HEALTHY INDIANA PLAN DEMONSTRATION

PROJECT NUMBER: 11-W-00296/5

SECTION 1115 QUARTERLY REPORT

State of Indiana

REPORTING PERIOD:

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

Demonstration Quarter: 2/2015 (5/15-7/15)

Date submitted to CMS: 10/8/15

Introduction:

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

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

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

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

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

Overview

The State of Indiana respectfully submits the 2nd quarter Healthy Indiana Plan 1115(a) demonstration report.

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1. **A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, enrollment, quality of care, access, health plan financial performance that is relevant to the demonstration, the benefit package, and other operational issues.**

The second quarter of performance for HIP 2.0 continued to show the high level of preparation and coordination that allowed the state to implement this innovative program with success. Total enrollment at the end of quarter two stands at 264,004 fully eligible and enrolled individuals, with an average of 70% actively making contributions to their health savings like account, the POWER Account. Further breakdown of this eligibility by plan and federal poverty levels is provided below.

Accomplishments during the quarter include receipt of final approval on the HIP Basic and HIP Plus Alternative Benefit Plan State Plan Amendments and submission of three required 1115 Protocols including the ER Copay Protocol, the HIP Link Protocol, and the Draft Evaluation Design, and completion and receipt of much positive feedback at the HIP post-award forum on July 9th. The State also launched new components of the HIP 2.0 program including the Fast Track via credit card, Gateway to Work, and HIP Link employer application functionality.

Two of the key components of HIP 2.0 launched during this period are designed to support HIP participants to find and maintain employment. First, the Gateway to Work call center opened May 4th. Gateway to Work assists HIP members with job training and job search activities. HIP members that work less than 20 hours a week, are not full-time students, and have not already been referred to work training through SNAP will be referred to Gateway to Work. The Gateway to Work program is a no-cost voluntary program that offers HIP members a variety of services including an initial assessment of their skills and abilities to identify personal actions to achieve their employment goals. Non-participation in Gateway to Work does not impact HIP eligibility. The program assists HIP members with completing job applications, creating resumes, improving job interview skills and job search assistance. Gateway to Work features tools to match participants experience and skills with employers who have job openings. Since the program start date there have been over 3,000 calls to the Gateway to Work call center and 479 job orientations have been attended by HIP members. Second, in June, the HIP Link program implemented the employer portal and began to take employer applications. HIP Link allows HIP eligible members, their spouses, and HIP eligible dependents, to enroll in their employer's health plan and receive a HIP Link POWER Account valued at $4,000 per person to help cover the costs of commercial insurance. The launch of the employer portal allowed the state to start the process of approving employers and employer health plans to offer HIP Link to their employees.

The state also made enhancements to the Fast Track process. Fast Track allows an individual to make a $10 payment prior to being found eligible, which allows members to gain coverage more quickly. If a member opts to make this payment and is found eligible, the effective date of coverage for them will be the 1st day of the month in which the application was submitted. If the individual is not found eligible, they will have the payment refunded. The ability to make a Fast Track payment via a paper invoice voucher began in March and health plans invoiced individuals that were potentially eligible days after they applied for HIP. In June of 2015, the State added a credit card payment option to the Fast Track process. An individual is given the opportunity to make their Fast Track payment on-line via credit card at the point of filling out their on-line application. Those individuals that do not make the credit card payment are invoiced by their chosen health plan following the paper voucher process.

2. **A discussion of key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed.**

The State continues to hold regular meetings with all involved stakeholders including the managed care entities, fiscal agent, systems and eligibility teams to monitor operational status and identify and implement solutions to operational challenges as they arise. These meetings include a daily meeting on all HIP operations and calls specifically focused on addressing individual client issues.

Generally, HIP's smooth transition continued. The State continued to see robust use of the Hospital Presumptive Eligibility (HPE) and Presumptive Eligibility (PE) programs. In calendar year 2014 just over 8,000 HPE determinations were made however this has increased to 10,000 per month with the addition of the adult group, as the number of providers conducting PE increased.

With this volume of newly covered HPE/PE members, and HPE/PE members residing in managed care, the State has increased provider and member education around how to access and use the HPE/PE benefits and the requirements to transition from HPE/PE full HIP coverage. Education efforts focus around ensuring members understand how to change their health plan during the HPE/PE period and to make payment have increased. Processes are being examined to ensure members have sufficient time to pay and fully understand their plan change options.

Some providers and members have reported confusion about how the HPE/PE program works due to the real-time nature of the coverage and existing systems limitations. While the system is able to generate proof of immediate HPE/PE coverage, the system cannot transfer this information to update the clients' chosen MCE immediately and the file transfer can take up to 24 hours. This is challenging if providers are seeking prior authorizations or members are seeking pharmacy benefits. Manual workarounds are in place to allow MCEs to confirm eligibility with pharmacies, and education has been targeted to providers about the lag in electronic confirmation of benefits. This operational issue arises from systems limitations and will continue to be monitored and development of new processes will be explored to resolve and ensure members immediate access to all HIP Basic benefits. The state continues to educate members about how the change their plan during their HPE/PE period.

3. **Enrollment figures for the quarter including enrollment figures for individuals by income level and benefit plan.**

Table 1 below shows HIP 2.0 enrollment as of the end of July. The table shows that only 27,828 individuals or approximately 10.5% of enrollees had income over 100% FPL, this lower than anticipated enrollment for this FPL level and is likely due to the fact that individuals who may be interested in receiving coverage and have income over 100% FPL may be enrolled in marketplace coverage. There were 64,216 individuals with income between 100% and 150% FPL who selected a plan on the federal marketplace. These individuals have not transitioned to HIP coverage as expected as federal policies continue to provide tax credits to individuals that are also eligible for Medicaid.

For individuals that enrolled in HIP, approximately 70% are making their POWER Account contributions and receiving HIP Plus benefits. For individuals below 100% FPL the likelihood of making a POWER Account contribution increases as individual income increases from 62% of individuals under 23% of the federal poverty level to 79% of individuals between 76% and 100% of the federal poverty level, even though the amount of the POWER Account contribution has a corresponding increase with increased income. Employers, non-profits, and other third parties are not making a substantial number of individual contributions as detailed below in #4.

Table 1
HIP 2.0 Enrollment
7/31/2015

% FPL	Basic				Plus				Total
	State	Regular	Total	Percentage	State	Regular	Total	Percentage	
<23%	43,609	14,535	58,144	37.99%	52,367	42,543	94,910	62.01%	153,054
23%-50%	2,090	3,428	5,518	24.1%	3,217	14,133	17,350	75.9%	22,868
51%-75%	1,849	5,050	6,899	22.9%	3,334	19,860	23,194	77.1%	30,093
76%-100%	1,469	4,894	6,363	21.1%	2,944	20,854	23,798	78.9%	30,161
Total <101%	49,017	27,907	76,924	32.57%	61,862	97,390	159,252	67.43%	236,176
101%-138%	1,080	478	1,558	6.0%	3,228	21,261	24,489	94.0%	26,047
>138%	762	5	767	43.1%	861	153	1,014	56.9%	1,781
Grand Total	50,859	28,390	79,249	30.02%	65,951	118,804	184,755	69.98%	264,004

*Source: EDW

4. **Data related to POWER account including the number and average amount of contributions to POWER accounts from third parties, by type of entity, and by beneficiary income level, the HIP Plus and HIP Basic rollover numbers and amounts, and the rate of disenrollment for failure to pay POWER Account contributions.**

Tables 2 and 3 below outline POWER Account contributions that were made by either an employer or a non-profit organization. There are not a substantial number of employers or non-profits contributing to POWER Accounts. Through June 2015, 101 employers and 40 non-profit organizations made contributions on behalf of a HIP Member. In total, 196 HIP Plus members had a POWER Account contribution made on their behalf.

Table 2
Employer Power Account Contributions
February 1, 2015-June 30, 2015

	YTD Total
Number of Employers Participating	101
Number of Members on Whose Behalf an Employer Makes a Contribution	99
Total Amount of Employer Contributions	$4,044.07
Average Amount of Employer Contributions	$40.85

*Source: OMPP Quality and Reporting

Table 3 Non-Profit Organization Contributions February 1, 2015-June 30, 2015	
	YTD Total
Number of Non-Profit Organizations Participating	40
Number of Members on Whose Behalf a Non-Profit Makes a Contribution	97
Total Amount of Non-Profit Contributions	$2,620.05
Average Amount of Non-Profit Contributions	$26.00

*Source: OMPP Quality and Reporting

Through six months of HIP 2.0 program performance, only 848 individuals were closed for failure to pay their POWER Account contribution. That is less than .005% of individuals in the HIP Plus program.

Table 4 HIP 2.0 Closure for Failure to Pay POWER Account February 1, 2015-July 31, 2015	
FPL	Count
100% FPL or less	0
100% FPL or more	848

*Source: EDW

There were a total of 32,247 individuals who left the HIP program for reasons other than non-payment. More than 2,393 of these closures represent a change in Medicaid aid category, meaning they are being served in another Medicaid program.

Table 5 HIP Closures February 1, 2015 – July 31, 2015	
HIP Category	**Closures By Category**
Regular Plus	11,651
Regular Basic	5,870
State Basic	10,012
State Plus	4,714
TOTAL Closures	**32,247**

*Source: EDW

The most frequent closure reasons for all HIP (above and below 100% FPL) are below. This table lists the Top 5 most cited reasons for a closure. There are many other closures for a variety of reasons and the below counts do not include all closures. The most common reason an individual is closed is the failure to provide information.

Table 6 All HIP Closures – Top 5 Reasons February 1, 2015-July 31, 2015	
Number of Closures	**Reason for Closure**
10,003	Failure to provide all required information
4,737	Receipt of or increase in earned or self-employment income
3,649	Income exceeds program eligibility standards
2,393	Moved to another Medicaid category
2,177	Not an Indiana resident
22,959	**Top 5 Total**

*Source: EDW

When the closure reasons are broken out for those above and below 100% FPL there are some differences. The vast majority of members under 100% who are closed are closed for failing to provide information. For those over 100% FPL a majority are due to the member's income exceeding program eligibility standards.

Table 7 HIP Closures 100% FPL and Under – Top 5 Reasons February 1, 2015-July 31, 2015	
Number of Closures	**Reason for Closure**
9,054	Failure to provide all required information
2,936	Receipt of or increase in earned or self-employment income
2,171	Moved to another Medicaid category
2,096	Not an Indiana resident
1,332	Income exceeds program eligibility standards

*Source: EDW

Table 8 HIP Closures over 100% FPL – Top 5 Reasons February 1, 2015-July 31, 2015	
Number of Closures	**Reason for Closure**
2,317	Income exceeds program eligibility standards
1,801	Receipt of or increase in earned or self-employed income
949	Failure to provide all required information
848	Failure to make payment to POWER Account
231	Receipt of or increase in unearned income

*Source: EDW

5. **Data related to emergency department use including the number of individuals by income level and a breakdown of the number of visits classified as an emergency vs.**

non-emergency by income level and benefit plan; the number of people who incurred the $8 and $25 copayments.

Table 9 below documents the number of emergency room visits by HIP 2.0 members in the first quarter of 2015. Reporting on ER utilization comes from actual claims experience, so data may vary over time as claims are submitted and adjudicated before reporting. Initial program data indicate that HIP Plus members are significantly less likely to utilize the emergency room for non-emergent services. Future reports will break out ER use by income level. The state is waiting for approval of our ER Co-payment protocol before we begin reporting on co-payment experience.

Table 9 Emergency Room Utilization January 2015-March 2015 (first calendar quarter)						
Category	Number of ER visits in the period	Number of ER visits deemed emergent	Number of visits deemed non-emergent	Number of Adjudicated ER claims per 1,000 members	Percent of claims deemed emergent	Percent of claims deemed non-emergent
Plus	9722	8364	1358	115	86%	14%
Basic	2041	1439	602	93	70%	30%
State Plan	15179	11383	3796	114	75%	25%

*Source: OMPP Quality and Reporting

6. **Reports on speed of eligibility determinations for HIP 2.0 eligible individuals, including the average number of days between the submission of an application and an eligibility determination, and the average number of days between an eligibility determination and HIP 2.0 plan enrollment.**

The State continues to report excellent application processing times. With most individual applications approved in less than 20 days. Individuals who make a POWER Account contribution can gain full coverage just days after their application is authorized, and eligibility begins the first day of the month in which payment is made

Table 10 Eligibility Processing May 1, 2105-July 31, 2015		
	Number of Days from application to authorization	Number of days from HIP Authorization for full eligibility
Case Type	**Average Days**	**Average Days**
Regular Plus	15.79	6.3
State Plan Basic	8.02	54
State Plan Plus	15.95	6.9
Native American HIP Plus	NA	NA
Regular Basic	18.32	17.3

*Source: ICES

7. **A discussion of the HIP Link program, including but not limited to enrollment, HIP Account balance amounts, grievances, changes in employer contribution levels,**

participants moving from ESI coverage to HIP Plus or HIP Basic, other operational issues; and evaluation activities.

The HIP Link operational protocol was submitted to CMS on May 26, 2015 and has been updated per CMS questions. The HIP Link program is a key initiative of Governor Mike Pence and he has met with business leaders throughout the state to champion the program. Dedicated HIP Link staff joined the Medicaid office in July and have been working to outreach to a variety of groups in the business community and began reviewing and approving employers eligible for the program. The office has met with the Indiana Restaurant and Lodging Association, Indiana Retail Council, Indiana Chamber of Commerce, local city/county Chamber of Commerce, and with individual businesses in the retail, education, restaurant, and health care industries. Other outreach initiatives have included program education to the health insurance agent, broker, and navigator community. HIP Link will continue to grow and be featured in future reports.

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

The POWER Account Contributions and Copayments Monitoring Protocol was submitted July 30, 2015. Greater detail on both activities will be reported in future reports.

9. **Reports on data required as part of the Health Incentives Protocol described in Section VIII and POWER Account Contributions and Copayments Monitoring Protocols.**

During the quarter, protocol documents for special monitoring requirements have been submitted to CMS and the state is awaiting final approval before this data can reported.

10. **The number of hospitals and other entities participating in Presumptive Eligibility, by type and the number of applications filed by each entity. The number of full applications filed and the number determined eligible, by entity.**

With the expansion of presumptive eligibility to Community Mental Health Centers, Federally Qualified Health Centers, Rural Health Clinics, and County Health Departments; we established a series of webinars to train providers and direct them in how to obtain the necessary qualified provider status. As mentioned above, this program has grown considerably with the introduction of the new adult group and new provider types. More applications are processed each month in the HPE/PE program than were done in the entire first year of Hospital Presumptive Eligibility in 2014. We continue to provide education, guidance, and training opportunities for active qualified providers and to providers who are interested in joining the program.

Table 11 Presumptive Eligibility Applications and Performance May 1, 2015-July 30, 2015						
Provider Type	**PE Applications Submitted**	**PE Applications Approved**	**Percent PE Applications Approved**	**IHCP Applications Submitted**	**IHCP Applications Approved***	**Percent IHCP Applications Approved***
Acute Care Hospital	33,467	26,523	79%	16,343	4,431	27%
Community Mental Health Center	1,768	1,425	81%	886	240	27%
Federally Qualified Health Center	3,232	2,765	86%	2,165	821	38%
Psychiatric Hospital	596	452	76%	263	67	25%
Rural Health Clinic	31	27	87%	18	4	22%
County Health Department	0	0	0	0	0	0
Grand Total	**39,094**	**31,192**	**80%**	**19,675**	**5,563**	**28%**

*****Source: Indiana AIM

*Applications submitted in the performance quarter may have still been pending when data was run. This number only reflects those that have had a determination made at that time. This data will be updated next quarter and may be adjusted.

Table 12 below provides information on the number of qualified providers that are completing HPE/PE applications for individuals. There are 174 qualified providers that are operating in 247 different locations. This provides individuals with many options in gaining presumptive eligibility coverage. The 3rd column outlines the total number of providers enrolled, by type, in the Indiana Health Coverage Programs. This allows us to see how many providers of any type are not participating as a qualified provider. In the Acute Care Hospital category, there are 168 hospitals enrolled with Indiana Medicaid. Of these 168 hospitals, 114 are participating in the HPE program. While we have access to HPE/PE statewide, we have not gotten Local County Health Departments or Rural Health Clinics interested in the program. Prior to the expansion of PE to these new provider types, a letter was mailed to each entity in the state. This included those not already enrolled with Indiana Medicaid. All providers were given information about the program and directions on how to participate. All of the providers who expressed

an interested in participating have been enrolled. We continue outreach efforts to grow providers in the program.

Table 12 Presumptive Eligibility Qualified Providers July 2015			
Provider Type	**Number of Qualified Providers**	**Number of Qualified Provider Locations**	**Total Potential Provider by Type***
Acute Care Hospital	114	114	168
Community Mental Health Center	20	49	25
Federally Qualified Health Center	21	65	68
Psychiatric Hospital	15	15	32
Rural Health Clinic	4	4	66
County Health Department	0	0	57
Total	**174**	**247**	**416**

*Source: Indiana AIM

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