HEALTHY INDIANA PLAN DEMONSTRATION

PROJECT NUMBER: 11-W-00296/5

SECTION 1115 QUARTERLY REPORT

State of Indiana

REPORTING PERIOD:

Demonstration Year: 2 (02/01/16 – 1/31/17)

Demonstration Quarter: 4/2016 (11/2016-01/2017)

Date submitted to CMS: March 31, 2016

Introduction:

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

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

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

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

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

Overview

The State of Indiana respectfully submits year two, quarter four 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.

During this quarter, an application to renew the HIP 2.0 waiver was submitted. In support of that waiver renewal application, the State completed public notice and hearing activities as required. The Medicaid Advisory Committee met on January 5, 2017 for a special meeting to address the waiver renewal application. Stakeholders present were allowed to provide comments at that forum. In addition, written comments were collected through January 20, 2017.

The vast majority of the comments provided at that meeting and in follow up submissions were supportive of the HIP waiver extension application, and there were no comments opposing the State's submission of the extension application. 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.

New managed care contracts began in January for members in the HIP 2.0 program. This added one managed care entity (MCE) to the three existing MCEs currently serving Medicaid members in the State.

Marketplace open enrollment concluded at the end of January. Over the course of open enrollment the State saw fewer applications submitted directly from the FFM as compared to last year. Through January 31, 2017 the State received a total of 42,669 applications from the FFM (down from 46,299 applications in 2016).

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's new MMIS system was in the final stages of development before go-live in February 2017. Most of the system discussions during this quarter focused on the transition from the current MMIS system to the new MMIS system. This included testing with the various vendor systems to assure a smooth transition.

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

Table 1 below shows enrollment in HIP 2.0 at the end of Jan 2017. These numbers do not include those who are conditionally eligible and will move into Plus if they make a POWER Account contribution or Basic if they do not. The total number of enrollees into the program have increased by 6,571 since last quarter. Table 1 shows that in this quarter, 259,297 individuals (64.53%) were making their POWER Account contributions and receiving HIP Plus benefits. We continue to see most of the lowest income members (60.51%), under 23% FPL making POWER Account contributions. At the end of the quarter, 57,831 individuals (14.3% of enrollees) had income over 100% FPL. We also see that over the last few quarters the enrollment figures have been consistent with less than 1% variation across various categories.

Table 1
HIP 2.0 Enrollment
Jan 31, 2017

% FPL	BASIC				PLUS				Total
	State Plan	Regular	Total	Percentage	State Plan	Regular	Total	Percentage	
<23%	52,547	36,257	88,804	39.49%	69,675	66,387	136,062	60.51%	224,866
23%-50%	3,299	8,484	11,783	38.70%	4,963	13,678	18,641	61.30%	30,424
51%-75%	3,736	12,534	16,270	38.50%	5,877	20,075	25,952	61.50%	42,222
76%-100%	3,324	13,406	16,730	36.00%	5,925	23,800	29,725	64.00%	46,455
Total <101 %	62,906	70,681	133,587	38.84%	86,440	123,940	210,380	61.16%	343,967
101%-138%	3,142	4,174	7,316	13.50%	9,925	36,806	46,731	86.50%	54,047
>138%	1,560	38	1,598	42.20%	2,046	140	2,186	57.80%	3,784
Total Enrollment	**67,608**	**74,893**	**142,501**	**35.47%**	**98,411**	**160,886**	**259,297**	**64.53%**	**401,798**

**Individuals over 138% may continue the program due to TMA or appeal status. *Source: SSDW/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. Third party contributions continue to represent a very small portion of the overall program. The number of employers electing to make POWER Account contributions in the quarter was 10. These employers made contributions on behalf of 12 members. This is slightly lower than last quarter (Q3) where 17 employers were contributing on behalf of 17 members. In this quarter, there were 55 non-profit organizations that made contributions on behalf of 2,240 members, we see that this number has dropped from 70 to 55 since last quarter, but the number of members receiving contributions from these non-profits increased by 191 members, a 10% increase. These numbers represent those groups that have made a formal arrangement with a Managed Care Entity (MCE) to pay on behalf of another individual. Some informal arrangements or payments on behalf of members may not be included in these numbers and the MCEs may not be aware of other payments made on behalf of members, including those from friends or relatives.

Table 2 **Employer Power Account Contributions** Oct1, 2016 – Dec 31, 2016	
	Total
Number of Employers Participating	10
Number of Members on Whose Behalf an Employer Makes a Contribution	12
Total Amount of Employer Contributions	$281
Average Amount of Employer Contributions	$23.42

*Source: OMPP Quality and Reporting

Table 3 **Non-Profit Organization Power Account Contributions** Oct 01, 2016 – Dec 31, 2016	
	Total
Number of Non Profit Organizations Participating	55
Number of Members on Whose Behalf a Non Profit Makes a Contribution	2,240
Total Amount of Non Profit Contributions	$27,794
Average Amount of Non Profit Contributions	$12.40

*Source: OMPP Quality and Reporting

Table 4 represents the number of individuals that were dis-enrolled from the program for failure to pay their required POWER Account contribution. In this quarter, out of the 57,381 members with incomes over 100% of the FPL, 4,602 members were disenrolled, which is about 8.02% of the population.

Table 4 **HIP 2.0 Closure for Failure to Pay POWER Account** Nov 1, 2016 – Jan 31, 2017		
FPL	**Count**	**Description**
FPL > 100%	4,602	Failure to make payment to power account

*Source: SSDW/EDW

Table 5 documents that 49,104 individuals left the HIP 2.0 program during the quarter. 5,870 of those were individuals who moved to a different Medicaid program outside of HIP. 43,234 individuals were closed out of the program all together. This number is slightly up from 36,747 individuals who closed out of the program in the last quarter. The closure reasons listed in the tables below continue to reflect non-compliance with redetermination and an increase in income as the main reasons for leaving the program. The numbers below show closures and do not account for the members who may have come back to the state and been reopened. Upon termination, individuals can have their eligibility restored should they return their paperwork within 90 days.

Table 5
HIP Closures
Nov 1, 2016 – Jan31, 2017

Closures by HIP Category	**Moved to Another Medicaid Category** (Non HIP)	**Moved Out of the Medicaid Program**
Regular Plus	1,825	15,639
Regular Basic	1,063	12,564
State Basic	990	7,298
State Plus	1,951	7,408
Other	41	325
Totals	**5,870**	**43,234**
Total		**49,104**

*Source: SSDW/EDW

The most frequent closure reasons for all HIP (above and below 100% FPL) are below. Table 6 lists the top five 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 top reason for closure in this quarter was that the individual failed to comply with or complete redetermination that left the member ineligible and these numbers have increased since last quarter (Q3). The second most common closure reason is that the individual's income exceeded program eligibility standards.

Table 6
All HIP Closures – Top 5 Reasons
Nov 1, 2016 – Jan 31, 2017

Number of Closures	**Reason for Closure**
18,516	Individual fails to comply with or complete redetermination
7,935	Individual income exceeds program eligibility standards
4,604	Failure to make payment to POWER account
2,867	Individual is not an Indiana resident
751	Written voluntary withdrawal from assistance

*Source: SSDW/EDW

When the closure reasons are broken out for those above and below 100% FPL there are some differences. As documented in table 7, for those under 100% FPL failure to comply with or complete redetermination remains a top reason for members to be closed out of HIP. Table 8 shows that for those over 100% FPL, the majority of closures were due to the member's income exceeding program eligibility standards. These individuals are referred to the Marketplace for coverage.

Table 7
HIP Closures 100% FPL and Under – Top 5 Reasons
Nov 1, 2016- Jan 31, 2017

Number of Closures	Reason for Closure
16,864	Individual fails to comply with or complete redetermination
2,492	Individual is not an Indiana resident
2,418	Individual income exceeds program eligibility standards
673	Individual eligible for SSI related income
454	Death of assistance group member

*Source: SSDW/EDW

Table 8
HIP Closures over 100% FPL – Top 5 Reasons
Nov 1, 2016- Jan 31, 2017

Number of Closures	Reason for Closure
5,517	Individual income exceeds program eligibility standards
4,602	Individual failed to make POWER Account contribution
1,652	Individual fails to comply with or complete redetermination
257	Written voluntary withdrawal from assistance
232	Individual is not an Indiana resident

*Source: SSDW/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 for calendar quarter 4. The data is collected on a paid basis not an incurred basis, meaning that this data reflects the claims paid during the experience period with a 90 day claims lag time. In this instance, the October - December 2016 reporting period, shows the claims payment activity for the July- September 2016 (Q3) experience period. The data shows a continued decrease in inappropriate ER usage by HIP members. During this quarter, a workgroup was convened to confirm a standardized methodology that will be utilized in the development of this report by all MCEs. Tables 10 – 12 below show the previous quarters experience reported with the new standardized methodology.

Table 9 Emergency Room Utilization Oct 1, 2016– Dec 31, 2016 (report period) Calendar Quarter 4						
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	40,331	33,795	6,536	100	83.8%	16.2%
Basic	20,074	16,711	3,363	138	83%	17%
State Plan	57,896	48,365	9,531	166	83.5%	16.5%

*Source: OMPP Quality and Reporting

Table 10 below documents the number of emergency room visits by HIP 2.0 members for calendar quarter 3, which shows claims activity for Apr-June 2016 experience period.

Table 10 Emergency Room Utilization July 1, 2016– Sept 30, 2016 (report period) Calendar Quarter 3						
Category	Number of ER visits in the period	Number of ER visits deemed emergent	Number of visits deemed non-emergent	Number of Adjudicated ER claims per 1,000 members	Percent of claims deemed emergent	Percent of claims deemed non-emergent
Plus	37,786	30,010	7,776	96	79.4%	20.6%
Basic	19,723	15,290	4,433	145	78%	22%
State Plan	59,110	45,647	13,463	178	77.2%	22.8%

*Source: OMPP Quality and Reporting

Table 11 below documents the number of emergency room visits by HIP 2.0 members for calendar quarter 2, which shows claims activity for Jan -March 2016 experience period.

Table 11
Emergency Room Utilization
April 01, 2016– June 30, 2016 (report period)
Calendar Quarter 2

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	33,662	24,948	8,714	93	74.1%	25.9%
Basic	18,722	13,550	5,172	140	72%	28%
State Plan	55,749	40,677	15,072	169	73%	27 %

*Source: OMPP Quality and Reporting

Table 12 below documents the number of emergency room visits by HIP 2.0 members for calendar quarter 1, which shows claims activity for Oct -Dec 2015 experience period.

Table 12
Emergency Room Utilization
Jan 01, 2016– March 31, 2016 (report period)
Calendar Quarter 1

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	29,385	21,448	7,937	95	73%	27%
Basic	15,953	11,513	4,440	141	72%	28%
State Plan	54,819	39,138	15,681	167	71.4%	28.6%

*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. On average, individual applications are approved in 22 days. In this quarter, there is a slight increase in the processing time and in the number of pending applications.

Table 13
Eligibility Processing
Nov 1, 2016- Jan 31, 2017

	Number of days from application to authorization	Number of days from HIP Authorization for full eligibility	Number of pending HIP applications
Case Type	**Average Days**	**Average Days**	**Count**
Regular Plus	24.05	3.34	18,424
State Plan Basic	18.52	14.28	273
State Plan Plus	20.59	4.21	4,331
Regular Basic	22.4	10.76	2,319
HIP Link	24.73	1	12

*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.

A new statewide marketing campaign, which began in November 2016, had a significant impact on interest in HIP Employer Link. The advertising coincided with traditional "open enrollment" periods for many Hoosier employers between November and December.

Additional HIP Employer Link recruiting staff allowed the State to attend more events targeted towards employees this quarter. The state attended health fairs, open enrollment meetings, and employee staff meetings where details of HIP Employer Link were presented to prospective members.

Member enrollment also saw growth in the quarter. The majority of members who participated in HIP Employer Link chose to stay with the program when renewing their insurance with their employer.

Table 14 HIP Employer Link Enrollment		
	Quarter 11/1/16-1/31/17	Program to Date 6/1/15-1/31/17
Employer enrollment	25	85
Employee enrollment	7	51
Grievances	0	0
Participants moving from ESI to HIP Plus	2	5

*Source: OMPP HIP Employer Link

Table 15 HIP Employer Link POWER Account Balances November 1, 2016 to January 1, 2017	
POWER Account Balance	Number of Employees
$4,000-$3,000	47
$3,000-$2,000	3
$2,000-$1,000	1
$1,000-$0	0

**Note: all account balances will start at $4,000*

*Source: OMPP HIP Employer Link

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

In this quarter, the State submitted an additional NEMT (non-emergency medical transportation) evaluation to CMS. An initial evaluation of the NEMT waiver was submitted to CMS on March 1, 2016 based on a survey of 600 HIP 2.0 members conducted in December 2015 and January 2016. A second survey was administered in June 2016, with a much larger sample size of 5,173 HIP 2.0 members. The larger sample size allowed for an in-depth analysis of differences in member access to health care between those receiving and not receiving NEMT services. Also, as the second survey was conducted about six months after the first survey, respondents had relatively more program experience than the respondents in the first survey.

The NEMT evaluation, published on November 2, 2016 and posted to the CMS website concludes that there was no evidence that members without NEMT coverage were more likely to miss appointments (due to transportation barriers or other reasons) relative to similar members with NEMT provided.

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

The ER co-payment study is on-going and Power Account Contribution Evaluation study will be submitted to CMS on March 31st, 2017.

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.

The Presumptive Eligibility program continues to be very active in Indiana. Table 16 details the activity for all qualified providers (QPs) in the program. The State is seeing some improvement in the number of PE recipients that are being approved for full IHCP benefits at application but the overall number is low at approximately 46%. The top denial reasons for PE members seeking full coverage include, failure to cooperate in verifying income, income exceeding program eligibility standards, and failure to verify Indiana residency.

Table 16
Presumptive Eligibility Applications and Performance
Nov 1, 2016 – Jan 31, 2017

Provider Type	PE Applications Submitted	PE Applications Approved	% PE Applications Approved	IHCP Applications Submitted	IHCP Applications Approved*	% IHCP Applications Approved**
Acute Care Hospital	24,075	17,279	71.7%	12,952	4,170	45.7%
Community Mental Health Center	1,340	1,020	76.1%	694	198	37.1%
Federally Qualified Health Center	2,387	2,023	84.7%	1,654	634	57.5%
Psychiatric Hospital	523	406	77.6%	265	83	46.6%
Rural Health Clinic	4	4	100%	4	2	66.7%
County Health Department	8	7	87.5%	5	1	20.0%
Grand Total	**28,337**	**20,739**	**73.2%**	**15,574**	**5,088**	**46.5%**

*Source: EDW

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

Table 17 provides information on the number of Qualified Providers (QPs) that are completing HPE/PE applications for individuals. The number in column (a) is the number of provider entities that are signed up to perform QP activities, broken out by provider type. The number in column (b) shows the number of physical locations where the entity operates and carries out QP activities. The number in column (c) shows the total number of provider entities that are eligible to sign up to be a QP. To date, 216 out of 333 (64.9%) eligible entities are signed up to be a QP.

Table 17
Presumptive Eligibility Qualified Providers
Nov 1, 2016 – Jan 31, 2017

Provider Type	Number of Qualified Provider Entities (a)	Number of Qualified Provider Locations (b)	Total Potential Provider Entities by Type (c)
Acute Care Hospital	117	117	125
Community Mental Health Center	21	55	25
Federally Qualified Health Center	26	152	26
Psychiatric Hospital	20	20	41
Rural Health Clinic	22	22	67
County Health Department	10	10	49
Total	**216**	**376**	**333**

*Source: Indiana AIM