HEALTHY INDIANA PLAN 2.0 SECTION 1115 MEDICAID DEMONSTRATION FACT SHEET

January 27, 2015

Name of Section 1115 Demonstration: Healthy Indiana Plan 2.0
Waiver Number: 11-W-00296/5
Date Proposal Submitted: August 21, 2014
Date Approved: January 27, 2015
Date Implemented: February 1, 2015
Date Expires: January 31, 2018

BACKGROUND

On August 21, 2014, the State of Indiana submitted a request to CMS for the "Healthy Indiana Plan 2.0" (HIP) section 1115 demonstration. This demonstration extends coverage to adults in Indiana with incomes through 133 percent of the federal poverty level (FPL) beginning February 1, 2015. The goal of the demonstration is to achieve the following to promote the objectives of title XIX:

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

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

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

Two primary routes to coverage are established under the demonstration: HIP Plus for those who contribute to the Personal Wellness and Responsibility (POWER) account, and HIP Basic for those who do not make such contributions. The state shall make contributions to POWER accounts for individuals enrolled in HIP Plus and HIP Basic. The POWER Account will be used to pay for some of beneficiaries' health care expenses covered under the demonstration. Through the use of such accounts the state intends to promote the efficient use of healthcare, including encouraging preventive care and discouraging unnecessary care.

ELIGIBILITY

The demonstration covers individuals in the following groups: 1931 parents and caretaker relatives, adults with incomes at or below 133 percent of the federal poverty level (FPL) plus a 5 percent income disregard, and the Transitional Medical Assistance (TMA).

BENEFITS

Both HIP Plus and HIP Basic will provide coverage of a full alternative benefit plan (ABP) for individuals in the new adult group, authorized through an amendment to the state plan. Individuals in the HIP Plus ABP will have access to additional benefits not available in the HIP Basic (ABP) although all individuals, whether enrolled in Plus or Basic, will receive all essential health benefits required by law. The demonstration provides authority for the state to not offer non-emergency medical transportation (NEMT) for the new adult group during the first year of the demonstration; this authority may be extended subject to evaluation regarding the impact of this policy on access to care.

COST SHARING

The demonstration authorizes the state to collect monthly premiums (contributions to the POWER account) from individuals up to 133 percent of the FPL in an amount not to exceed 2 percent of household income, except that the POWER account contributions from individuals with income below 5 percent of the FPL will be no more than $1 per month. POWER account contributions are required as a condition of eligibility for individuals with incomes above 100 percent of the FPL but not for individuals with lower incomes, who will enroll in HIP Basic if they do not make POWER account contributions.

Individuals covered under the demonstration, regardless of income, who make POWER account contributions shall be enrolled in HIP Plus. Those enrolled in HIP Plus will not be subject to cost sharing, with the exception of a copayment for nonemergency use of emergency department services, as discussed below. Adults with incomes at or below 100 percent of the FPL who do not choose to make contributions will be enrolled in HIP Basic and will be subject to co-payments at levels permitted under federal Medicaid rules.

Individuals with incomes above 100 percent of the FPL, who begin but subsequently cease making POWER account contributions will, after a 60 day grace period, be disenrolled from HIP 2.0 coverage and disqualified from such coverage for six months. Exceptions to this “lock out,” which applied to all beneficiaries in the existing HIP demonstration, will be afforded to individuals who are medically frail and those with specific circumstances as described in the special terms and conditions. Because payment of premiums (contributions to the POWER account) is not a requirement for coverage for individuals with incomes at or below 100 percent of the FPL, if such

individuals begin but cease making payments, they will not lose coverage (or be subject to a lock out) but will be automatically enrolled, without a new application or gap in coverage, into HIP Basic (instead of HIP Plus).

Also reflecting the unique design of HIP 2.0, coverage will be effective: 1) the first day in the month in which an individual makes a POWER account contribution; or, for those with incomes at or below 100 percent of the FPL who do not make a POWER account contribution, coverage will start 2) the first of the month in which the 60 days payment period expires. Expanded access to presumptive eligibility processes will be available at qualified entities throughout the state for individuals seeking immediate coverage, and a "fast track" method for billing and paying POWER account contributions will be available to all individuals under the demonstration to expedite coverage.

Under the demonstration all beneficiaries will be subject to a copayment for non-emergent use of the Emergency Department (ED). We have granted the state authority to demonstrate whether a graduated co-payment—$8 for the first instance and $25 for recurrent non-emergent use of the ED, with education and referrals to primary care providers—will reduce unnecessary ED use and improve beneficiaries' use of health care in the most appropriate setting. Per federal law regarding experimental approaches to cost sharing, this authority requires a control group for evaluation and is granted for a period of two years.

DELIVERY SYSTEM

Services for the demonstration will be provided primarily using managed care organizations. Under the demonstration, the state will also offer a voluntary premium assistance program called HIP Link for individuals above age 21 with access to cost effective health care coverage through employer sponsored insurance (ESI) that has met qualification criteria specified in the STCs. Individuals electing the HIP Link program will receive full ABP coverage, but their ESI plan will pay primary to Medicaid for all such services; individuals will be able to use POWER account funds to cover any out-of-pocket costs above Medicaid permissible limits.

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