization of Plus to Basic Switchers Compare to the Other Groups?

It appears that members who switch from Plus to Basic are more likely to have health conditions relative to their exclusive Basic counterparts. However, the utilization patterns across different groups do not help reach a definitive conclusion regarding why these individuals might have chosen to become Plus members initially. In the final evaluation with more member utilization experience, it will be possible to look at the impact of health, income, and plan choice in a multivariate analysis.

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[103] The utilization rates for preventive services are calculated for members irrespective of their length of enrollment in HIP 2.0. This likely underestimates utilization of preventive care.

Table 2.1.5: Utilization of Preventive Care Services

Health Status	Percent Using At Least One Preventive Care Services			
	"Exclusive" Plus >100% of FPL	"Exclusive" Plus <=100% of FPL	Plus to Basic Switcher (<=100% of FPL)	"Exclusive" Basic <=100% of FPL
All Members	52%	64%	51%	36%
At least one **PH condition**	81%	89%	84%	76%
At least one **BH condition**	72%	80%	72%	64%
At least one PH **and** at least one BH condition	88%	94%	89%	84%
More than **two BH or PH conditions**	93%	91%	82%	84%
Medically Frail	75%	86%	77%	69%

Source: Claims data from FSSA. Notes: BH = Behavioral Health, PH = Physical Health. The utilization rates are calculated for members irrespective of their length of enrollment in HIP 2.0. This likely underestimates utilization of preventive care.

1. Seven physical health conditions, namely, Diabetes, Congestive Heart Failure, Coronary Artery Disease, Asthma, Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease, and Rheumatoid Arthritis are included in this category.

2. Seven behavioral health conditions, namely, Autism, Depression, Schizophrenia, Bipolar Disorder, Other Severe and Persistent Mental Illness, Attention Deficit Hyperactivity Disorder, and Substance Abuse are included in this category.

3. For the row of "all members" the denominator is the total member count for each group presented in Table 2.1.4. Denominator for each of the other percentages reported is the respective count of unique members with a relevant BH or PH condition or the count of unique members with medical frailty in the corresponding row in Table 2.1.4.

Table 2.1.6: Utilization of Primary Care

Health Status	"Exclusive" Plus >100% of FPL		"Exclusive" Plus <=100% of FPL		Plus to Basic Switcher (<=100% of FPL)		"Exclusive" Basic <=100% of FPL	
	Percent Using Primary Care	Visits per 1,000 Member Years	Percent Using Primary Care	Visits per 1,000 Member Years	Percent Using Primary Care	Visits per 1,000 Member Years	Percent Using Primary Care	Visits per 1,000 Member Years
All Members	23%	1,023	31%	1,314	26%	815	17%	622
At least one **PH condition**	43%	2,031	51%	2,333	49%	1,849	42%	1,644
At least one **BH condition**	40%	1,911	46%	2,091	42%	1,565	36%	1,295
At least one PH **and** at least one BH condition	50%	2,556	59%	3,075	54%	2,213	51%	2,065
More than **two BH or PH conditions**	45%	2,056	56%	2,757	49%	1,957	43%	1,748
Medically Frail	40%	1,891	49%	2,215	44%	1,651	37%	1,374

Source: Claims data from FSSA. Notes: BH = Behavioral Health, PH = Physical Health.

1. Seven physical health conditions, namely, Diabetes, Congestive Heart Failure, Coronary Artery Disease, Asthma, Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease, and Rheumatoid Arthritis are included in this category.

2. Seven behavioral health conditions, namely, Autism, Depression, Schizophrenia, Bipolar Disorder, Other Severe and Persistent Mental Illness, Attention Deficit Hyperactivity Disorder, and Substance Abuse are included in this category.

3. For the row of "all members" the denominator is the total member count for each group presented in Table 2.1.4. Denominator for each of the other percentages reported is the respective count of unique members with a relevant BH or PH condition or the count of unique members with medical frailty in the corresponding row in Table 2.1.4.

Table 2.1.7: Utilization of Specialty Care

Health Status	"Exclusive" Plus >100% of FPL		"Exclusive" Plus <=100% of FPL		Plus to Basic Switcher (<=100% of FPL)		"Exclusive" Basic <=100% of FPL	
	Percent Using Specialty Care	Visits per 1,000 Member Years	Percent Using Specialty Care	Visits per 1,000 Member Years	Percent Using Specialty Care	Visits per 1,000 Member Years	Percent Using Specialty Care	Visits per 1,000 Member Years
All Members	34%	2,311	47%	3,400	40%	1,803	30%	1,688
At least one **PH condition**	63%	5,077	74%	6,280	72%	4,463	68%	4,808
At least one **BH condition**	65%	5,801	75%	7,278	73%	5,031	70%	5,002
At least one PH **and** at least one BH condition	86%	9,132	89%	10,729	85%	8,482	88%	8,598
More than **two BH or PH conditions**	92%	12,411	96%	14,260	96%	9,981	94%	11,759
Medically Frail	69%	7,496	81%	8,430	76%	5,665	70%	5,474

Source: Claims data from FSSA. Notes: BH = Behavioral Health, PH = Physical Health.

1. Seven physical health conditions, namely, Diabetes, Congestive Heart Failure, Coronary Artery Disease, Asthma, Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease, and Rheumatoid Arthritis are included in this category.

2. Seven behavioral health conditions, namely, Autism, Depression, Schizophrenia, Bipolar Disorder, Other Severe and Persistent Mental Illness, Attention Deficit Hyperactivity Disorder, and Substance Abuse are included in this category.

3. For the row of "all members" the denominator is the total member count for each group presented in Table 2.1.4. Denominator for each of the other percentages reported is the respective count of unique members with a relevant BH or PH condition or the count of unique members with medical frailty in the corresponding row in Table 2.1.4.

Table 2.1.8: Utilization of Emergency Service

Health Status	"Exclusive" Plus >100% of FPL		"Exclusive" Plus <=100% of FPL		Plus to Basic Switcher (<=100% of FPL)		"Exclusive" Basic <=100% of FPL	
	Percent Using Emergency Care	Visits per 1,000 Member Years	Percent Using Emergency Care	Visits per 1,000 Member Years	Percent Using Emergency Care	Visits per 1,000 Member Years	Percent Using Emergency Care	Visits per 1,000 Member Years
All Members	18%	623	31%	1,118	39%	1,188	33%	1,294
At least one **PH condition**	33%	1,116	45%	1,678	59%	2,194	60%	2,533
At least one **BH condition**	35%	1,466	50%	2,149	61%	2,465	60%	2,597
At least one PH **and** at least one BH condition	47%	1,932	62%	2,901	71%	3,843	74%	3,877
More than **two BH or PH conditions**	63%	2,929	73%	3,827	76%	3,938	79%	5,174
Medically Frail	33%	1,431	52%	2,209	61%	2,459	61%	2,651

Source: Claims data from FSSA. Notes: BH = Behavioral Health, PH = Physical Health.

1. Seven physical health conditions, namely, Diabetes, Congestive Heart Failure, Coronary Artery Disease, Asthma, Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease, and Rheumatoid Arthritis are included in this category.

2. Seven behavioral health conditions, namely, Autism, Depression, Schizophrenia, Bipolar Disorder, Other Severe and Persistent Mental Illness, Attention Deficit Hyperactivity Disorder, and Substance Abuse are included in this category.

3. For the row of "all members" the denominator is the total member count for each group presented in Table 2.1.4. Denominator for each of the other percentages reported is the respective count of unique members with a relevant BH or PH condition or the count of unique members with medical frailty in the corresponding row in Table 2.1.4.

Table 2.1.9: Prescription Drug Utilization

Health Status	"Exclusive" Plus >100% of FPL	"Exclusive" Plus <=100% of FPL	Plus to Basic Switcher (<=100% of FPL)	"Exclusive" Basic <=100% of FPL
	Percent Filling Prescription	Percent Filling Prescription	Percent Filling Prescription	Percent Filling Prescription
All Members	60%	71%	62%	46%
At least one **PH condition**	91%	95%	94%	89%
At least one **BH condition**	87%	91%	87%	81%
At least one PH **and** at least one BH condition	94%	98%	97%	95%
More than **two BH or PH conditions**	98%	98%	97%	94%
Medically Frail	88%	95%	90%	84%

Source: Claims data from FSSA. Notes: BH = Behavioral Health, PH = Physical Health.

1. Seven physical health conditions, namely, Diabetes, Congestive Heart Failure, Coronary Artery Disease, Asthma, Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease, and Rheumatoid Arthritis are included in this category.

2. Seven behavioral health conditions, namely, Autism, Depression, Schizophrenia, Bipolar Disorder, Other Severe and Persistent Mental Illness, Attention Deficit Hyperactivity Disorder, and Substance Abuse are included in this category.

3. For the row of "all members" the denominator is the total member count for each group presented in Table 2.1.4. Denominator for each of the other percentages reported is the respective count of unique members with a relevant BH or PH condition or the count of unique members with medical frailty in the corresponding row in Table 2.1.4.

Hypothesis 2.2: HIP Plus Members will Exhibit More Cost-conscious Healthcare Consumption Behavior than: a) HIP Basic Members; and b) Traditional Hoosier Healthwise Members in the Areas of Primary, Specialty, and Pharmacy Service Utilization without Harming Beneficiary Health.

HIP 2.0 policies are intended to encourage members, particularly HIP Plus members, to make cost-conscious healthcare decisions in the short term by managing their healthcare spending, and in the longer term by improving their health.[104] To test this hypothesis, the analysis focuses on four research questions:

1. Do HIP Plus members exhibit cost-conscious consumption behavior, e.g. prescription drug adherence, primary care vs specialty care use, chronic disease management, appropriate use of the ED, and generic vs. brand name medication use? In what area(s)?
2. Do HIP Plus members ask about the cost of care before receiving the care?
3. Do HIP Plus members avoid getting needed care because of the cost of that care?
4. Are HIP Plus members less likely to reach the 5 percent of household income limit (threshold) on out-of-pocket costs?

To address the first research question, the healthcare consumption behavior of two populations with different incentives for cost-conscious behavior were compared: HIP Plus and HIP Basic members. Specifically, utilization between these two groups was compared for the following services:

- Appropriate use of the Emergency Department;
- Use of generic prescription drugs rather than brand name drugs;
- Adherence to prescription drugs;
- Completion of qualifying preventive services; and
- Use of primary and specialty care for members with chronic diseases.

The Final Evaluation Report will compare utilization of services by Hoosier Healthwise members transitioning into HIP 2.0, before and after the transition. Due to data issues, we are unable to report on utilization for this population in this report.

Research questions two and three use data from the *current member survey* to explore whether HIP Plus members are more likely to report engaging in cost conscious behavior. Question two addresses whether HIP Plus members are more likely to report that they ask about the cost of care, suggesting that they are sensitive to the cost of services. Question three examines whether members report ever foregoing needed care because of the cost of care. Data is currently not available to address the fourth question on the likelihood of members reaching the 5 percent threshold on out-of-pocket costs.

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[104] See ***Table 3*** in the Program Overview for a comparison of HIP Plus and HIP Basic policies that could affect healthcare utilization behavior.

Research Question 2.2.1: Are HIP Plus members more likely to exhibit cost-conscious consumption behavior, e.g. prescription drug adherence, primary care vs specialty care use, chronic disease management, appropriate use of the ED, and generic vs. brand name medication use? In what area(s)?

To estimate the effect of HIP policies on cost-conscious behavior, we compare the utilization of HIP Plus and HIP Basic members. For these analyses, where possible, any members transitioning between HIP Plus and HIP Basic during the year were excluded. Members moving between the two plans are subject to different incentives compared to exclusively HIP Plus or exclusively HIP Basic members and including them in the comparison could affect the results (as implied by the results discussed under Goal 2.1). The previous section (Goal 2.1) examines 'switchers' in depth, and Goal 3 provides a comparison of all Basic and Plus members.

Appropriate use of the Emergency Department

As described previously, both HIP Basic and HIP Plus members must pay a co-payment if they use the ED unnecessarily: $8 for the first non-emergency visit and $25 for each subsequent visit within the same 12 month benefit period. At the point of service, providers are responsible for determining whether a member is subject to the co-payment based on whether the member has an emergency condition meeting the 'prudent layperson standard.' All ED claims are then subject to additional review by the MCEs.

It is not possible to report on the percentage of visits deemed non-emergent *by the MCEs,* as there were some inconsistencies on how each MCE reported their data. These will be resolved for future reports. Instead, the New York University (NYU) Emergency Department algorithm was used to estimate the percent of ED visits that were non-emergent.[105] The NYU algorithm uses diagnosis codes to assign a probability to whether a visit was non-emergent, primary care treatable, emergent but preventable, emergent but not preventable, or due to injury, mental health problems or alcohol or substance abuse. See ***Table 2.2.1*** below for descriptions of each category. A weighted mean across all visits is then computed for each category, which serves as an estimate of the proportion of visits that are within that category.

Table 2.2.1: NYU Emergent Classification

	Description
Non-emergent	Immediate medical care was not required within 12 hours
Emergent/Primary Care Treatable	Treatment was required within 12 hours, but care could have been provided effectively and safely in a primary care setting
Emergent - ED Care Needed - Preventable/Avoidable	Emergency department care was required based on the complaint or procedures performed/resources used, but the emergent nature of the condition was potentially preventable/avoidable if timely and effective ambulatory care had been received during the episode of illness
Emergent - ED Care Needed - Not Preventable/Avoidable	Emergency department care was required and ambulatory care treatment could not have prevented the condition

[105] The algorithm was developed by the NYU Center for Health and Public Service Research in collaboration with a panel of experts. For a description of the methods, see NYU Background/Introduction. Retrieved June 20, 2016 from http://wagner.nyu.edu/faculty/billings/nyued-background.

	Description
Injury	Visit is the result of an injury
Mental health problem	Visit is the result of a mental health problem
Alcohol or substance abuse	Visit is the result of alcohol or substance abuse

Source: NYU Wagner Background/Introduction.[106]

The classification of each claim is based on the primary diagnosis code of the visit and does not take into account other factors such as age or comorbidities of the patient. For this reason, the NYU method differs fundamentally from the MCE's method for determining non-emergency visits: the NYU method is based on the member's discharge diagnosis whereas the MCE's method is based on the member's presenting complaint. A member's presenting complaint does not correspond directly to the member's discharge diagnosis: for example, a 65-year-old patient with diabetes may be discharged with the "non-emergency" diagnosis of gastroesophageal reflux after presenting with a chief complaint of chest pain; however, that patient still required an emergency evaluation to rule out acute coronary syndrome."[107] The NYU algorithm takes into account this uncertainty in its probability assignments, however because of this difference, NYU estimates of non-emergency use will differ from MCE-reported rates of non-emergency use.

***Table* 2.2.2** below presents data on the total number of ED visits and the percentage that are non-emergent by plan type. The analysis is restricted to 'exclusive' Plus and Basic members, i.e. members who did not switch between the two plans during the year.

Plus members demonstrated lower rates of ED use overall compared to Basic members, including lower rates of non-emergency use of the ED. Correspondingly, HIP Plus members are also more likely to use the ED for visits that were not preventable/avoidable. These trends are consistent with HIP Plus members using more preventive and primary care (discussed below).

Table 2.2.2: Emergency Department Utilization, by Plan Type

Emergency Department Utilization	Basic	Plus
Total members	126,275	231,826
Total number of Emergency Department visits	80,233	115,168
Visits to ED per 1000 member years	1,033.6	775.4
Non-emergent visits to ED per 1000 members per year	262.6	182.6
Percent of visits non-emergent	25.4%	23.5%
Percent of visits emergent/primary care treatable	24.0%	23.6%
Percent of visits emergent - ED care needed - preventable/avoidable	6.0%	5.7%
Percent of visits emergent - ED care needed - not preventable/avoidable	11.3%	13.2%

[106] NYU Background/Introduction. Retrieved June 20, 2016 from http://wagner.nyu.edu/faculty/billings/nyued-background.

[107] Raven, M., Lowe, R. A., Maselli, J., & Hsia, R. Y. (2013). Comparison of presenting complaint vs. discharge diagnosis for identifying "non-emergency" emergency department visits. JAMA : The Journal of the American Medical Association, 309(11), 1145–1153. Retrieved June 20, 2016 from http://doi.org/10.1001/jama.2013.1948

Emergency Department Utilization	Basic	Plus
Percent of visits due to injury	15.0%	15.7%
Percent of visits due to mental health problems	2.1%	2.4%
Percent of visits due to alcohol or substance abuse	2.1%	1.9%

Source: Claims data from FSSA. Note: 14 percent of Basic claims and 14 percent of Plus claims are unclassified.

Use of Generic Prescription Drugs over Brand Name Prescription Drugs

There are some differences in HIP Plus and HIP Basic policies for prescription drugs that could affect prescription drug utilization, presented in ***Table 2.2.3*** below.

Table 2.2.3: Comparison of HIP Plus and HIP Basic Prescription Drug policies

Policy	HIP Basic	HIP Plus
Provider network	Must use a pharmacy that participates with member's MCE	Must use a pharmacy that participates with member's MCE
Use of generic drugs	Generic drugs must be dispensed when available	Generic drugs must be dispensed when available
Preferred Drug List (PDL)	Covers mostly generic drugs along with a limited number of brand-name drugs; updated 4 times a year[108]	Covers many generic drugs along with a larger list of brand-name drugs; updated 4 times a year
Non-preferred drugs	Non-preferred drugs generally require prior authorization from MCE	Non-preferred drugs generally require prior authorization from MCE
Co-pays	$4 (Preferred drugs) $8 (Non-preferred drugs; brand name drugs)	None
Mail order prescriptions	*Cannot* receive medications by mail order	Can receive medications by mail order
Supply/refills	30 day supply limit	Maintenance drugs have a 90 day supply limit; non-maintenance drugs have a 30 day supply limit

Note: Maintenance drugs are medications prescribed for chronic, long-term conditions and are taken on a regular, recurring basis.

In this section, the use of generic prescription drugs over brand name prescription drugs are examined. Specifically, generic fill rates between exclusively HIP Basic and HIP Plus members are compared.

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[108] Indiana Medicaid for Members; Covered Medications. Retrieved June 3, 2016 from http://member.indianamedicaid.com/programs--benefits/medicaid-programs/pharmacy/covered-medications.aspx.

As explained in ***Table 2.2.3***, HIP Basic members have higher co-pays for brand name drugs: $8 (compared to $4 for generic drugs) while HIP Plus members do not pay co-pays for either brand name or generic drugs. In addition, the Regular Plus Preferred Drug List (PDL) contains more brand name drugs than the Regular Basic PDL. These differences could lead to higher rates of brand use for HIP Plus members.

However, this trend may be mitigated by Indiana laws requiring generic substitution, as set out by statute at Indiana Code (IC) 16-42-22-10. Brand name drugs can be dispensed if 1) generics are not available, 2) Indiana Medicaid determined the brand name drug is less costly or 3) the member's physician provides a medical reason for prescribing the brand. (If the member or their practitioner feels a brand-name drug is medically necessary, the practitioner can request the drug using the Prior Authorization process.[109])

Most importantly, taken together, these policies suggest that a comparison of the use of generic drugs between HIP Plus and HIP Basic may not reveal any differences in cost-conscious behavior. Rather, any differences could reflect 1) the circumstances of members' prescriptions—of the drugs prescribed (e.g., availability and cost of brand) and of the member and their doctor (e.g., whether the doctor thinks there is a medical reason the member should take the brand) or 2) differences in benefits between the two plans, specifically differences in co-pays and PDLs.

Table 2.2.4 below compares use of generics for exclusively HIP Plus members (n=231,826) and exclusively HIP Basic members (n=126,275). Generic fill rates represent the number of generic scripts divided by the total number of scripts, brand fill rates represent the number of brand scripts divided by the total number of scripts.[110] 'Brand fill rates when generic is available' represent instances in which a brand was dispensed, but a generic exists. HIP Basic enrollees have slightly higher generic fill rates (as well as lower total brand fill rates, and brand fill rates when a generic is available) compared to HIP Plus enrollees, across all income levels. As explained above, this is likely due to the higher co-pays for brand drugs for HIP Basic members, or to differences in the circumstances of HIP Plus members' versus HIP Basic members prescriptions. For both Plus and Basic, the generic fill rates are comparable to national Medicaid rates.[111]

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[109] Indiana Medicaid for Members; Covered Medications. Retrieved June 3, 2016 from http://member.indianamedicaid.com/programs--benefits/medicaid-programs/pharmacy/covered-medications.aspx

[110] Whether a drug is generic or brand is determined using an indicator in the claims data, provided by Indiana's Medispan database.

[111] Brian Bruen and Katherine Young (2014). "What Drives Spending and Utilization on Medicaid Drug Benefits in States?" Retrieved June 3, 2016 from http://kff.org/report-section/what-drives-spending-and-utilization-on-medicaid-drug-benefits-in-states-issue-brief/

Table 2.2.4: Generic fill rates and brand fill rates when generics are available, HIP Plus vs HIP Basic

Plan	Generic fill rate	Brand fill rate	
		Total	When generic is available
HIP Basic	84.3%	15.7%	0.2%
HIP Plus	82.0%	18.0%	0.4%

Source: Claims data from FSSA.

Adherence to Prescription Drugs

Prescription drug adherence was compared by drug category, for HIP Plus and HIP Basic enrollees. Adherence is measured using a standard pharmaceutical measure called 'percent days covered,' which shows the percentage of days when the recipient had possession of the medication divided by the days in the period. For example, a member who has a 90-day supply in a 180-day period is 50 percent adherent. For this calculation, long-term adherent is defined as rates of 75 percent days covered or greater, consistent with HEDIS standards.

This analysis was limited to members with at least six months of enrollment following the first date in the period when a drug was dispensed, with no more than one gap (of up to 45 days) in enrollment, consistent with HEDIS continuous enrollment criteria. Adherence is measured by drug class, so the analysis was also limited to members who filled a prescription in the relevant drug classes. The drug classes and the drugs, specifically the National Drug Codes (NDCs) included within each class, are based on HEDIS specifications.[112] The following drug classes were included in the analysis: angiotensin converting enzyme (ACE) inhibitors and angiotensin-receptor blockers (ARBs), Attention-Deficit/Hyperactivity Disorder (ADHD) medications, anti-asthmatics, anti-depressants, anti-psychotics, Rheumatoid Arthritis medications, beta-blockers, bronchodilators, and statins.

Across all drug categories, the exclusively HIP Plus members who filled at least one prescription (n=36,958) demonstrated greater adherence (84.0 percent) than the exclusively HIP Basic members who filled at least one prescription (67.1 percent) (n=6,456). Benefit design may have contributed to differences. HIP Plus members can obtain a 90-day supply of maintenance drugs compared to a 30-day limit under HIP Basic, meaning HIP Basic patients have to return to the pharmacy for their refills every four weeks, whereas HIP Plus members must return every three *months* for refills. HIP Plus members can also receive mail order drugs, for which patients do not need to request a refill. Greater drug adherence may be associated with cost conscious behavior, but further analysis with a larger population is necessary before conclusions can be drawn.

[112] The NDC code lists used are based on the 2015 HEDIS specifications. Source: HEDIS 2015 Final NDC Lists. Retrieved June 6, 2016 from http://www.ncqa.org/hedis-quality-measurement/hedis-measures/hedis-2015/hedis-2015-ndc-license/hedis-2015-final-ndc-lists.

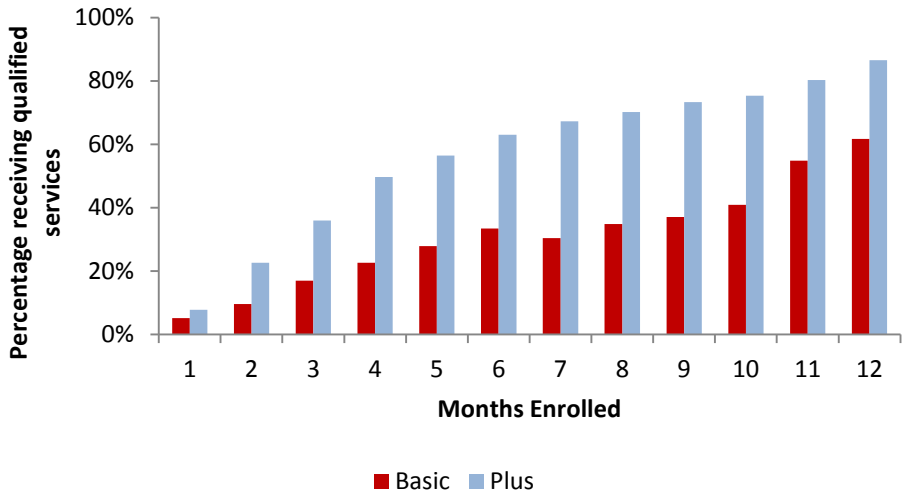
Completion of Qualifying Preventive Services

HIP Plus and HIP Basic members receive rollover benefits for receiving at least one qualifying preventive service. HIP Plus members can double their rollover amount if they receive at least one qualifying service (and have money leftover in the POWER Account), thereby reducing or eliminating future contributions. HIP Basic members are eligible for rollover if they receive at least one qualifying service, and can reduce future contributions for HIP Plus by up to 50 percent (if they move to HIP Plus).[113]

Members have a full 12 months to obtain a preventive service to qualify for rollover. As many members in HIP 2.0 have not yet reached 12 months of enrollment in the data available for this evaluation, the preventive service results are presented by the total number of months members were enrolled.

Exhibit 2.2.1 shows the percentage of HIP Plus and HIP Basic members who received a qualifying preventive care service (the discussion in Goal 3 provides more detail on what distinguishes a "qualifying" preventive care service) by number of months enrolled in the program. For this analysis, any members transitioning between HIP Plus and HIP Basic were excluded because these members are subject to different incentives than exclusively HIP Plus or HIP Basic members. HIP Plus members exhibit higher rates of preventive services at all durations of enrollment. For those enrolled during the full first demonstration year, about 86.5 percent of HIP Plus members compared to 61.7 percent of HIP Basic members received at least one qualifying preventive care service.

Exhibit 2.2.1: Percentage of members receiving at least 1 qualifying service, HIP Plus vs HIP Basic, by duration of enrollment



Source: Claims data from FSSA. These counts exclude any members who transitioned between Plus and Basic over the course of the demonstration year.

[113] For more detail on preventive service use and rollover calculations, see Goal 3.

Primary Care and Specialty Care Use for Members with Chronic Diseases

Table 2.2.5 below shows rates of primary and specialty care use for members with chronic diseases in the exclusively HIP Plus group (n=231,826) and exclusively HIP Basic group (n=126,275).HIP 2.0 members use more specialty care than primary care, whether in Plus or Basic. Plus members are more likely to use specialty care and primary care than Basic members. HIP Plus members are 57 percent more likely to use *specialty* care, but 82 percent more likely to use *primary* care. This difference is smaller for members with at least one disease: Plus members are 8 percent more likely to use specialty care and 28 percent more likely to use primary care (Plus n=61,525, Basic n=18,294).

Table 2.2.5: Percent of members with chronic diseases, using Primary and Specialty Care, by disease category, for HIP Plus vs. HIP Basic

Disease Category	Basic		Plus	
	Percent of Members using Primary Care	Percent of Members using Specialty Care	Percent of Members using Primary Care	Percent of Members using Specialty Care
All Members (regardless of having a disease)	17.1%	29.7%	31.1%	46.5%
Members with at least one disease below	36.9%	67.5%	47.4%	72.7%
Attention Deficit Hyperactivity Disorder	47.1%	57.6%	49.5%	61.1%
Asthma	45.5%	68.2%	58.2%	78.4%
Bipolar Disorder	40.6%	87.0%	50.8%	91.8%
Coronary Artery Disease	40.6%	84.6%	49.2%	85.0%
Congestive Heart Failure	36.4%	83.0%	46.4%	87.5%
Chronic Kidney Disease	37.6%	82.8%	44.6%	86.1%
Chronic Obstructive Pulmonary Disease	40.4%	75.7%	52.6%	81.3%
Depression	41.4%	71.4%	50.1%	77.9%
Diabetes	43.3%	61.9%	50.3%	68.5%
Rheumatoid Arthritis	58.8%	82.5%	66.6%	80.2%
Substance Abuse	28.8%	72.1%	37.4%	77.6%
Schizophrenia	29.3%	84.5%	38.8%	90.7%
Other Severe and Persistent Mental Illness	39.8%	90.1%	47.4%	95.4%

Source: Claims data from FSSA. We excluded results for autism from the table because of low member counts.

Research Question 2.2.2: Do HIP Plus members ask about the cost of care before receiving the care?

The HIP Plus survey asked all members, "When you need treatment from a doctor or other health professional, do you ask how much the treatment will cost?" 'Cost' could theoretically refer to any type of cost for the member: spending of POWER Account funds or other out-of-pocket costs. However, because HIP Plus members should not incur any out-of-pocket costs (except for co-pays for non-emergency use of the ED) if a HIP Plus member is asked about the 'cost of care,' cost likely refers to POWER Account spending.

In total, approximately 27 percent of HIP Plus members reported asking about the cost of care (see ***Table 2.2.6***).

Table 2.2.6: Percentage of HIP Plus members asking about the cost of care, by income

Federal Poverty Level	Members Surveyed	Percentage indicating asking about cost of care
All Income Levels	420	27%
Less than 100%	351	27%
100% or greater	69	31%

Source: Current member survey.

Research Question 2.2.3: Do HIP Plus members ever resist getting needed care because of the cost of that care?

One of the risks of encouraging members to be more cost-conscious is that members will forego needed care. There is not adequate data to use claims for this analysis. The *current member survey* asked members whether they had missed any appointments in the past six months. HIP Basic members reported higher rates of missed appointments (23 percent) compared to HIP Plus members (18 percent). Members who indicated that they had missed an appointment were asked to provide a reason for missing the appointment. Plus and Basic members demonstrated similar rates: about two percent of HIP Basic members reported that they had missed an appointment in the past 6 months because of cost, compared to about one percent of HIP Plus members.

Research Question 2.2.4: Are HIP Plus members less likely to reach the 5 percent of household income limit (threshold) on out-of-pocket costs?

Per federal regulation 42 CFR 447.78, HIP members do not pay more than five percent of their household income in a given benefit quarter towards HIP cost sharing requirements.[114] This limit is often referred to as the "5 percent threshold" and includes all payments by the member or his/her family members for the following:

- Monthly contributions
- Co-pays
- Children's Health Insurance Program (CHIP) premiums

Members who meet the threshold on a quarterly basis will have their cost-sharing responsibilities eliminated for the remainder of the quarter, members will no longer be responsible for co-pays, and HIP Plus members will have a PAC amount of $1 (the minimum) for the remainder of the quarter.

The Final Evaluation Report will include an analysis of this element of the program.

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[114] Benefit quarters are defined as every three months of coverage beginning on the member's first effective date.

Hypothesis 2.3: HIP's (i) graduated co-payments required for non-emergency use of the emergency department (ED), (ii) the ED prior authorization process, and (iii) efforts to expand access to other urgent care settings will together effectively deter inappropriate ED utilization without harming beneficiary health. The graduated co-payment structure for non-emergency use of the emergency department will decrease inappropriate ED utilization without harming beneficiary health. The prior authorization process for hospital emergency department use and efforts to expand access to other urgent care settings will decrease inappropriate ED without harming beneficiary health.

Hypothesis 2.3 focuses on the effect of HIP policies intended to reduce inappropriate ED utilization among HIP members.

Three research questions are included in the Final Evaluation Plan for this hypothesis:

1. What is the rate of non-emergency use of the ED among individuals in the no-co-pay group vs. the graduated co-pay group?
2. What portion of individuals calling the Nurse Hotline are recommended to go to the ED and what portion of individuals use the ED in spite of the Nurse Hotline advising a different course of action?
3. What portion of individuals are accessing urgent care settings outside of the ED?

Each research question corresponds to a HIP policy aimed at deterring ED use.

Research Question 2.3.1: What is the rate of non-emergency use of the ED among individuals in the control group vs. the graduated co-pay group?

As decribed earlier (see discussion of Goal 2.2.1), to discourage non-emergency use of the emergency department (ED), the state established graduated co-payments for non-emergency use of the ED: $8 for the first non-emergency visit and $25 for each subsequent visit within the same 12 month benefit period. The co-pay cannot be paid through the member's POWER Account. All HIP members in the Regular and State Basic and Plus plans, except pregnant women and Native Americans, are subject to the co-pay.

To test if applying a $25 co-payment for subsequent ED visits impacts member utilization when compared to a flat $8 co-payment, the state selected a control group that is not subject to the $25 ED co-payment. The control group represents a random sample of 5,000 HIP members who will only have the $8 co-pay obligation, regardless of the number of non-emergency ED visits. The state received approval of the ED co-payment protocol on February 4, 2016; the MCEs are currently working to identify members to be part of the control group.[115] Results will be presented in the Final Evaluation Report.

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[115] HIP 2.0 ER Co-Payment Protocol. (2015, May 1). Retrieved June 27, 2016 from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-er-copay-protocol.pdf.

Research Question 2.3.2: What portion of individuals calling the Nurse Hotline are recommended to go to the ED and what portion of individuals use the ED in spite of the Nurse Hotline advising a different course of action?

HIP 2.0 required each MCE to establish a 24 hour Nurse Hotline to serve as a prior authorization process. Any member who calls the nurse line prior to going to the ED will have their co-payment waived. Members do not have to receive authorization to have the co-pay waived; if they call the hotline prior to visiting the ED, regardless of whether the nurse hotline advised the member to go to the ED, the co-pay is waived.

The MCEs and the state are finalizing the nurse hotline data. The analysis of the effectiveness of the nurse hotline will be included in the Final Evaluation Report.

Research Question 2.3.3: What portion of individuals are accessing urgent care settings outside of the ED?

In conjunction with ED co-pay policies, Indiana is working to expand access to other urgent care settings as an alternative to the ED. MCEs are required to develop urgent care networks and are encouraged to include nontraditional urgent care providers, like retail clinics, in their networks.

In ***Table 2.3.1*** below, data on urgent care utilization is presented. Urgent care locations are defined by their place of service listed in the claims data; however, the data does not allow for inclusion of *alternative* urgent care locations, such as drug store or supermarket walk-in clinics. Therefore, these estimates may under-report use of urgent care.[116] Overall, since the start of HIP 2.0, 5.2 percent of members had an urgent care visit, 6.0 percent of HIP Plus members and 2.6 percent of HIP Basic members.

Table 2.3.1: Urgent Care Utilization, by plan type

	All HIP 2.0	Basic	Plus
Total members	407,746	175,920	281,471
Total number of unique members with urgent care visits	21,178	4,612	16,873
Percent of unique members with urgent care visits	5.2%	2.6%	6.0%
Total number of urgent care visits	34,167	6,971	27,196
Visits to urgent care centers (per 1000 members per year)	127.1	77.7	151.8

Source: Claims data from FSSA. Note that some members will be in both Plus and Basic during the year. In these estimates, they are counted in both the Plus and Basic programs. Hence, the number of members for Plus and Basic will be greater than the number of all members.

[116] Consistent with CMS' definition of urgent care, all claims with a place of service equal to 20 are included in this analysis. Alternative urgent care locations, such as retail clinics, are not categorized with a place of service equal to 20, therefore these locations are not included in the analysis. (Unfortunately, there is no mechanism other than a text search of a provider name to identify these types of clinics.)

Summary

HIP 2.0 seeks to encourage prudent management of POWER Account funds and to promote responsibility for personal health. In order to achieve these objectives, HIP 2.0 has several incentives to encourage member compliance with required contributions and judicious use of healthcare services. For instance, depending on income level, members are either subject to a six-month disenrollment period or are transferred to the Basic plan if they fail to make a required PAC payment. There is also the potential to decrease future PAC requirements by rolling over funds left over in the POWER Account from the previous enrollment year.

According to a current member survey, 60 percent of the respondents reported hearing of the HIP POWER Account. The proportion was higher for members required to make PACs, i.e., Plus members (66 percent). About 72 percent of HIP Plus members and 76 percent of HIP Basic members who reported hearing of the POWER Account also reported having one. Among members who reported having a POWER Account, 40 percent of HIP Plus and 30 percent of HIP Basic members reported checking their POWER Account balance monthly. A previous survey of members in HIP 1.0, which also required PACs, also asked about POWER Account awareness. In that survey, which was conducted after the HIP 1.0 program had been implemented for several years, 77 percent of respondents reported hearing about the POWER Account. At the time of the HIP 2.0 survey, many members had only been in the program for a few months, which may explain some of the difference.

Despite relatively low levels of POWER Account awareness and monitoring, this analysis finds very high compliance with PAC payments at all income levels. Also a large majority of Plus members surveyed indicated that they were aware that if they did not make payments they would be disenrolled from the program or required to make co-payments.

Drawing on data from the *current member survey*, a majority of surveyed HIP 2.0 members were also not aware of the HIP policy that they could get no-cost preventive care; however, a majority of members have used such services. The lack of awareness of preventive care coverage is not unique to HIP 2.0. Previous surveys of commercial populations and HIP 1.0 members have found similarly large proportions of members with a lack of awareness about rules for coverage regarding preventive services.

Data from the *provider survey* suggest that providers were largely aware of and in compliance with policies regarding charging co-payments to Basic members. This is critical, since if co-payments are not appropriately charged for the Basic plan members, then PAC payments for Plus membership will appear disproportionately burdensome.

In exploring if health status and utilization varies among members by whether they make a PAC payment or not, as well as by income, exclusively Plus members with incomes up to the FPL were more likely to have physical and/or behavioral health conditions compared to the exclusively Plus members above the FPL, exclusively Basic members, and the Plus to Basic switchers. Utilization was also generally higher for the lower income Plus members. It appears that those with an option to move to Basic were strategically choosing Plus. Basic members were generally the lowest utilizers of care, with the exception of emergency services. Exclusively Basic members show higher rates of ED use overall, as well as for non-emergency use of the ED. In addition, HIP Plus members demonstrated greater medication adherence (84.0

percent) than HIP Basic members (67.1 percent). This may be due to differential prescription drug benefits in Plus compared to Basic (including coverage for longer day supplies and mail order drugs), as well as greater need and use of care by Plus members.

Cost did not appear to be a major barrier to care in data available for this evaluation. Approximately 27 percent of HIP Plus members surveyed reported asking about the cost of care. About one percent of Plus members and two percent of Basic members reported missing appointments due to cost.

Goal 3: Promote Disease Prevention and Health Promotion to Achieve Better Health Outcomes

The HIP 2.0 program includes incentives for members to use healthcare appropriately—with a specific focus on increasing the use of preventive care. These incentives aim to help achieve better outcomes for its members. In this section, we focus on the trends of preventive care use for all members ever-enrolled in HIP 2.0 during the first demonstration year.

Hypothesis 3.1: HIP Will Effectively Promote Member Use of Preventive, Primary, and Chronic Disease Management Care to Achieve Improved Health Outcomes.

There are two related research questions associated with this hypothesis:

> ***Research Question 3.1: How do primary care, chronic disease management, and preventive care utilization vary among HIP members?***
>
> ***Research Question 3.2: How does primary care, chronic disease management, and preventive care utilization vary by population age, gender, benefit plan, FPL, etc.?***

The second research question adds on sub-group analyses to the first. Hence, similar measures are utilized for each and both questions will be addressed together throughout this section. The measures and methods, as with the other goal analyses, are based on those outlined in the Final Evaluation Plan.

Background

As described in ***Table 3*** of the Program Overview section above, Plus and Basic members face different incentives to use healthcare, particularly preventive care, more wisely. For both Basic and Plus members, preventive services are exempt from PAC funds and member co-payments, and both Basic and Plus members can potentially reduce the amount of future contributions if they receive recommended preventive services. In addition, because both Basic and Plus members are potentially eligible to rollover their share of unused POWER Account funds, both groups have an incentive to use healthcare judiciously. Plus members may have more of an incentive because they make contributions to the POWER Account and would have the ability to rollover a greater amount of any unused POWER Account funds.

Qualifying Preventive Services Exempt from PAC Funds and Eligible for Fulfilling the Rollover Incentive

Each HIP 2.0 member is enrolled in a managed care entity (MCE). Each member is assigned a PMP to help her or him navigate their healthcare needs. The MCEs are also required to educate members about recommended preventive services and the recommended frequencies. In practice, the PMPs are supposed to consult and recommend preventive services specific to each member's risk factors and other circumstances.

Preventive services are exempt from PAC funds and can also qualify members for a PAC rollover. Although PMPs recommend specific preventive services to their members, MCEs cannot omit or limit credit towards the member's rollover incentive for services based on age or risk factor guidelines.

For the analyses, qualifying preventive care services (for both the rollover and from exclusion of PAC funding) were identified according to the list of Current Procedure Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) indicated by the *Hoosier Healthwise and Healthy Indiana Plan MCE Policies and Procedures Manual*.[117] Procedural codes for vision and dental services were added to this list to reflect the state's policy decision to add vision and dental services to the list of qualifying preventive services. However, it is important to note that HIP benefit packages in regards to vision and dental coverage did not change. Including these codes increased the overall percentage of preventive care users by about five percent; the relative proportions across plan types (i.e., Plus and Basic) and other cohorts remained similar.

Based on the rules for meeting the rollover criteria, no restrictions are placed on where the services need to be provided or which provider needs to deliver the services to the patient. In addition, there were no restrictions based on member circumstances, including diagnoses, age or gender. As long as one service from the list appeared on any of a member's billed claims, the member would be considered as qualifying for the rollover.

Research Question Findings

Before discussing the results, it is important to note some limitations to the analysis in terms of being able to identify members that have received a qualifying preventive care visit.

- Members have a full 12 months to obtain the requisite service for the rollover incentive (Note that estimates of HIP 1.0 members achieving the rollover would have been based on those meeting the 12 months criteria). As the HIP 2.0 program started in February 2015, many members did not have a full 12 months of experience.
- Medicaid generally tends to have relatively high turnover, further limiting the number of members enrolled for a full 12 months.
- Claims data were extracted in May 2016. Typically, the billing process can take several months to complete. This lag in billing processing may lead to underreporting of healthcare utilization. For the Final Evaluation Report, data will be available directly from MCEs on which members qualify for the rollover, as well as the amounts of the rollovers.

Based on the data received to date, about 36 percent of members were enrolled for six months or less between February 2015 through January 2016 (the first demonstration year). ***Exhibit 3.1.1*** shows the percentage of members who received at least one qualifying preventive care service based on the number of months enrolled in HIP 2.0. As expected, those with more months of

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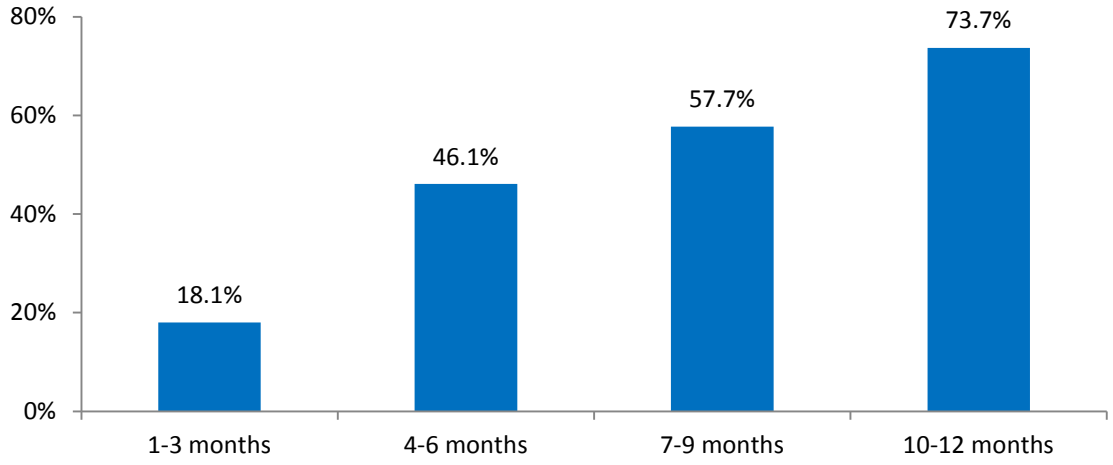
[117] The list of qualifying services is found here: Hoosier Healthwise and Healthy Indiana Plan MCE Policies and Procedures Manual. (2016, May 10). Retrieved May 23, 2016, from http://www.indianamedicaid.com/ihcp/HoosierHealthwise/content/MCO_QA/Hoosier%20Healthwise%20and%20HIP%20MCE%20Policies%20and%20Procedures%20Manual%20MC10009.pdf. Note however, that the way that qualifying services are counted for purposes of meeting the rollover criteria has been updated since this publication, which is reflected in this analysis. Specifically, the following dental and vision procedure codes were added to the list of qualifying preventive services: D0120, D0150, D0160, D1110, 92002, 92004, 92012, and 92014. Also, there are no requirements for any of the procedural codes to be accompanied by a diagnosis code on the claims in order to qualify for the rollover.

enrollment had a greater likelihood of receiving a qualifying preventive care service, ranging from 18.1 percent for members with no more than three months of enrollment to about 73.7 percent for members with ten or more months of enrollment.

Exhibit 3.1.1: Percentage of HIP 2.0 Members Receiving Qualifying Preventive Care Services based on number of Months of Enrollment: February 2015 – January 2016



Source: Claims data from FSSA.

Only 25 percent of members enrolled during the first demonstration year (105,361 members) were enrolled for a full 12 months. About three-quarters of these members (75.9 percent) received a qualifying preventive care service according to the available claims data.

Table 3.1.1 compares the percentage of HIP Plus and HIP Basic members who would be expected to meet the PAC rollover criteria based on preventive care utilization exhibited in the claims analysis. Note that these and the subsequent estimates are based on all members enrolled at some point between February 2015 through January 2016. Hence, these estimates would likely increase substantially as members accrue more months of HIP 2.0 experience (as discussed above). As expected, a greater proportion of HIP Plus members received preventive care during the first demonstration year (64.1 percent compared to 45.0 percent).

Table 3.1.1: Percentage of Members Receiving Qualifying Preventive Care Services, Plus and Basic: February 2015 – January 2016

HIP 2.0 Members	Number of Members	Number of Members who Received Qualifying Preventive Care	Percent of Members who Received Qualifying Preventive Care
All Members who were in **Plus** at Any Point in the Year	281,471	180,472	64.1%
All Members who were in **Basic** at Any Point in the Year	175,920	79,073	45.0%
All Members who were considered **Medically Frail** at Any Point in the Year	50,464	41,451	82.1%

Source: Claims data from FSSA. Note that some members will be in both Plus and Basic during the year. In these estimates, they are counted in both the Plus and Basic programs.

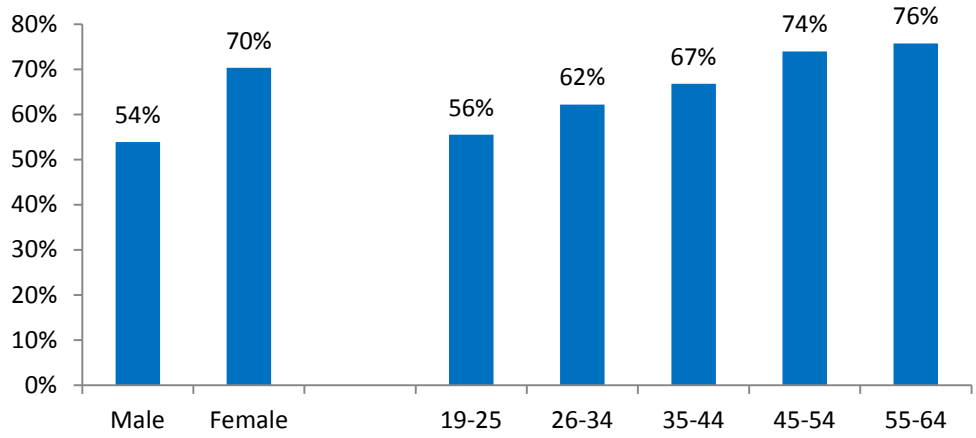
Table 3.1.1 also displays the percentage of medically frail members who have received at least one qualifying preventive care service. The percentage is substantially higher for medically frail than for the general HIP 2.0 population, whether enrolled in Plus or Basic. Given the eligibility criteria for medically frail, it is not surprising that they use more preventative care services, as it is likely they are using more healthcare and require more care management in general.

Comparison of Preventive Care Use by Age and Gender

Exhibit 3.1.2 displays the percentage of HIP 2.0 members who received a qualifying preventive care service by age and gender categories. For these and proceeding estimates (unless otherwise noted), the percentages are weighted by the number of months a member was in a given category.

Females are more likely than males to utilize preventive care (70 percent compared to 54 percent). The percentage of members who utilize preventive care also increases with age, ranging from 56 percent for 19 to 25 year-olds to 76 percent for 55 to 64 year-olds.

Exhibit 3.1.2: Percentage of HIP 2.0 Members by Gender and Age Receiving Qualifying Preventive Care Services: February 2015 – January 2016



Source: Claims data from FSSA. Note that some members can have different ages at different points in time during enrollment. The percentages are based on the number of months each member was in a given category.

Table 3.1.2 displays the percentage of members who received a qualifying preventive care service by age and gender categories for HIP Plus and HIP Basic. The proportion of males who used preventive care services almost doubles in HIP Basic and increases by about 57 percent in HIP Plus when comparing the youngest to the oldest age groups. While the proportion of females is higher than that of males at all age groups for both HIP Plus and HIP Basic, the differences across ages are not as pronounced. In fact, the proportions remain relatively steady across age groups in HIP Basic, ranging from 50 percent to 58 percent. In general, these age and gender trends are similar to those found in the HIP 1.0 population from 2010 through 2013, with females being more likely to use preventive care than males; the proportion of members using

preventive care increasing with age, and the proportion of members using preventive care increasing more with age for males than females.[118]

Table 3.1.2: Percentage of Members by Gender and Age Receiving Qualifying Preventive Care Services, Plus and Basic: February 2015 – January 2016

Gender	19-25	26-34	35-44	45-54	55-64
Plus Members					
Total	65%	70%	75%	79%	79%
Male	47%	54%	64%	73%	74%
Female	72%	76%	80%	84%	83%
Basic Members					
Total	45%	50%	50%	50%	45%
Male	21%	28%	36%	41%	41%
Female	53%	56%	56%	58%	50%

Source: Claims data from FSSA. Note that some members will be in both Plus and Basic during the year and some will only be enrolled for part of the year in total. Additionally members can have different ages at different points in time during enrollment. The percentages are based on the number of months each member was in a given category during the year.

Comparison of Preventive Care Use by Income

Exhibit 3.1.3 displays the percentage of members who received qualifying preventive care services by federal poverty level (FPL) and gender categories. Members with income above 100 percent of the FPL in HIP Plus may face being disenrolled from the HIP 2.0 program for six months if they do not make their required PAC, whereas members with income below 100 percent of the FPL can generally transition into HIP Basic if they do not make their required PACs. Hence, we compared the differences between those members with incomes below 100 percent of the FPL and those members with incomes above 100 percent of the FPL.

The proportions of preventive care use are relatively similar across income categories. However, there is a consistent trend that those below poverty have a slightly higher likelihood of utilizing at least one preventive care service whether in HIP Plus or HIP Basic, or when comparing males to females.[119] This pattern may be reflective of lower income members having a greater need for healthcare as they are shown to have larger risk scores (i.e., based on the prevalence of chronic conditions) compared to those with income above the poverty level (see ***Table 3.1.7***).

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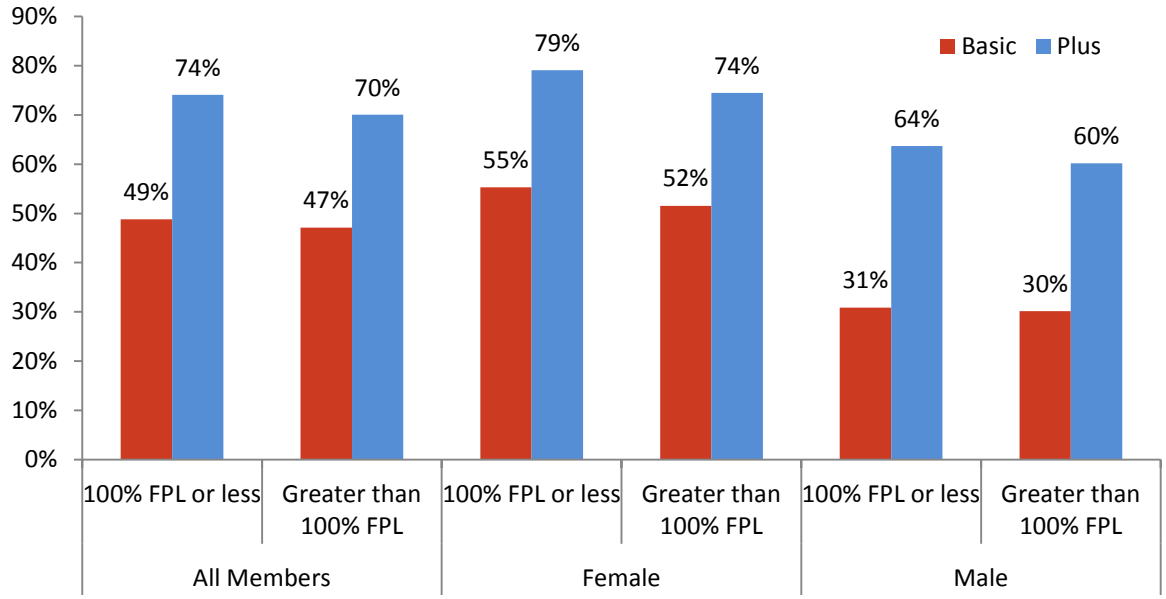
[118] Healthy Indiana Plan, Section 1115 Demonstration, Project Number: 11-W-00237/5, 2013 Annual Report and Interim Evaluation Report. (2014, October).

[119] Note, that there are not many members above the poverty level in Basic, as they are generally only eligible for Plus. Indiana residents with income above 100 percent of the FPL are not eligible for the Basic program, with the exception of Transitional Medical Assistance participants.

Exhibit 3.1.3: Percentage of Members by FPL Receiving Qualifying Preventive Care Services, Plus and Basic: February 2015 – January 2016



Source: Claims data from FSSA. Note, some members will be in both Plus and Basic during the year and some will only be enrolled for part of the year in total. Additionally members can have different FPLs at different points in time during enrollment. The percentages are based on the number of months each member was in a given category.

Utilization of Preventative and Primary Care Services

Table 3.1.3 displays utilization of primary and specialty care visits, as well as preventive care services for HIP Plus and HIP Basic members. As discussed above, a greater proportion of Plus members use preventive care relative to Basic members. The HIP Plus population is also about twice as likely to use primary care; 31 percent of HIP Plus members used primary care compared to 16 percent of HIP Basic members. A greater proportion of HIP Plus members also use specialty care (46 percent compared to 28 percent). HIP Plus members also exhibit greater rates of use of primary, specialty and preventive care, whether looking at a per user or per 1,000 member year basis. As discussed earlier, Plus members also exhibited lower rates of ED use, including non-emergent ED use (see discussion of Goal 2 results).

Table 3.1.3: Primary, Specialty and Preventive Care Utilization, Plus and Basic Members: February 2015 – January 2016

Utilization Statistic	Plus			Basic		
	Primary Care Visits	Specialty Care Visits	Preventive Care Services	Primary Care Visits	Specialty Care Visits	Preventive Care Services
Total Members	281,471	281,471	281,471	175,920	175,920	175,920
Total number of unique Members who used the Service/Visit	86,888	128,637	180,472	27,771	48,608	79,073
Percent of unique Members who used the Service/Visit	31%	46%	64%	16%	28%	45%

Utilization Statistic	Plus			Basic		
	Primary Care Visits	Specialty Care Visits	Preventive Care Services	Primary Care Visits	Specialty Care Visits	Preventive Care Services
Total Number of Services/Visits Used	231,198	579,123	961,890	58,210	155,591	274,948
Average Services/Visits used (by those who used a service)	2.66	4.50	5.33	2.10	3.20	3.48
Services/Visits Used per 1,000 HIP 2.0 Member Years	1,290	3,232	5,369	649	1,734	3,064

Source: Claims data from FSSA. Note that the calculations of member years takes into account the number of months each member was enrolled in Plus and Basic.

Enrollment in Chronic Disease Management Programs

Managed care entities (MCEs) provide disease management programs to their members, varying by the type of condition. The state requires each MCE to provide several different disease management programs. These programs are expected to be multidisciplinary, continuum-based approaches to healthcare delivery that proactively identify members with, or at least at risk for, chronic medical conditions. The programs are also expected to emphasize the prevention of exacerbation and complications using cost-effective, evidence-based practice guidelines and patient empowerment strategies such as self-management.

Table 3.1.4 displays member participation in several disease management programs required by the state, for each MCE. The MCEs may also provide similar services for other conditions at their discretion. This data is supplied directly from the MCEs to the state, and is reported for the calendar year. Thus, there are two months of HIP 1.0 experience included in the estimates. Future evaluations will aim to report HIP 2.0 only estimates.

The potential candidates for each program are identified by MCEs through various means such as Health Needs Screenings or predictive modeling. Members may also self-refer for a program.

Table 3.1.4: Total Ever Enrolled in Disease Management Programs by MCE: 2015

Program	Anthem	MHS	MDwise
Physical Health			
All Conditions of Interest Combined	49,085	24,472	42,047
Asthma	9,277	4,699	17,051
Diabetes	10,410	5,520	12,381
Pregnancy	3,850	9,447	16,110
Chronic Obstructive Pulmonary Disease	3,112	2,269	17,494
Coronary Artery Disease	2,904	1,490	962
Congestive Heart Failure	1,270	407	1,433
Chronic Kidney Disease	1,206	220	54

Program	Anthem	MHS	MDwise
Behavioral Health			
All Conditions of Interest Combined	19,489	24,136	14,020
Depression	12,430	22,954	13,268
ADHD	569	360	980
Autism/Pervasive Developmental Disorder	21	55	22

Source: MCE data..

Table 3.1.5a and ***Table 3.1.5b*** provide information on preventive and primary care use by HIP 2.0 Plus and Basic members with specific conditions, related to those for which the MCEs typically provide disease management support. For this analysis, members are identified with each of the diseases using diagnosis codes on the claims data.[120] For each condition, there appear to be more people enrolled in the relevant disease management program than are identified in the claims as having that disease. This may be indicative of the way the MCEs reported the data (i.e., including two months of data prior to the start of HIP 2.0). It is also possible that some patients are not getting all relevant diagnoses coded on their billed claims (particularly since this is the first year of the program) and that there is fairly aggressive outreach for these programs.

In total, the prevalence rates (according to the claims data) for the various diseases are greater in HIP Plus than HIP Basic. Over one-quarter of HIP Plus members (***Table 3.1.5a***) have at least one of the conditions listed in the table, compared to 17.8 percent for HIP Basic members (***Table 3.1.5b***).

Table 3.1.5a: Preventive and Primary Care Utilization by Specific Disease Category, Plus Members: February 2015 – January 2016

Disease Category	Total Members with Disease	Percent of Members with Disease	Preventive Care Services for Those with Disease		Primary Care Visits for Those with Disease		
			Unique Members using Preventive Care	Percent of Members using Preventive Care	Unique Members using Primary Care	Percent of Members using Primary Care	Primary Care Visits Used per 1,000 Member Months
All Members (regardless of having a disease)	281,471		180,472	64%	86,888	31%	1,290
Members with at least one disease below	73,591	26.2%	61,592	84%	34,336	47%	1,641
Diabetes	21,120	7.5%	19,263	91%	10,536	50%	2,329
Congestive Heart Failure	1,766	0.6%	1,553	88%	814	46%	2,440

[120] The specifications for identifying members with specific conditions are generally based on Agency for Healthcare Research and Quality or Healthcare Effectiveness Data and Information Set measure specifications using primary diagnosis codes on any claim for the member.

Disease Category	Total Members with Disease	Percent of Members with Disease	Preventive Care Services for Those with Disease		Primary Care Visits for Those with Disease		
			Unique Members using Preventive Care	Percent of Members using Preventive Care	Unique Members using Primary Care	Percent of Members using Primary Care	Primary Care Visits Used per 1,000 Member Months
Coronary Artery Disease	5,022	1.8%	4,430	88%	2,467	49%	2,282
Asthma	5,893	2.1%	5,268	89%	3,271	56%	2,515
Chronic Obstructive Pulmonary Disease	12,673	4.5%	11,197	88%	6,573	52%	2,456
Chronic Kidney Disease	508	0.2%	452	89%	231	45%	2,570
Autism	108	<0.1%	75	69%	43	40%	1,484
Depression	26,931	9.6%	22,705	84%	13,282	49%	2,274
Attention Deficit Hyperactivity Disorder	5,789	2.1%	4,509	78%	2,830	49%	2,112
Substance Abuse	12,687	4.5%	9,474	75%	4,647	37%	1,657

Source: Claims data from FSSA. Any member identified in HIP Plus at any point in the first demonstration year is included in these statistics, even if the member switched to HIP Basic. For preventive care, use is counted even if the member only received the relevant services as a HIP Basic member. For primary care, use is only counted based on the months in which the member was enrolled in HIP Plus.

In general, members with one of the specified conditions are more likely to use preventive and primary care, relative to the overall HIP 2.0 population whether in HIP Plus or in HIP Basic. This holds for any of the chronic conditions listed in the tables.

The gap between HIP Plus and HIP Basic in terms of the percentage of members that use preventive care is much less when focusing on members with at least one chronic condition (84 percent in HIP Plus compared to 75 percent in HIP Basic), as opposed to all HIP Plus and HIP Basic members (64 percent compared to 45 percent). Thus, regarding their preventive care use, members in HIP Basic with the diseases listed in the tables look more like HIP Plus members, relative to HIP Basic members without any such diseases. The same can also be said for primary care use.

However, for members with each of the chronic conditions, HIP Plus members are more likely to use a qualifying preventive care service. Also, for all conditions, HIP Plus members are more likely to use primary care and have higher rates of primary care use.

Table 3.1.5b: Preventive and Primary Care Utilization by Specific Disease Category, Basic Members: February 2015 – January 2016

Disease Category	Total Members with Disease	Percent of Members with Disease	Preventive Care Services for Those with Disease		Primary Care Visits for Those with Disease		
			Unique Members using Preventive Care	Percent of Members using Preventive Care	Unique Members using Primary Care	Percent of Members using Primary Care	Primary Care Visits Used per 1,000 Member Months
All Members (regardless of having a disease)	175,920		79,073	45%	27,771	16%	649
Members with at least one disease below	31,351	17.8%	23,394	75%	9,174	29%	1,147
Diabetes	6,035	3.4%	5,339	88%	1,856	31%	1,760
Congestive Heart Failure	586	0.3%	479	82%	172	29%	1,638
Coronary Artery Disease	1,232	0.7%	1,021	83%	370	30%	1,728
Asthma	2,861	1.6%	2,340	82%	950	33%	1,545
Chronic Obstructive Pulmonary Disease	3,500	2.0%	2,829	81%	1,036	30%	1,794
Chronic Kidney Disease	161	0.1%	136	84%	57	35%	2,134
Autism	29	<0.1%	14	48%	12	41%	1,200
Depression	12,258	7.0%	9,399	77%	3,938	32%	1,526
Attention Deficit Hyperactivity Disorder	2,672	1.5%	1,944	73%	957	36%	1,797
Substance Abuse	9,034	5.1%	5,925	66%	2,256	25%	1,064

Source: Claims data from FSSA. Any member identified in HIP Basic at any point in the first demonstration year is included in these statistics, even if the member switched to HIP Plus. For preventive care, use is counted even if the member only received the relevant services as a HIP Plus member. For primary care, use is only counted based on the months in which the member was enrolled in HIP Basic.

Risk Profile of HIP 2.0 Members

To assess the risk profile of HIP 2.0 members, the Chronic Illness and Disability Payment System (CDPS) algorithm was applied to inpatient and outpatient claims records for enrollees with six or more months of enrollment during the first demonstration year. The CDPS is a diagnostic classification system developed to describe different burdens of illness among Medicaid beneficiaries. The CDPS categorizes diagnoses into several major categories, which correspond to body systems or type of diagnosis. For example, the cardiovascular category includes diagnoses such as heart transplant, congestive heart failure, angina, and hypertension. Within a major category, there are subcategories that distinguish diagnoses that are typically associated with higher or lower costs (e.g., heart transplant is in the high subcategory for the cardiovascular group, whereas, congestive heart failure is considered medium, angina is low and hypertension is extra low).

In this analysis, the CDPS data 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.[121]

Again, we see that the prevalence of chronic diseases, even when focusing on members with six months of enrollment, is greater for HIP Plus members than HIP Basic members. Among those enrolled in HIP 2.0 for at least six months during the first demonstration year, the most common chronic conditions classified by the CDPS algorithm were those associated with the psychiatric (22.2 percent), cardiovascular (20.5 percent), skeletal (14.2 percent), and gastrointestinal systems (12.8 percent) (***Table 3.1.6***).

The MRx algorithm identifies 4.8 percent of members who were treated with medications for cardiovascular conditions—these would be members in addition to the 20.5 percent identified with cardiovascular conditions using the CDPS data alone. The largest proportion of members that the MRx algorithm identified were those that filled a prescription for psychosis, bipolar disorder or depression (9.2 percent).

Table 3.1.6: Percent of HIP Enrollees with 6+ months of enrollment with Chronic Conditions

Category	Scored Members (6+ Member Months)			Percent		
	All	Basic	Plus	All	Basic	Plus
CPDS						
Psychiatric	63,490	16,688	46,802	22.2%	16.6%	25.2%
Cardiovascular	58,613	11,739	46,874	20.5%	11.7%	25.3%
Skeletal	40,741	8,767	31,974	14.2%	8.7%	17.2%
Gastrointestinal	36,640	7,388	29,252	12.8%	7.3%	15.8 %
Pulmonary	35,707	9,202	26,505	12.5%	9.1%	14.3%
Diabetes	22,239	3,829	18,410	7.8%	3.8%	9.9%
Substance Abuse	20,931	7,204	13,727	7.3%	7.2%	7.4%
Skin	17,557	5,470	12,087	6.1%	5.4%	6.5%
Nervous System	16,853	3,698	13,155	5.9%	3.7%	7.1%
Pregnancy	13,772	7,174	6,598	4.8%	7.1%	3.6%
Genital	12,377	3,699	8,678	4.3%	3.7%	4.7%
Metabolic	12,075	2,891	9,184	4.2%	2.9%	5.0%
Infectious Disease	8,397	2,081	6,316	2.9%	2.1%	3.4%
Renal	7,245	1,272	5,973	2.5%	1.3%	3.2%
Eye	6,520	506	6,014	2.3%	0.5%	3.2%
Cancer	3,745	489	3,256	1.3%	0.5%	1.8%
Hematological	3,140	771	2,369	1.1%	0.8%	1.3%
Cerebrovascular	964	180	784	0.3%	0.2%	0.4%
Developmental Disability	200	53	147	0.1%	0.1%	0.1%
MRx						
Psychosis/Bipolar/ Depression	26,454	6,366	20,088	9.2%	6.3%	10.8%
Cardiac	13,716	3,115	10,601	4.8%	3.1%	5.7%
Seizure disorders	11,904	2,394	9,510	4.2%	2.4%	5.1%

[121] More information about the CDPS and MRx algorithm is available at: http://cdps.ucsd.edu/

Category	Scored Members (6+ Member Months)			Percent		
	All	Basic	Plus	All	Basic	Plus
Diabetes	3,211	750	2,461	1.1%	0.7%	1.3%
Anti-coagulants	2,628	455	2,173	0.9%	0.5%	1.2%
Malignancies	1,575	250	1,325	0.6%	0.2%	0.7%
Parkinsons / Tremor	1,097	213	884	0.4%	0.2%	0.5%
Inflammatory /Autoimmune	586	117	469	0.2%	0.1%	0.3%
HIV	204	71	133	0.1%	0.1%	0.1%
Infections, high	236	51	185	0.1%	0.1%	0.1%
ESRD / Renal	3	-	3	0.0%	0.0%	0.0%
Hemophilia/von Willebrands	1	-	1	0.0%	0.0%	0.0%
Hepatitis	86	12	74	0.0%	0.0%	0.0%
Multiple Sclerosis / Paralysis	42	10	32	0.0%	0.0%	0.0%
Tuberculosis	88	19	69	0.0%	0.0%	0.0%

Source: Claims data from FSSA. This includes 286,101 total members who were enrolled for six or more months.

In general, the conditions identified by CDPS and MRx as most prevalent are very similar to those identified as such for the HIP 1.0 population using 2013 data and also focusing on members with at least six months of enrollment.[122] However, the prevalence rates tended to be higher for HIP 1.0. This is likely due to the substantially higher enrollment in HIP 2.0, leading to a relatively healthier population mix.

Approximately 37 percent of HIP 2.0 members (with at least six months of enrollment) had one to two chronic conditions and an additional 24 percent had more than two (numbers not shown in the table). By comparison, in 2013, 41 percent of HIP 1.0 members with at least six months of enrollment had one to two conditions, while 32 percent had more than two.

Table 3.1.7 describes the risk scores obtained by using the combined CDPS and MRx diagnoses categorizations. The risk scores are a summary index of the relative expected medical costs for each member given their identified chronic conditions. The risk score for the HIP 2.0 population as a whole is normalized to 1.000. The average score among all HIP Plus members was 1.149, whereas the average score among HIP Basic members was 0.726 (numbers not shown in table). Hence, HIP Plus members are about 15 percent greater risk than the average HIP 2.0 member and HIP Basic members are about 27 percent lower risk. This helps explain why utilization statistics were substantially higher for HIP Plus members. ***Table 3.1.7*** also shows how risk scores increase substantially for members with more chronic conditions, whether in HIP Plus or HIP Basic.

[122] Healthy Indiana Plan, Section 1115 Demonstration, Project Number: 11-W-00237/5, 2013 Annual Report and Interim Evaluation Report. (2014, October).

Table 3.1.7: Combined MRx and CDPS Risk Score and Number of Conditions Identified, by Enrollee Group

Category	Number of Members	Scored Members (6+ Member Months)	Average Risk Score	Members with no Chronic Conditions	Members with 1-2 Chronic Conditions	Members with 3 or more Chronic Conditions
All Members	407,746	286,101	1.000	0.137	0.830	2.629
Basic						
Female	103,258	73,757	0.747	0.141	0.823	2.492
Male	44,221	26,888	0.666	0.124	0.822	2.704
19-25	44,088	26,843	0.509	0.134	0.835	2.333
26-34	50,529	36,013	0.679	0.135	0.829	2.434
35-44	32,387	23,718	0.839	0.134	0.806	2.538
45-54	14,735	10,308	1.076	0.150	0.816	2.762
55-64	5,582	3,678	1.053	0.149	0.816	2.876
Other	158	85	0.933	0.150	0.826	2.837
At or less than 100% of	140,337	94,556	0.735	0.136	0.826	2.557
Greater than 100% of the	7,142	6,089	0.579	0.137	0.783	2.261
Plus						
Female	171,638	126,270	1.153	0.143	0.827	2.585
Male	88,629	59,186	1.141	0.127	0.848	2.805
19-25	42,227	27,316	0.638	0.132	0.823	2.316
26-34	65,677	46,783	0.890	0.134	0.834	2.441
35-44	60,398	44,604	1.156	0.133	0.828	2.568
45-54	52,777	38,576	1.502	0.151	0.846	2.764
55-64	38,178	27,472	1.582	0.151	0.833	2.842
Other	1,010	705	1.463	0.150	0.860	2.765
At or less than 100% of	220,356	157,700	1.176	0.137	0.838	2.653
Greater than 100% of the	39,911	27,756	0.998	0.138	0.807	2.648

Source: Claims data from FSSA. Note: Scored members had at least six months of HIP enrollment. Risk scores are normalized, using combined CDPS and MRx Risk Scores. Also, concurrent risk scores were used, weighted by HIP Member Months.

Summary

One of the goals for the HIP 2.0 program is to promote disease prevention and health promotion. As part of this effort, several incentives are used in the HIP 2.0 program, particularly for HIP Plus members, to encourage preventive care utilization, such as the potential to decrease future PAC requirements by using preventive care which does not require any patient cost. Members have until the end of their benefit period (a full 12 months) to obtain preventive care and qualify for this incentive. Only 25 percent of members enrolled during the first demonstration year (105,361 members) were enrolled for a full 12 months. Over three-quarters of these members received a qualifying preventive care service according to the available claims data.

When looking at all members enrolled during the first demonstration year, those that were ever-enrolled in HIP Plus were approximately 42 percent more likely to utilize preventive care services than HIP Basic members. This difference is likely at least partially due to differences in benefit design in HIP Plus versus HIP Basic, as the HIP Plus benefit design includes stronger

incentives for members to actively manage their care. The analysis of risk scores also reveals that chronic conditions are more prevalent in HIP Plus than HIP Basic, therefore HIP Plus members may also have a greater need for care. As higher users of care, HIP Plus members may achieve greater value from forgoing co-payments in return for a monthly PAC not to exceed two percent of their income.

Members with chronic conditions were more likely to use preventive and primary care services, for both HIP Plus and HIP Basic plans. Medically frail members also exhibited a relatively high likelihood of obtaining preventive care in comparison to the overall HIP 2.0 population. It would be expected that sicker members be more active users of preventive and primary care.

As expected, females were shown to be more likely to use preventive care, as well as older age groups. In contrast, there was not much difference in preventive care use by income levels.

Goal 4: Promote Private Market Coverage and Family Coverage Options to Reduce Network and Provider Fragmentation within Families

HIP 2.0 builds on the private insurance market by providing premium assistance to low-income families who are offered coverage through employers. Leveraging the existing private market may conserve Medicaid resources while also keeping families enrolled in a single health insurance plan. HIP Employer Benefit Link (HIP Link) Program is an optional program for Indiana residents with household income up to 138 percent of the FPL. Member participation is dependent on their employer's willingness to participate.

The hypothesis of Goal 4 is that HIP Link will increase the proportion of low-income working Indiana adults who are enrolled in Employer Sponsored Insurance (ESI). The rollout of the program began in June 2015 and much of the early work centered on communication with employers, enrolling them in the program, and determining if their insurance plans meet HIP Link criteria. Due to the extended rollout designed to test program operations, there is not sufficient data available to evaluate the program at this time. We plan to report on HIP Link in the final evaluation.

For purposes of this Interim Evaluation Report, background on the HIP Link program, progress towards implementation, and the research questions to be addressed in the Final Evaluation Report is provided.

Background

What is HIP Link and who can join?

- HIP Link is an optional premium assistance program for all HIP eligible individuals age 19 or older who have access to HIP Link qualifying ESI.

What does HIP Link provide?

- HIP Link helps pay a portion of the employee's premium cost for employer group health insurance.
- HIP Link provides enrolled individuals with a HIP Link POWER Account valued at $4,000, which is used to pay for premium amounts and other medical expenses charged to the employee up to $4,000 per year.

What do members have to contribute to HIP Link?

- Like HIP Plus, individuals enrolled in HIP Link will be required to contribute 2 percent of their income towards the cost of their employer-sponsored insurance. Premiums will be deducted from the employee's paycheck as usual, and the state will send the employee reimbursement for the difference between the premium amount and their 2 percent POWER Account contribution on a monthly basis.

HIP Link is one of the two new programs HIP 2.0 introduced to build a connection between healthcare and employment (the other program, Gateway to Work, is discussed in Goal 5). As described in the HIP 2.0 Waiver Application, this connection is grounded in research demonstrating that employed individuals are both physically and mentally healthier, as well as more financially stable.[123,124]

In contrast to the HIP Plus and HIP Basic programs, HIP Link offers employed low-income Indiana residents and their eligible family members a higher-value POWER Account, greater choices in plans, and increased access to providers. Spouses and dependents 19 years of age or older and covered on a HIP Link eligible insurance plan may be eligible to participate as well.

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123 F. M. McKee-Ryan, Z. Song, C. R. Wanberg, and A. J. Kinicki. (2005). Psychological and physical well-being during unemployment: a meta-analytic study. *Journal of Applied Psychology*, 90 (1), 53–76.

124 K. I. Paul, E. Geithner, and K. Moser. (2009). Latent deprivation among people who are employed, unemployed, or out of the labor force. *Journal of Psychology*, 143 (5), 477–491.

The funds available to eligible family members are pooled to help cover the costs of insurance with each member receiving a HIP Link POWER Account valued at $4,000. Gaining insurance in the private market is expected to reduces the risk of churn – moving on and off of Medicaid – should family income rise above 138 percent of the FPL.

HIP Link Program Activities to Date

In June 2015, the HIP Link program implemented an employer portal to receive employer applications for participation, which allowed the state to approve employers and employer health plans that offer HIP Link to their employees. In the first year of implementation, HIP Link enrolled 31 employers. The state initiated a slow rollout with a small set of members ("data users") to test the program and to ensure smooth running operations. The rollout took place in diverse geographic regions and with employers of various sizes and types (e.g., private sector, public sector, schools, and car dealerships). During the testing period, HIP Link staff were in frequent communication with both employers and employees; daily one-on-one contact allowed for feedback which informed program improvements. Based on the findings from this test phase, the state has undertaken some modifications and is seeking CMS authorization to rollout the program more broadly.

According to the state's Annual Report on HIP 2.0 submitted the CMS in April 2016, HIP Link accomplishments to date include:

- The employer approval process began by phone and then extended to include onsite visits, which gives the option to discuss the program with eligible employees and facilitate enrollment.
- Employer plans already approved by the Indiana Department of Insurance as meeting the essential health benefits were posted online as having pre-approved benefits for HIP Link.
- The HIP 2.0 call center has activated a separate phone line for HIP Link tracking all calls to identify areas for improvement. The call center will also be handling employer-related questions regarding the application process.
- Resources have been developed for employers and employees including a detailed handbook and a video tutorial about the program to assist with all aspects of enrollment from the application process to reimbursement.
- Stakeholder engagement has involved outreach and presentations across the state. The state will continue to augment resources to promote the program and bring on new expertise for marketing purposes.

The state has also continued efforts to develop the HIP Link program by submitting a State Plan Amendment, adding benefit standards for employer-sponsored insurance to qualify as HIP Link-eligible. These Alternative Benefit Plan (ABP) standards are only for HIP Link enrollees, therefore ensuring that employers participating in HIP Link are providing comprehensive benefits comparable to a standard ABP.

Future Evaluation of HIP Link

The final evaluation of the HIP 2.0 demonstration will include an evaluation of the efficacy of HIP Link in increasing the proportion of low-income Indiana residents covered by employer-sponsored insurance. To that end, the number of Indiana residents under 138 percent of the FPL covered by employer-sponsored insurance before and after the implementation of the program will be examined. To understand the effects of HIP Link on employers and employees, among other metrics, the number of employers enrolled in HIP Link and the number of employees with an approved HIP Link employer enrolled in HIP Plus or Basic versus their employers' sponsored insurance/HIP Link will be also be included in the Final Evaluation Report.

Goal 5: Provide HIP Members with Opportunities to Seek Job Training and Stable Employment to Reduce Dependence on Public Assistance

Indiana developed the Gateway to Work program in order to assist unemployed individuals and those working fewer than 20 hours a week in securing new or better employment. Research suggests that employed individuals experience better health compared to unemployed individuals,[125] so assisting members to gain access to jobs may, in the long run, be an effective health improvement strategy. The program launched in May 2015, and as such, there is not sufficient data available to date to perform an evaluation of the initiative. The impact of the Gateway to Work program will be assessed in the Final Evaluation Report.

Background

The Gateway to Work program aims to improve health outcomes by encouraging and facilitating individuals to gain employment. Eligible HIP 2.0 members are referred to ResCare,[126] a contractor that provides education and training services. In addition, ResCare helps connect HIP 2.0 members to potential employers and facilitate participation in the workforce.

To be eligible, HIP members cannot work more than 20 hours a week, be full-time students, nor referred to work training through SNAP (Supplemental Nutrition Assistance Program). The program is free to HIP 2.0 members. They are offered a variety of services including an initial assessment of their skills and abilities to achieve their employment goals. Non-participation in Gateway to Work does not affect HIP 2.0 coverage or benefits. Once engaged in the Gateway to Work program, members may receive case management services, participate in a structured job readiness program and receive help with their job search. The program also assists HIP members in completing job applications, creating resumes, practicing job interview skills, and researching job openings. Gateway to Work features tools to match participants experience and skills with employers who have job openings. Financial assistance may be available to pay for short term skills training for high-demand jobs. Services may also be available to help members overcome barriers including money for transportation or clothing required to start a new job.

Gateway to Work Program Accomplishments during Year One of Demonstration

The Gateway to Work call center opened on May 4, 2015. Since opening, there have been 3,277 calls received from HIP 2.0 recipients with questions or an interest in participating. As of

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[125] See, for example: "Stable Jobs = Healthier Lives". Culture of Health. Robert Wood Johnson Foundation, 14 January 2013. Retrieved May 26, 2016 from http://www.rwjf.org/en/culture-of-health/2013/01/stable_jobs_health.html. Goodman, Nanette. The Impact of Employment on the Health Status and Health Care Costs of Working-age People with Disabilities. Lead Center, Nov 2015. Retrieved May 26, 2016 from http://www.leadcenter.org/system/files/resource/downloadable_version/impact_of_employment_health_status_health_care_costs_0.pdf3. Fonseca, Daniel Andrés Pinzón. *The Relationship between Health and Employment.* Thesis. Erasmus University of Rotterdam, 2011. Rotterdam: Netspar, 2011. Retrieved May 26, 2016 from http://arno.uvt.nl/show.cgi?fid=122184. Work Matters for Health. Issue brief no. 4. Robert Wood Johnson Foundation, December 2008. Retrieved May 26, 2016 from http://www.commissiononhealth.org/PDF/0e8ca13d-6fb8-451d-bac8-7d15343aacff/Issue%20Brief%204%20Dec%2008%20-%20Work%20and%20Health.pdf

[126] ResCare Workforce Services. Retrieved May 14, 2016 from http://www.rescare.com/education-and-training-services/

January 31, 2016, a total of 307,156 letters were mailed to inform HIP members of the Gateway to Work program. A total of 1,196 Gateway to Work orientations have been scheduled, with a total of 551 orientations attended.

Evaluation of the Gateway to Work Program

Over the next two years, the assessment of the Gateway to Work program will focus on the central hypothesis that referrals to ResCare employment resources help increase member employment rates over the course of the demonstration. More specifically, the evaluation of the goal will be structured around the following research questions:

1. What percent of members referred to ResCare become employed (part time vs. full time)?
2. How do referrals to ResCare impact member income and eligibility for HIP?
3. How many referred members stay in HIP and how many leave?
4. How do referrals to ResCare impact the number of Indiana residents enrolled in HIP Link?

In assessing the impact of providing HIP 2.0 members with opportunities to seek job training and employment through the Gateway to Work program, the number of HIP 2.0 members who participate in work search and job training programs, and compare rates of full and part-time employment among the HIP enrollees at specific intervals (e.g., after six months, one year, and two years into the program) will be examined. It will also be of interest to explore the extent to which change in employment status facilitates the transition of HIP members off of HIP 2.0 due to increased income. Ultimately, the answers to these research questions will provide a better understanding of the efficacy of the program and offer opportunities to tailor it to the needs of HIP 2.0 members.

Next Steps in Data Collection and Analysis

The data available for this interim evaluation report allowed for analysis of most measures identified in the Final Evaluation Plan submitted to CMS December 29, 2015. Because the Interim Evaluation is being conducted a little more than a year after the program's inception, and members joined throughout the year, data does not exist to answer all the research questions or for all members. This is particularly the case for components of HIP 2.0 with later start dates such as the HIP Link and Gateway to Work programs. These components will be discussed in the Final Evaluation Report.

The Final Evaluation Report will also encompass longer enrollments and claims history, as well as a longer claims runout period. This will allow for more robust profiles of member health status to be developed and utilized in the analyses. As members remain in the program longer, it will be possible to measure more complete disease profiles for a larger cohort of members.

In addition, the state will have completed validation processes of certain administrative data related to PAC payments, eligibility status changes, MCE reporting, and other information that will allow for a more comprehensive evaluation in the Final Evaluation Report.

Data limitations that result from short enrollment periods and previously untested data are common problems of evaluations of new initiatives. However even with these limitations, this evaluation can provide an early indication of the progress and potential impacts of the HIP 2.0 programs. Many of these estimates will also act as baselines from which to gauge changes in HIP 2.0 over the duration of the waiver period.