Healthy Indiana Plan (HIP 2.0)

HIP Interim Evaluation Overview

Indiana Family and Social Services Administration
Office of Medicaid Policy and Planning
July 26, 2016

Presentation Outline

1. *Purpose of Study*
2. *How Study was Completed*
3. *Key Methods*
4. *Goals of HIP 2.0*
5. *Results of Study*

Purpose of Study

As part of the Special Terms of Conditions (STCs) for HIP 2.0, CMS requires the State to conduct an **Interim Evaluation** of the program

- The evaluation is intended to assess the success of the program within its first year (February 2015 – January 2016)

The State selected the **Lewin Group** (Lewin), through a competitive bidding process, to complete the evaluation

- Lewin has 45 years of unbiased and independent experience in health care policy, Medicaid, evidence-based medicine and human services programs

How Study was Completed

January – June 2015:

The State developed a comprehensive evaluation strategy for HIP.

June 1, 2015:

The State submitted a **Draft Evaluation Plan** to CMS.

December 28, 2015:

The State submitted a **Final Evaluation Plan** to CMS, based on extensive discussions with CMS, and input from Lewin.

CMS approved the plan.

Key Methods

Member Enrollment & Claims Data: Contains member-level eligibility data (e.g., date of enrollment, age, income) and health care utilization data (e.g., number of hospital visits)

Survey Data: Contains data from HIP members (current and previously enrolled), non-members, and providers on perceptions of HIP and overall health care experiences.

MCE Data: Contains data from MCEs on member behavior (e.g., POWER account payments).

Goals of HIP 2.0 and Study

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

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

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

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

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

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FSSA

Results: Enrollment

Estimates

- The State's actuary, Milliman, estimated that **nearly 559,000** Indiana residents would be eligible for HIP.
- **At the end of the demonstration year**:
  - Over 60% of eligible Indiana residents between ages 19 and 64 with family income at or below 138% of the FPL may have had HIP 2.0 coverage.

Observations

- **As of January 2016:**
  - **Over 345,000** actively enrolled members.
  - More than **30,000** conditionally approved members.

Results: Enrollment

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: The Lewin Group

KEY RESULT: "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."

Results: Enrollment

Nearly 89% of HIP 2.0 enrollees in January 2016 had a family income at or below the federal poverty level (FPL).

Percent FPL	Total HIP Enrollment
0%-50%	**227,958**
51%-100%	**80,324**
101%-138%	33,778
>138%*	3,596
Total*	**345,656**

Source: The Lewin Group

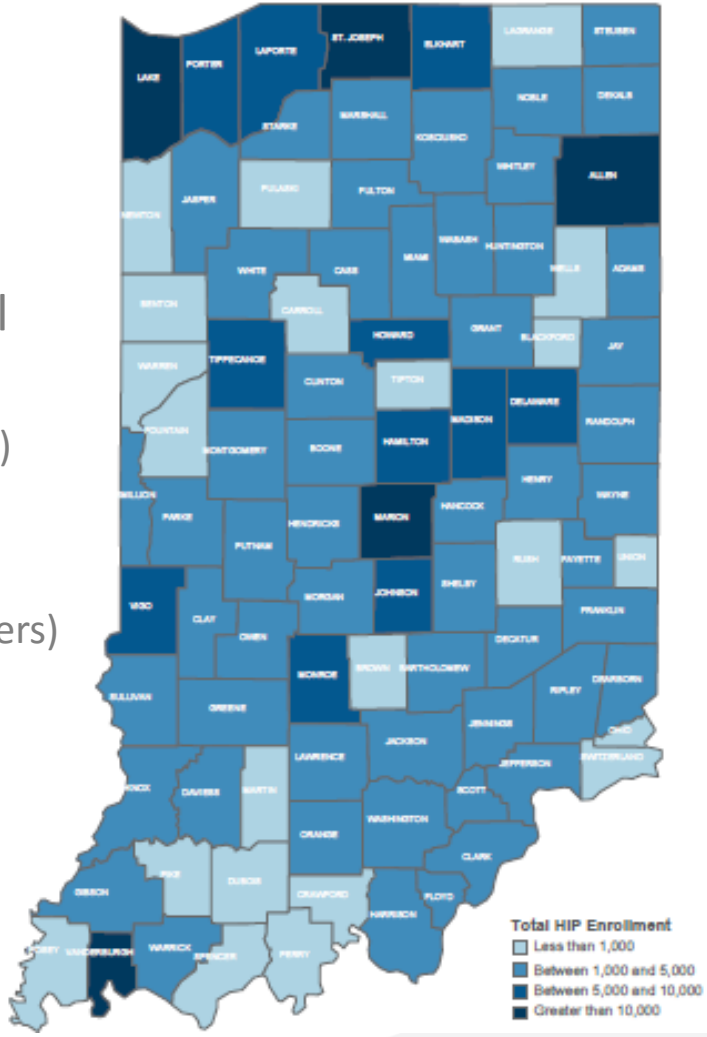
KEY RESULTS:

- 60% of HIP 2.0 members previously uninsured or underinsured, or experienced an income change that made them eligible for HIP 2.0.
- 40% of HIP 2.0 members were previously insured through Hoosier Healthwise or HIP 1.0.

Results: Enrollment

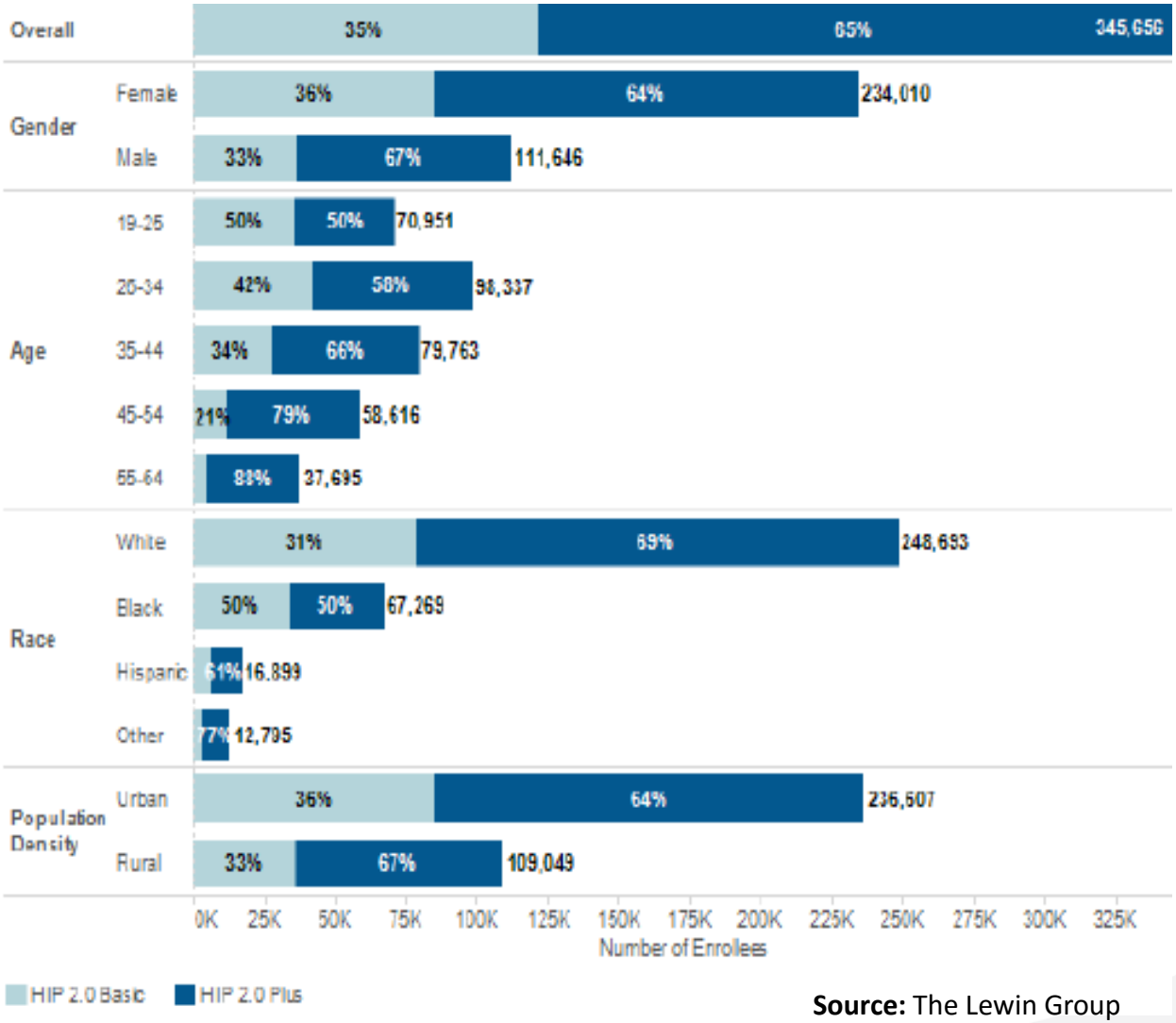
County membership:

- 203 to 67,371 members per county
- Highest enrollment and overall population:
  - Marion County (67,371 members)
  - Lake County (32,744 members)
  - Allen County (19,263 members)
  - St. Joseph County (14,355 members)



Source: FSSA

Results: Enrollment



Source: The Lewin Group

ASSESSMENT:

- Examine enrollment to determine if any specific cohorts would select HIP Plus over HIP Basic

KEY RESULTS:

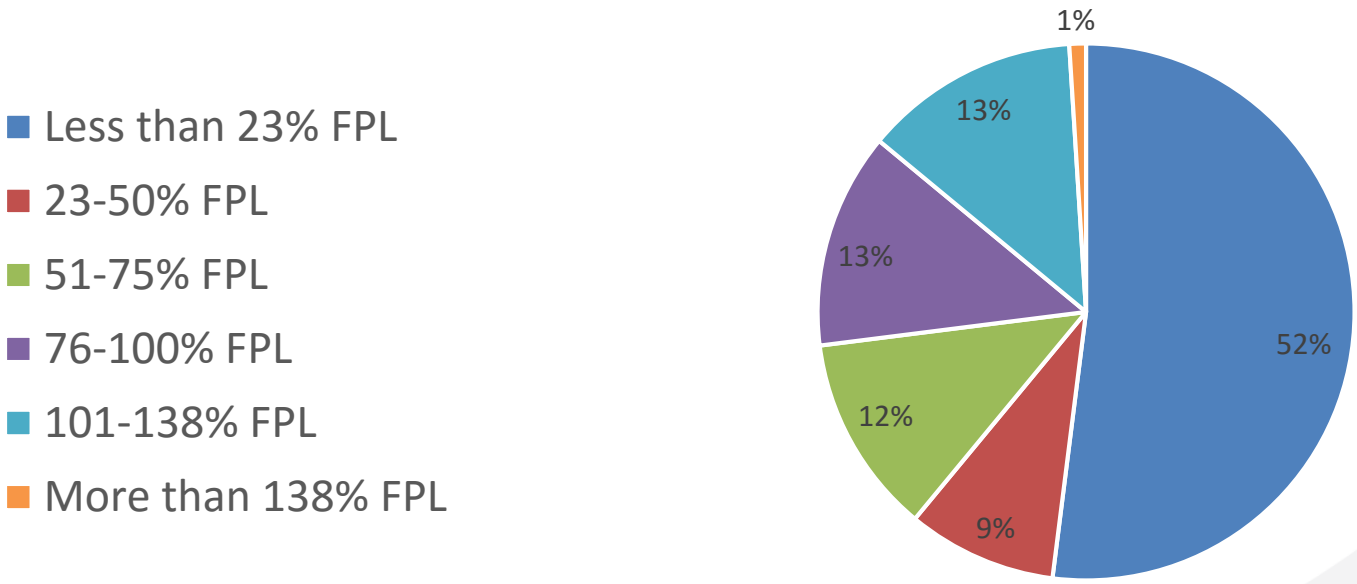
- Greater HIP 2.0 enrollment in the Plus plan relative to the Basic plan was generally consistent across all demographic groups

Results: Affordability (continued)

KEY RESULT:. HIP Plus members:

- About 65% of all enrollees
- About 62% of enrollees with income under the federal poverty level

Plus Plan Membership as of January 2016 by Federal Poverty Level



Source: The Lewin Group

Results: Affordability (continued)

- **Self-reported POWER Account contributions (PACs) by frequency**
  - **Monthly PAC:** Average contribution of $15.89 per month.
  - **Annual PAC:** Average amount was $32.33.

Average POWER Account Contribution	
For those Making Monthly Contribution	For those Making Annual Contribution
All HIP Plus Members	
Average: $15.89 (N=239)	Average: $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)

Note: * Sample size to small for reported average to be reliable. **Source:** The Lewin Group

- **Reported monthly PACs by family income**:
  - **Less than or equal to 100% FPL**: Average contribution of $13.17 per month.
  - **More than 100% FPL**: Average contribution of $28.48 per month.

Results: Affordability (continued)

As of the end of the first year of the program:

- 124 employers contributed on behalf of 131 HIP 2.0 members.

Employer Contributions	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

- 75 non-profit organizations contributed on behalf of 1,244 HIP 2.0 members.

Non-profit Organization Contributions	YTD Total
Number of Non-Profit Organizations Participating	75
Number of Members on Whose Behalf a Non-Profit Makes a Contribution	1,244
Total Amount of Non-Profit Contributions	$17,482.29
Average Amount of Non-Profit Contributions	$14.05

Source: FSSA

- Less than 1% of the HIP 2.0 population required to contribute is relying on a non-profit organization or employer for assistance with the PAC.

Results: Affordability (continued)

KEY RESULT: Most HIP Plus members did not require help making their POWER Account contributions (PACs)

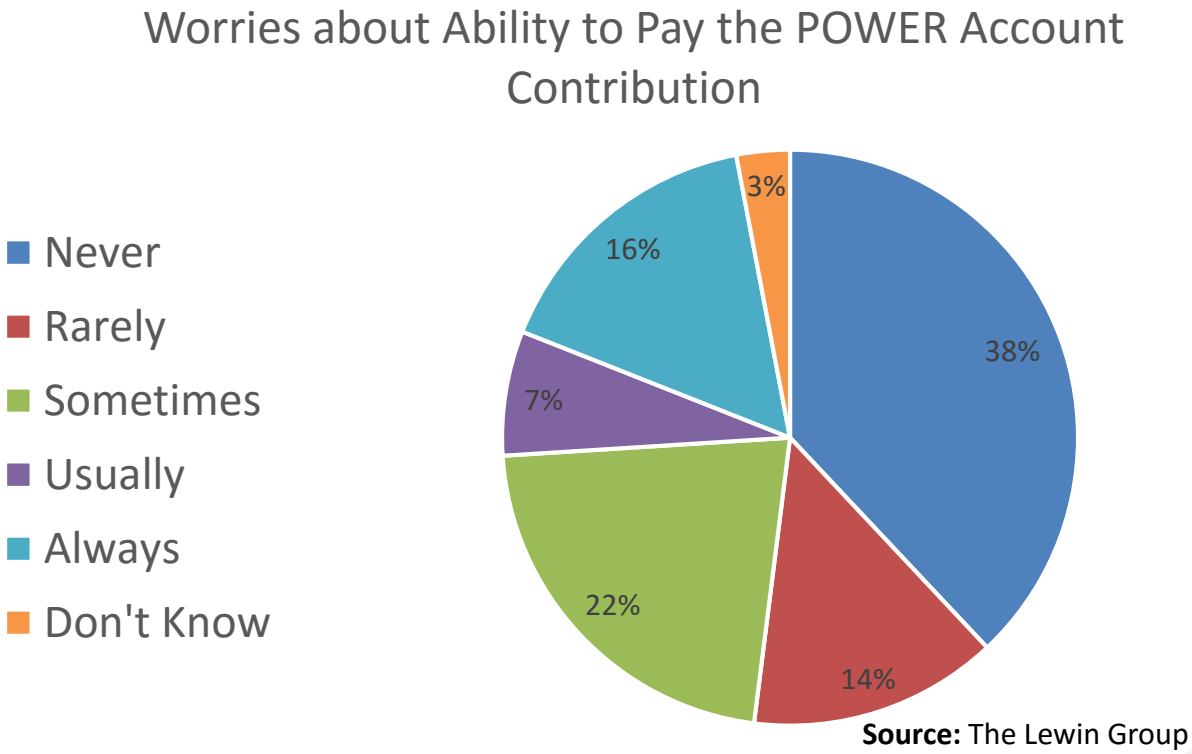
- 70% made their PAC on their own
- 30% received help paying their PAC
  - Almost all of the individuals receiving help had income less than or equal to 100 percent FPL
  - Individuals could receive help from employers, non-profit organizations, family members **and** friends

Source of Assistance	Proportion
Family Member	86%
Friend	25%

Source: The Lewin Group

Results: Affordability (continued)

KEY RESULT: Over half (52%) of members never or rarely worried about PACs during the previous six months.



Source: The Lewin Group

- Always or usually worried about PAC, and very satisfied: 50%
- Rarely or never worried about PAC, and very satisfied: 73%

Results: Affordability (continued)

HIP Plus		HIP Basic	
Yes (%)	**No (%)**	**Yes (%)**	**No (%)**
Continue to Stay Enrolled if Required to Pay $5 More			
80%	10%	87%	9%
Continue to Stay Enrolled if Required to Pay $10 More			
59%	23%	79%	13%

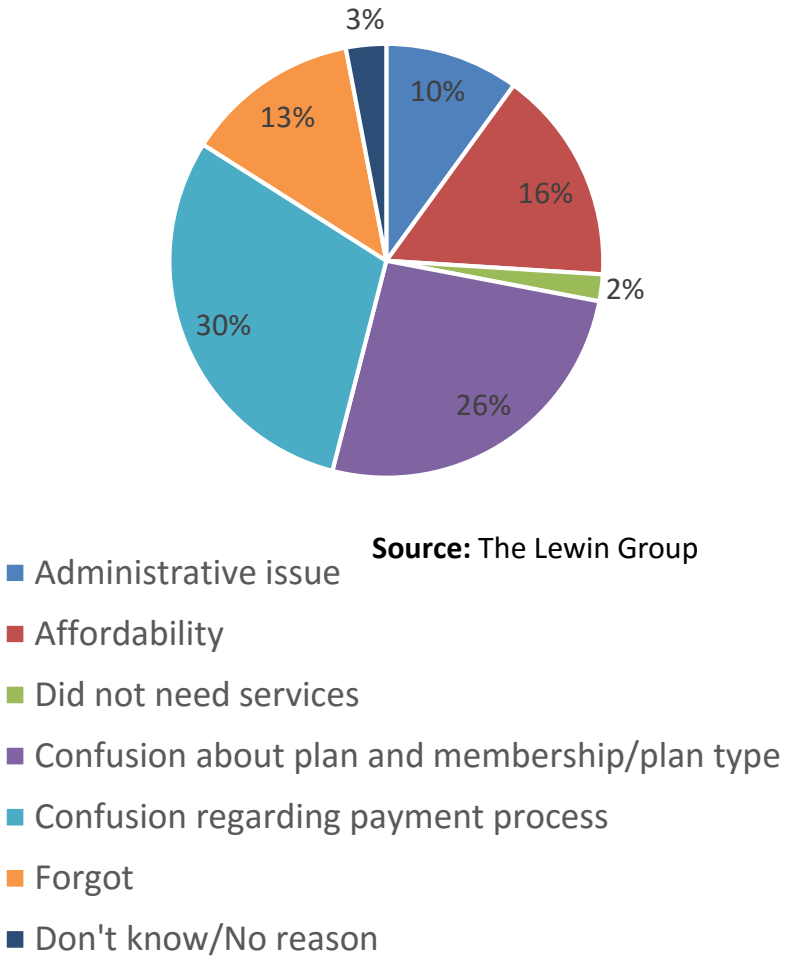
Note: Remaining responses are "Don't Know".

Source: The Lewin Group

KEY RESULTS: Among members not making monthly contributions (i.e., Basic members), 87% would be willing to pay $5 more each month for HIP coverage, and 79% said they would be willing to pay $10 more each month.

Results: Non-Payment (continued)

Reasons for Non-payment of PAC



Source: The Lewin Group

KEY RESULT: Most HIP Plus members maintain their POWER Account contributions (PACs):

- 92% of individuals with income below poverty
- 94% of individuals with income above poverty

Non-payment of PAC:

- 84% cited reasons other than affordability for not making PAC.

Results: Non-Payment

KEY RESULT: HIP Plus members were aware of the consequences for non-payment of the POWER Account contribution.

Below 100% FPL:

- **Policy**: Movement to HIP Basic
- **Awareness of the policy**: 78%

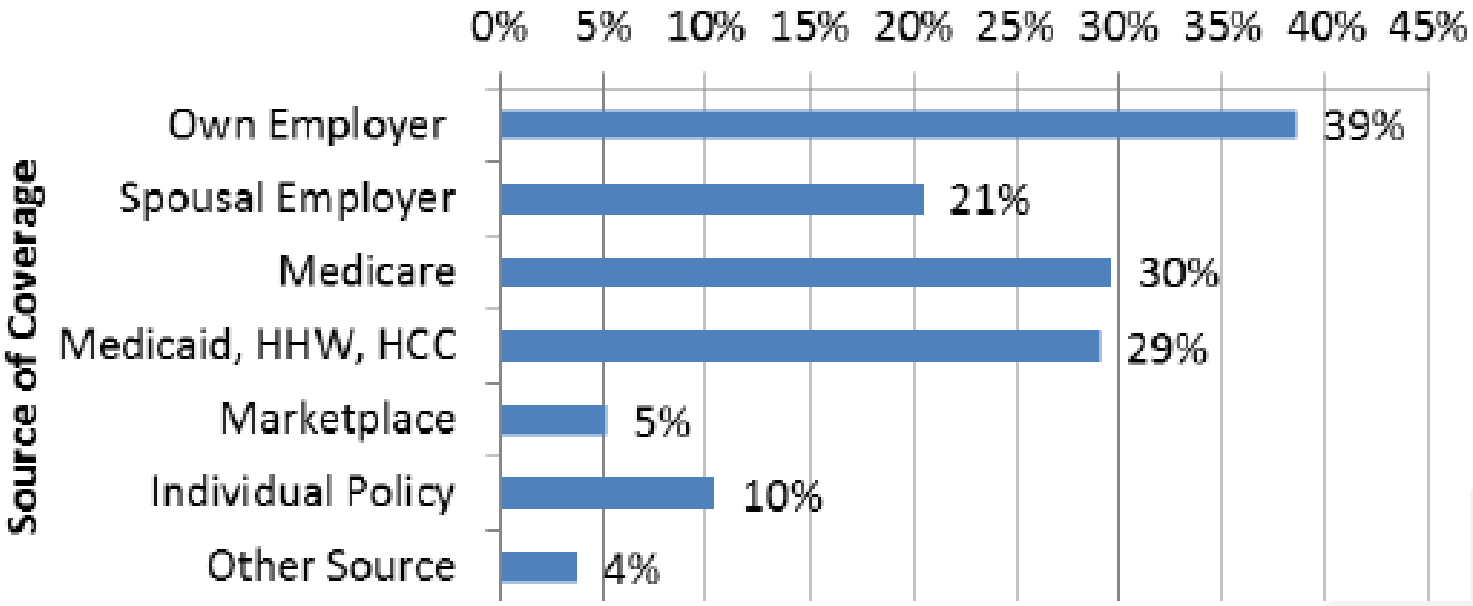
Above 100% FPL:

- **Policy**: 6 month disenrollment period
- **Awareness of the policy**: 97%

Results: Disenrollment (PAC)

HIP Plus members disenrolled for failure to pay a POWER Account contribution:

- 56% acquired other coverage
  - 39% got coverage through their employers
  - 21% got coverage through a spouse's employer



Source: The Lewin Group

Results: Disenrollment (continued)

6 month disenrollment for non-payment of POWER Account contribution (PAC):

- 5.9% of ever-enrolled members, or 2,677 individuals

Individuals may apply for a waiver of the six-month disenrollment period if they have experienced a qualifying event

- Only 6 of the 176 members who applied for exemption from disenrollment were denied

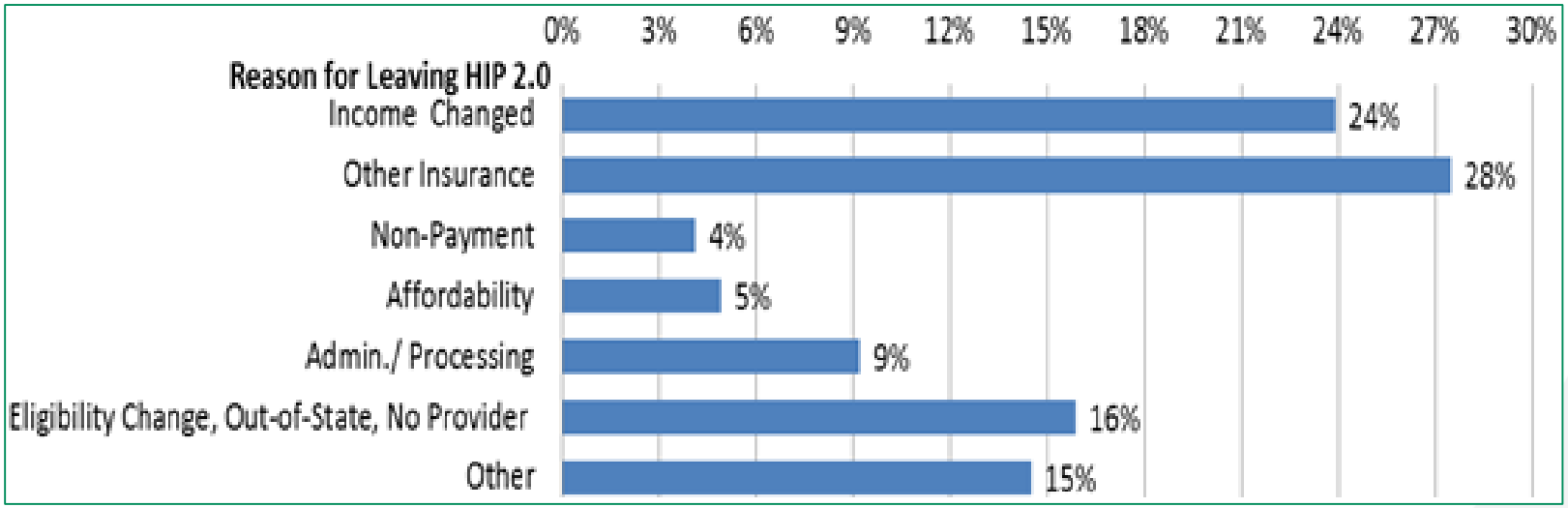
HIP Members Applied for Waiver/Exemption	Granted Waiver/Exemption	Denied	Pending
176	166	6	4

Source: FSSA

Results: Disenrollment (any reason)

Members leaving HIP in the first year:

- Approximately 61,500 members (15%) disenrolled (for any reason)
- About 16% of disenrolled members were served in another Medicaid program



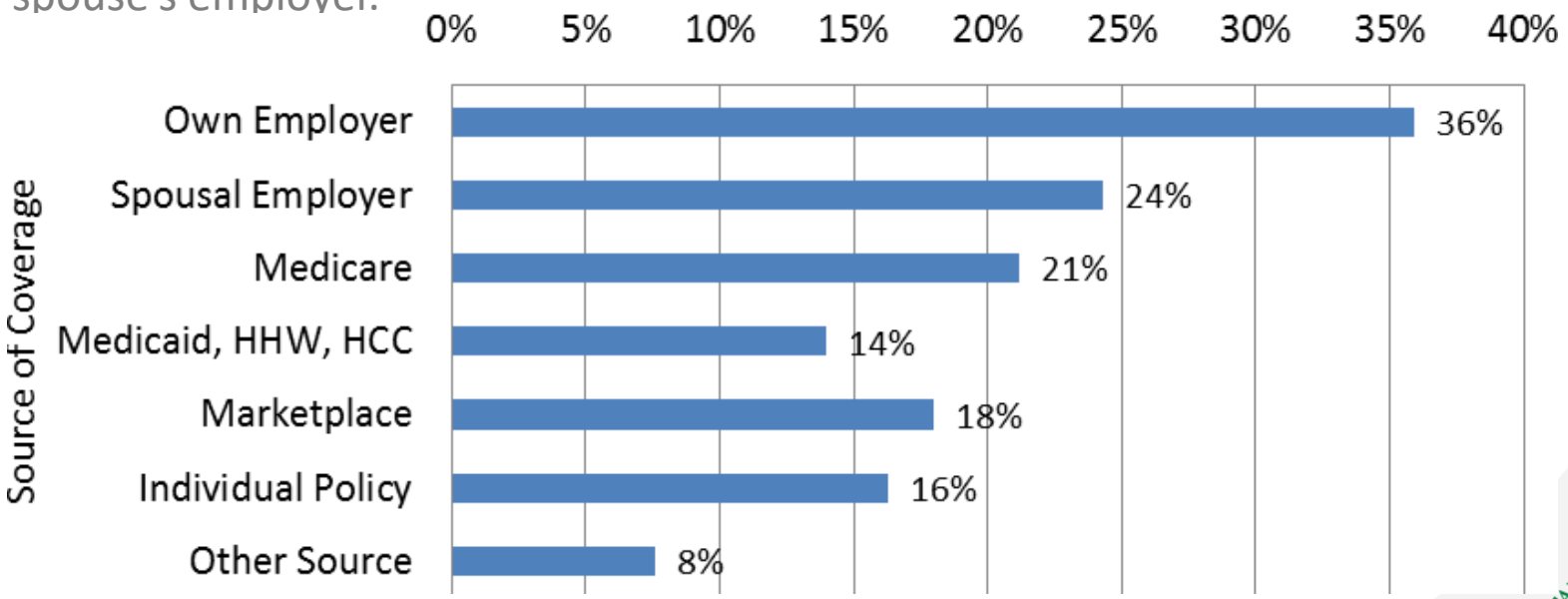
Source: The Lewin Group

Common reasons for leaving HIP*:*

- ***Income exceeds program eligibility standards.***
- Failing to comply with redetermination
- Failing to provide required supporting documentation.

Results: Disenrollment (continued)

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. 36% of members who leave HIP obtain health coverage through their employer, and 24% of members who leave HIP obtain health coverage through their spouse's employer.



Source: The Lewin Group

Results: Fast Track

Unique Members Making Fast Track Payment

- 30,856 enrollees
- 11% of Plus members

Members Making Fast Track Payments Since Policy Began

- 18% of ever enrolled members
- 26% of Plus members

Presumptive Eligibility (PE) Members Making Fast Track Payments

- 6,365 members
- Represents 22% of all previously PE members & 40% of all previously PE Plus members.
- Higher than Fast Track payment rates 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% FPL are particularly likely to make a Fast Track payment; about 60% of previously-PE members make a Fast Track payment.

Using Care Within First Month of Enrollment

- Fast Track members are not using more care in their first month of enrollment than members who do not make Fast Track payments.

Fast Track payments were established in April 2015 as a way for eligible HIP members to expedite the start of their coverage. If a member makes a Fast Track payment HIP Plus coverage begins the first of the month in which the payment was made.

Source: The Lewin Group

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Results: Network Adequacy & Access

Member Access Requirement	Outcome Achieved?
Primary care provider within 30 miles	✓
At least 90% of members have access to at least one vision provider within 60 miles	✓
At least 90% of members have access to at least one dental provider within 60 miles of their home	✓

Source: The Lewin Group

Results: Member Perspective on Access

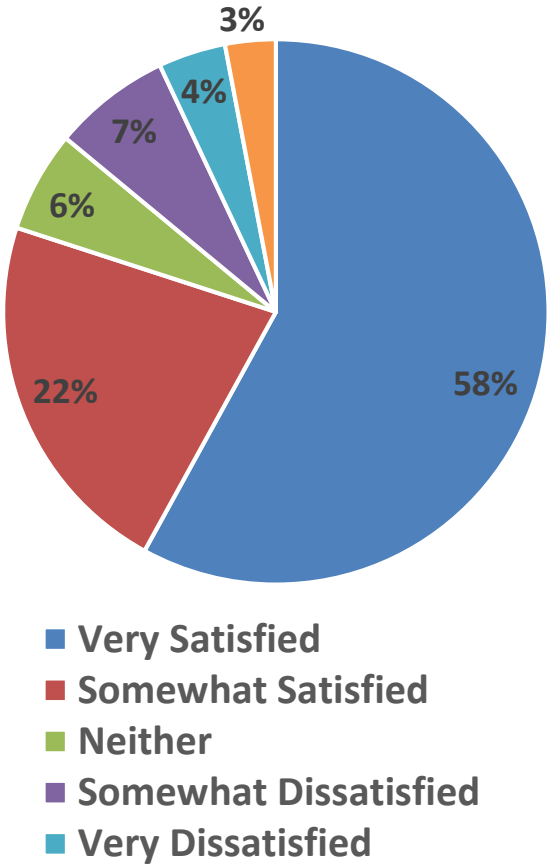
- HIP enrollees' perspective on their ability to access care was aligned with national averages on the Consumer Assessment of Healthcare Providers (CAHPS).
- Current members reported having a ***greater likelihood of accessing routine care, specialist care and prescription drugs,*** compared to respondents who were disenrolled or never enrolled.

	Adult Medicaid CAHPS Survey	HIP Enrollees
Always or usually acquired routine appointments as soon as needed	79%	74%
Always or usually acquired appointment with specialists as soon as needed	80%	79%

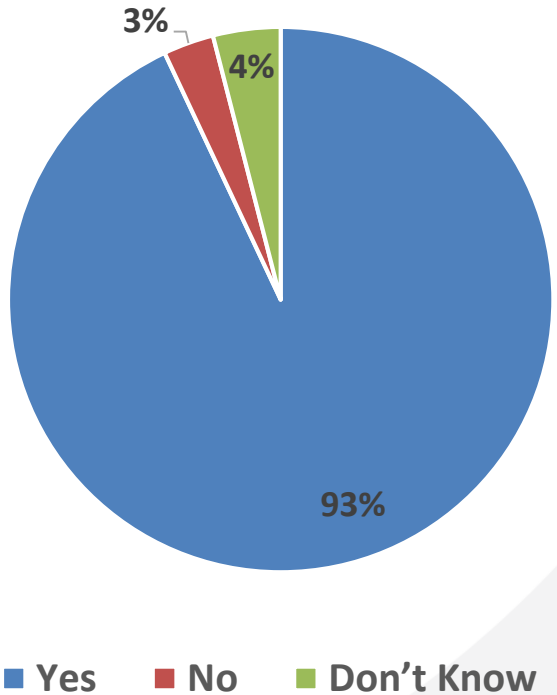
Source: The Lewin Group

Results: Satisfaction

Overall Experience with HIP in Past Six Months



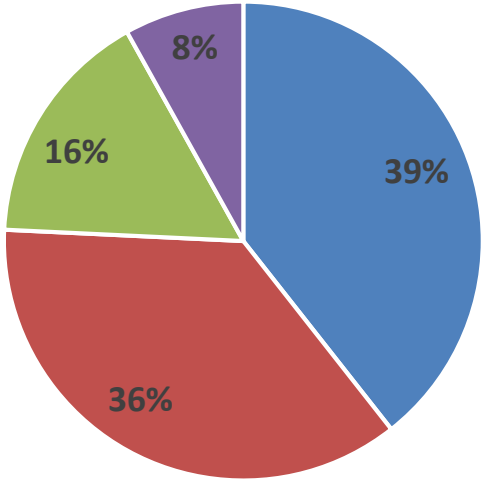
Would Try to Re-enroll in HIP if Left HIP but Became Eligible Again



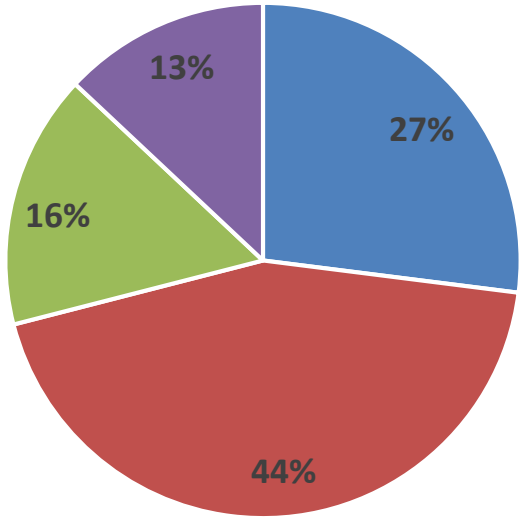
Source: The Lewin Group

Results: Provider Impact

Provider Responses Regarding Change in Requests for Charity Cases

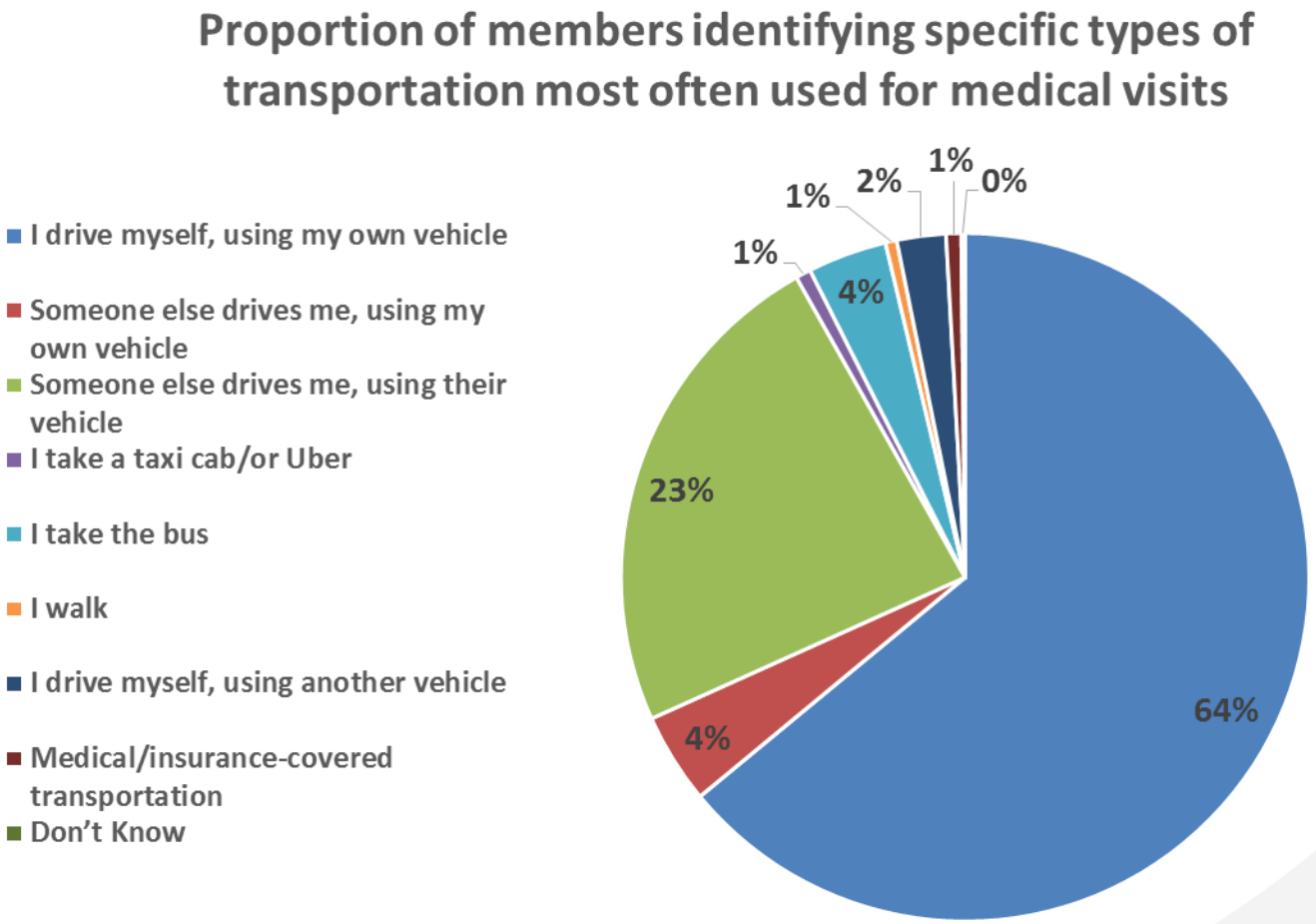


Provider Responses Regarding Change in Instances of Bad Debt



Source: The Lewin Group

Results: Non-emergency Medical Transportation



Source: The Lewin Group

Results: Non-emergency Medical Transportation (continued)

1. Transportation was reported as a reason for missing an appointment by approximately 6% of members ***without*** state-provided non-emergency medical transportation (NEMT).

2. Transportation was reported to be a reason for missing appointments by 10% of members ***with*** state-provided NEMT.

3. Members without NEMT benefits did not appear to be substantially more likely to report transportation problems compared to those with MCE or state-provided NEMT benefits.

In summary, a relatively small number of HIP 2.0 members missed appointments due to transportation-related issues.

Results: POWER Account and Cost-conscious Behavior

HIP 2.0 enrollees acknowledge and monitor their POWER accounts and ask their providers about their cost of care

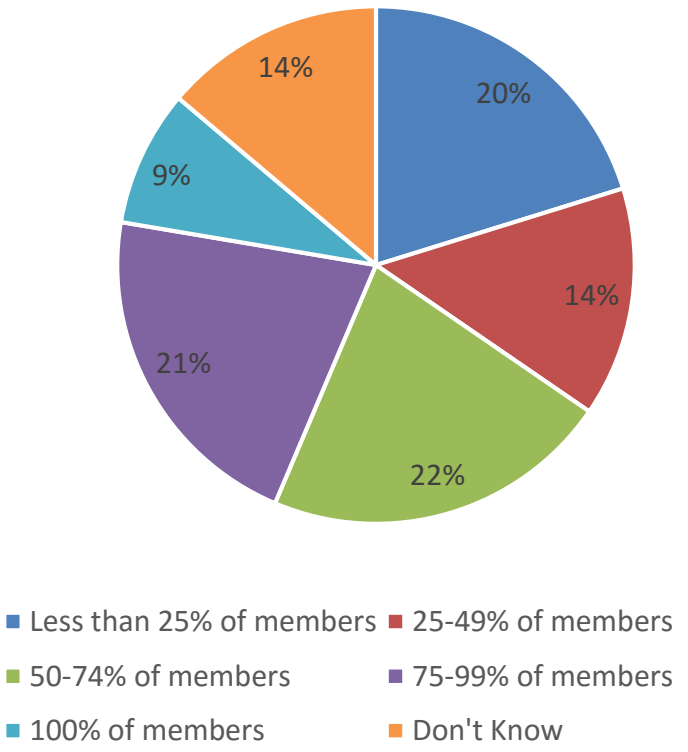
	HIP Plus Respondents	HIP Basic Respondents
Heard of the HIP POWER account	66%	46%
…and report having a POWER account	72%	76%
…and report checking the POWER account balance monthly	40%	30%
Ask provider about cost of care	27%	N/A

Source: The Lewin Group

*Sample sizes too small to be reliable

Results: Co-payments

Percentage of HIP members making their co-payments, as reported by surveyed providers



Providers understand how to identify HIP members with a co-payment obligation and collect payment as appropriate	
Providers who know how to identify if HIP members are required to pay co-payments	88%
…and report using the Eligibility Verification System to identify co-payment requirements	83%
Providers who report charging co-payments to HIP members	84%
…and report collecting co-payments at the point of service	80%

Source: The Lewin Group

Results: Member Knowledge of the Program

Topic	Member Understanding of Key Program Policies	HIP Plus Respondents	HIP Basic Respondents
Cost sharing for preventive services	Believe preventive services would be deducted from the POWER account if enough money available in the account	52%	51%
	Believe that getting preventive services suggested by the plan every year and having money left in their POWER account will allow part of that money to be rolled over into the POWER account for next year.	65%	57%
Rollover policies	**Basic members** that believe that if they do not get health plan recommended preventive care during the year, and have money left over in the POWER account, they will not be able to reduce monthly contributions if they move to HIP Plus.	N/A	35%
	Plus members that believe that if they do not get health plan recommended preventive care during the year, and have money left over in the POWER account, the amount that is rolled over will not be doubled.	52%	N/A

Source: The Lewin Group

No cost sharing for preventive services

- 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
- 39% of HIP Plus and 40% of HIP Basic survey respondents reported "Don't Know"
- Members surveyed were not enrolled for a full year

Rollover

- The majority of Plus members understand that they must get preventive services to get rollover

Results: Health Status

For members with at least 6 months enrollment:

- 37% had one to two chronic conditions and an additional
- 24% had more than two

Percent of Reported Chronic Conditions

Psychiatric	Cardiovascular	Skeletal	Gastrointestinal
22.2%	20.5%	14.2%	12.%

Source: The Lewin Group

HIP Plus members have higher morbidity than HIP Basic Members

- Out of all HIP members, HIP Plus members with income up to 100% FPL are the most likely to have chronic conditions and the most likely to be medically frail

Results: Health Status (continued)

Disease Category	Total Members with Disease	Percent of Members with Disease
Members with at least one disease below	73,591	26.2%
Diabetes	21,120	7.5%
Congestive Heart Failure	1,766	0.6%
Coronary Artery Disease	5,022	1.8%
Asthma	5,893	2.1%
Chronic Obstructive Pulmonary Disease	12,673	4.5%
Chronic Kidney Disease	508	0.2%
Autism	108	<0.1%
Depression	26,931	9.6%
Attention Deficit Hyperactivity Disorder	5,789	2.1%
Substance Abuse	12,687	4.5%

Source: The Lewin Group

Note: There were 281,471 members enrolled for more than 6 months used for this analysis. Prevalence based on data in claims.

- Prevalence rates are greater in HIP Plus than HIP Basic.
  - More than 25% of HIP Plus members have at least one of the conditions compared to 17.8% of HIP Basic members
- Members with one of the specified conditions are more likely to use preventive and primary care.

Results: Utilization of Services

- HIP Plus members miss fewer appointments (18%) than HIP Basic members (23%)
- HIP Plus enrollees are more likely to use health care than HIP Basic members
  - HIP Plus members are 64% more likely to use specialty care, but 93% more likely to use primary care

Utilization Statistic	HIP Plus			HIP Basic		
	Primary Care Visits	Specialty Care Visits	Preventive Care Services	Primary Care Visits	Specialty Care Visits	Preventive Care Services
Percent of unique Members who used the Service/Visit	31%	46%	64%	16%	28%	45%

- HIP Plus enrollees are more likely to adhere to prescription drugs compared to Basic members..

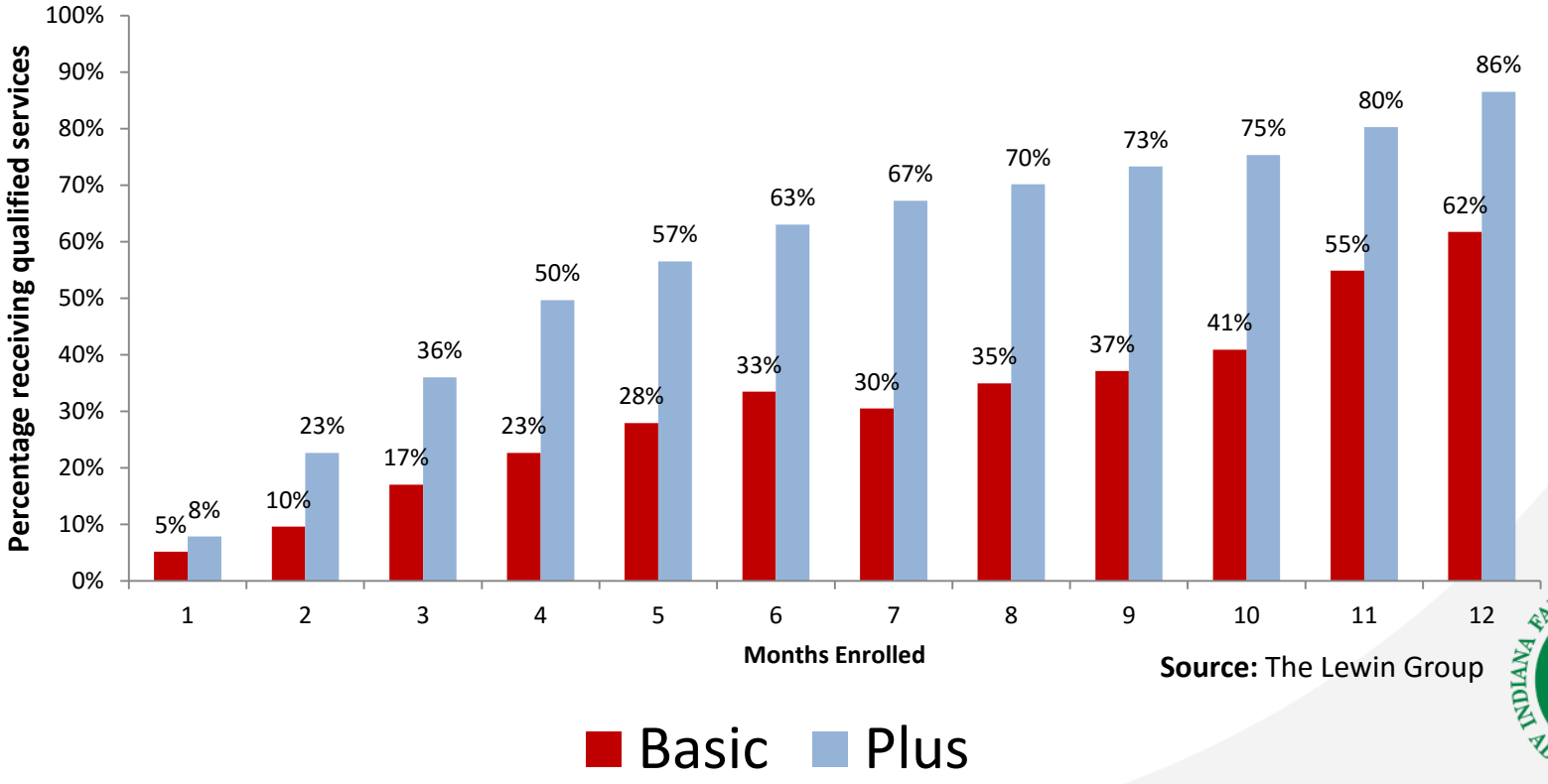
Plan	Adherence	Generic fill rate	Brand fill rate	
			Total	When generic is available
HIP Basic	67.1%	84.3%	15.7%	0.2%
HIP Plus	84.0%	82.0%	18.0%	0.4%

- HIP Plus enrollees are more likely to use urgent care (6.0%) than HIP Basic (2.3%)

Source: The Lewin Group

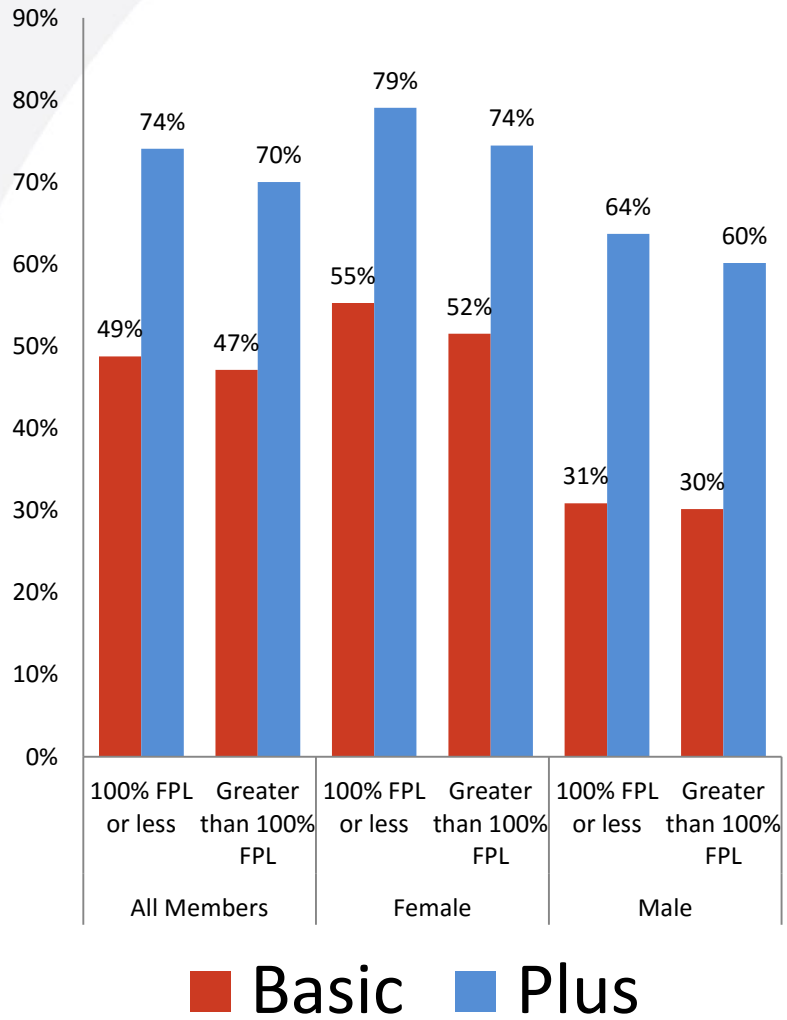
Results: Preventative Care

KEY RESULT: The longer members are enrolled, the more likely they are to get preventive services – ***75% + of all members enrolled for 12 months received preventive care.***



Source: The Lewin Group

Preventative Care (continued)



- **KEY RESULT:** HIP Plus members were ~42% more likely to utilize preventive care services than HIP Basic members

- **KEY RESULT:** Plus members at all income levels and genders are more likely to use preventive care. Same for all age groups (data not shown here).

Source: The Lewin Group

Results: Emergency Room Usage

1. HIP Plus members had lower rates of hospital emergency department (ED) use compared to HIP Basic members (for both overall utilization and non-emergency utilization)

	ED Utilization	Non-Emergency Use of ED
HIP Plus	775.4 (per 1,000)	183.6 (per 1,000)
HIP Basic	1,033.6 (per 1,000)	262.6 (per 1,000)

Source: The Lewin Group

2. In addition, HIP Plus members are also *more likely* than HIP Basic members to utilize the ED for conditions or issues that were *not preventable or avoidable*
   - These trends are consistent with the finding that HIP Plus members generally use more preventive and primary care services

Results: HIP Link

1. June 2015: HIP Link implemented an employer portal to receive employer applications for participation
   - ***50 eligible employers*** have been enrolled as of July 20, 2016

2. Future Evaluation Planned
   - Future evaluation activities include:
     - Evaluating the effectiveness in the program at increasing the proportion of low-income residents covered by employer-sponsored insurance
     - Analyzing the effects of HIP Link on employers and employees

Results: Gateway to Work

Gateway to Work is a voluntary referral program that connects HIP members who are unemployed or working less than 20 hours per week to available employment, work search and job training programs.

- As of January 31, 2016, a total of 307,156 letters were mailed to inform HIP members of the Gateway to Work program.
- 3,277 calls have been received from interested HIP 2.0 members
- A total of 1,196 Gateway to Work orientations have been scheduled, with a total of 551 orientations attended.

Results: Presumptive Eligibility (continued)

In the first year, 208 Presumptive Eligibility (PE) providers (about 6% of potentially qualifying providers) made a PE eligibility determination.

Provider Prime Specialty	Number of Potentially Qualifying Providers	Number of Providers Making PE Determinations
Acute Care Hospital	125	113
Community Mental Health Center	25	21
Federally Qualified Health Center	26	22
Psychiatric Hospital	41	20
Rural Health Clinic	67	22
County Health Department	49	10
Total	333	208

Source: FSSA

87% reported that the PE process is either very effective or somewhat effective at eliminating gaps in healthcare coverage.

32% reported that they track whether members complete a full Medicaid application and 56% report that they believed the success rate of their PE members getting full Medicaid coverage is over 50%.

Other State Findings: Presumptive Eligibility

	PE Applications Submitted	PE Applications Approved	% PE Applications Approved	IHCP Application Submitted	% of PE Member with IHCP Application Submitted (Goal 95%)	IHCP Applications Approved	IHCP Applications Denied	% IHCP Applications Approved (Goal 95%)	% IHCP Applications Denied	% IHCP Applications Pending
Acute Care Hospital	31,083	22,688	73%	20,255	**89.3%**	4,817	12,788	27.4%	72.6%	13.19%
FQHC	3,687	3,098	84%	2,739	**88.4%**	1,016	1,387	42.3%	57.7%	12.3%
CMHC	1,468	1,137	77.5%	1,017	**89.4%**	210	681	23.6%	76.4%	12.4%
Psych Hospital	533	434	81.4%	385	**88.7%**	82	244	25.2%	74.8%	15.3%
RHC	21	15	71.4%	13	**86.7%**	2	11	15.4%	84.6%	0
Total	**36,792**	**27,372**	**74.4%**	**24,409**	**89.2%**	**6,127**	**15,111**	28.8%	**71.2%**	**13%**

Source: FSSA

Hospital PE Performance Standards

405 IAC 2-3.3-3

(2) Beginning January 1, 2016, as follows:

(A) Ninety-five percent (95%) of presumptively eligible individuals from a qualified hospital shall complete and submit an application before the end of the presumptive eligibility period.

(B) Ninety percent (90%) of applications submitted for applicants will be sufficiently complete.

(C) Ninety-five percent (95%) of the applicants who complete and submit an application shall be determined eligible for a Medicaid program.

This code applies only to Acute Care Hospitals and Psychiatric Hospitals. Identical standards are in the Rule promulgation process for all other qualified provider types.

In the Feb-April 2016 quarter, 31 Acute Care Hospitals, 5 FQHCs, 8 CMHCs, 6 Psychiatric Hospitals, and 1 RHC meet the first metric of 95% or more PE members completing a full IHCP application. (A) above.

No Qualified providers have meet the standard for (C) above.

Hospital PE Performance Standards (cont.)

- *"The office shall periodically review a qualified hospital's application submissions and assess its performance. The office shall initiate the following actions if its review of a qualified hospital's performance indicates it fails to meet the performance standards in subsection (a) during any given calendar quarter:*
- *The office shall issue a written warning to the qualified hospital and require the qualified hospital to submit a ninety (90) day corrective action plan within thirty (30) days of its receipt of the written warning" 405 IAC 2-3.3*

OMPP is committed to working with hospitals and QPs to improve performance in the PE program.

QPs will be given the opportunity to improve their performance before their eligibility to be a QP is revoked.

Corrective Action Plan letters to hospitals will be sent out starting in August 2016.

Next Steps and Q&A

KEY DATE

- **March 2018**: Final Evaluation due to CMS

Presentation will be available online at FSSA HIP 2.0 Documents & Resources Webpage: http://www.in.gov/fssa/hip/2468.htm