

Healthy Indiana Plan 1115 Waiver Renewal Application

Document Draft for Public Review

Public Comment Period: October 12, 2011 to November 16, 2011

The following draft application for public review will be submitted to the Centers for Medicare and Medicaid Services to extend the Healthy Indiana Plan (HIP) for the maximum renewal period of three years. HIP is set to expire December 31, 2012 and approval of this renewal application is necessary to continue the program.

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Section 1: Executive Summary

Indiana is pleased to submit a request to extend the groundbreaking Healthy Indiana Plan (HIP) section 1115 demonstration project to the Centers for Medicare and Medicaid Services (CMS) for the maximum waiver renewal period of 3 years. As a result of the recent changes to Medicaid eligibility initiated by the Patient Protection and Affordable Care Act (ACA) and changes requested by the Indiana General Assembly, this waiver renewal application includes minor modifications to HIP, as well as a request for HIP to serve as the coverage vehicle for individuals newly eligible under the ACA Medicaid expansion.

The HIP demonstration project was approved in December 2007, and the program began January 1, 2008. HIP covers caretaker and non-caretaker adults up to 200% of federal poverty level (FPL)¹. HIP represents one of the first Medicaid demonstration projects that worked towards harnessing the promise of consumerism through member participation to incentivize positive health behaviors and improve health outcomes. The program created Personal Wellness and Responsibility (POWER) accounts modeled after Health Savings Accounts (HSA) to encourage enrollees to think about health care as consumers. Over three years later, HIP has demonstrated significant success and remains the sole Medicaid demonstration project modeled on the principals of consumer-driven health plans.

In 2010, the Indiana Legislature passed Senate Enrolled Act 461, which became Indiana Code (IC) 12-15-44.2, calling for HIP to be the coverage vehicle for the newly eligible Medicaid population under the ACA. This legislation also adds a requirement for enrollees to make a minimum contribution to their POWER account of \$160 annually, allows not-for-profits to make up to 75% of the members required contribution to the POWER account, authorizes health plans (MCEs) to contribute to the POWER account to incentivize positive health habits, and changes HIP eligibility from 200% FPL to align with the ACA expansion limit of 133% FPL starting in 2014. The \$160 annual contribution will still be subject to requirements in IC 12-15-44.2 that stipulate that an enrollee may not contribute more than 5% of their income in contributions and copayments for health care; for individuals who have reached the 5% contribution limit contribution requirements will be suspended.

Over the first three demonstration years, HIP experienced success. Between January 2008 and December 2010, HIP served 77,466 Hoosiers. In two separate independent evaluations of the program, HIP members have shown high satisfaction and member satisfaction surveys conducted by the contracted health plans show satisfaction rates greater or comparable to commercial plans. The HIP program has noted differences in care utilization patterns compared with traditional Medicaid programs, including greater use of preventive care, lower Emergency Room (ER) use,

¹ Caretakers are a categorically eligible Medicaid population; these individuals have a dependent under the age of 19. Non-caretakers are adults without dependents under the age of 19 that the HIP waiver grants the State permission to cover to an enrollment cap of 36,500 individuals, contingent upon the waiver's budget neutrality agreement.

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and increased utilization of generic pharmaceuticals. Eighty-percent of HIP enrollees complete the preventive services required for a POWER account rollover and during the first 12 months of enrollment HIP member utilization of the ER decreased by 14.8%.

Within HIP itself, differences in care utilization have been observed between members who contribute to their POWER account and members who do not contribute, suggesting significant impacts of empowering individuals through an HSA type account. Non-contributors overall have a higher use of ER services and non-emergency ER visits that could be partially explained by not having to pay into POWER accounts. Non-contributors have 66.8 non-emergent ER visits per 1,000 members while contributors have 34.7 non-emergent ER visits per 1,000 members. The non-contributing population in general suffers from higher morbidity, however, the POWER account contributions and the influence of consumerism cannot be ruled out as factors contributing to this vast difference in utilization².

Over the course of the program HIP members have engaged in positive health behaviors including: seeking preventive services at rates higher than comparable Medicaid populations, decreasing their non-emergency use of the ER and increasing their utilization of services offered by primary care physicians. HIP members are aware of their POWER account balance and supportive of the program: 94% are satisfied or highly satisfied with their coverage, and 99% of HIP enrollees would choose to reenroll in the program³.

A primary goal of the HIP program has been to promote personal responsibility. After the first three years of the program HIP is making significant progress on this goal. Survey data collected by Mathematica in 2010 suggests that the majority of respondents knew key features of the program. For example, most HIP members were aware of their POWER account, believed that they had been given adequate information about the account, and knew where to look for more information if they needed it. Additionally, most members pay their POWER account contribution on time, and during the first two years of the program only 3% of enrollees were disenrolled for failing to pay their POWER account contribution. While in 2010 this number grew to 8% of enrollees, data for 2011 shows a decrease back to the 3% level. In addition to POWER account payments, enrollees are required to complete a redetermination packet and return it in a timely manner. A Mathematica analysis for the first two years of the program showed that 85% of HIP enrollees submitted redetermination packets on time. And for the third year of the demonstration, 2010, 96% of enrollees submitted their redetermination packet on time. These results suggest that HIP is encouraging members to engage in their health care and that the members value the program.

The HIP demonstration period ends December 31, 2012, and Indiana would like to extend the program for the maximum waiver renewal period of three years. Eligibility and budget

² Data from Mathematica Data Enclosure, December 2010.

³ Product Acceptance Research Telephone Survey of HIP members, 2009.

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neutrality requirements would remain the same in 2013 with the exception that disproportionate share hospital payments (DSH) will not be diverted. With the changes in Medicaid eligibility in 2014, the caretaker and non-caretaker categories under HIP become the 'Adult group'⁴; this waiver renewal application reflects these proposed changes to the Medicaid categories. Starting in 2014, consistent with the requirements of the ACA that all individuals under 133% FPL receive Medicaid coverage the State would like to designate HIP as the vehicle to cover the newly eligible Medicaid population. The State requests minor modifications to the waiver and budget neutrality agreement to correlate with the recent legislation and the ACA.

Section 2: Program Description and Background

HIP provides an alternative to traditional Medicaid and is the nation's first consumer-driven coverage program for low-income adults. HIP features a comprehensive high deductible health plan and a modified Health Savings Account (HSA) called the POWER account, which invites members to be thoughtful and engaged health care consumers. Contingent on payment of a monthly contribution to their POWER account, the current waiver provides HIP eligibility to Hoosiers between the ages of 19 and 64, earning below 200% FPL, and who have not had access to employer sponsored insurance for at least six months.

As covering deductible costs is a known challenge for low income populations, HIP modifies the traditional HSA model to make it compatible with low income needs and limitations. First, the State subsidizes the POWER account to ensure the account is fully funded, up to the amount of the deductible. It requires health plans to provide payment to providers for deductible costs, even though the account may not contain the individual's full annual contribution. The State also ensures that the deductible is not a barrier to recipients receiving preventive services, as the first \$500 in preventive services are provided outside the deductible. While HIP contributions are not tax deductible, most participants are below federal poverty level and would not avail income tax benefit from tax deductible contributions.

After a \$1,100 deductible is met, the HIP program includes comprehensive health plan benefits which are waived from certain benchmark requirements⁵. Instead of traditional cost-sharing of premiums and copayments, HIP participants make upfront contributions for their health care through required POWER account contributions. The funds contributed to the POWER account are used to pay for deductible expenses. Contributions are based on a sliding scale so that individuals can afford to make the monthly payments but still have "skin in the game." The program ensures that no participant pays more than 5% of their income, consistent with CMS rules. Employers are also allowed to contribute up to 50% of the required contribution.

⁴ As described by the *Medicaid Program: Eligibility Changes under the Affordable Care Act* notice of proposed rulemaking at 435.119.

⁵ HIP is not a benchmark plan due to the lack of maternity and dental coverage, and the annual and lifetime coverage limits.

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Participants have control over how POWER account dollars are spent and receive monthly statements on POWER account expenditures and account balances. If participants fail to make their contributions within sixty days, they are removed from the program and may not reenroll for twelve months. Unlike traditional Medicaid premiums or copayments, HIP members own their contributions and can have any unused contributions returned if they leave the program. Additionally, HIP members who receive required preventive services are rewarded by allowing any remaining balance--including the State's contribution-- in their POWER account to rollover to offset required contributions in the next year. If individuals do not complete the required preventive services only the pro-rated balance of their individual contribution rolls over. Any rollover can reduce required contributions in the following year, though it should be noted that not all HIP enrollees have POWER account balances remaining as some of them meet their deductible during the covered year. The incentive is designed to increase use of preventive care and in the long term, the regular use of preventive services under the HIP program should reduce costs and improve the health of the individual and population.

HIP provides benefits including physician, inpatient, outpatient, mental health services, pharmaceuticals, labs, and other therapies. HIP requires copayments for non-emergency use of the emergency department; these copayments vary from \$3 to \$25 dependent on an individual's caretaker status and his or her federal poverty level (FPL). Different from traditional Medicaid programs, individuals are provided with monthly Explanations of Benefits that explain costs of care. These provisions are aimed at increasing members' awareness of the cost of care and promoting consumerism and efficient care seeking behavior.

HIP promotes personal responsibility by requiring that members are timely with payments and eligibility paperwork submission; otherwise enrollees face a twelve month penalty period before they can reenroll in the program. This also ensures that individuals do not enroll only when they are ill and require treatment and then drop coverage when they recover. HIP provides reimbursement to health care providers at Medicare rates, which in Indiana is higher than traditional Medicaid, encouraging a more robust provider network. These increased rates also improve enrollee access to care. HIP's progress towards meeting its program goals will be discussed later in this document.

Section 3: Historical Narrative

In 2006, Indiana ranked second in the nation for incidence of adult smoking, had poor general health indicators, and a low rate of preventive care utilization; additionally, 860,000 individuals⁶ had been without health insurance in the last year and 62% of these uninsured were working age adults below 200% FPL⁷. Prior to HIP, the Indiana Medicaid program had one of the lowest

⁶ U.S. Census Bureau, Current Population Survey (CPS), 3-year average, 2003-2005

⁷ State Health Access Data Assistance Center (SHADAC), University of Minnesota, *2003 Health Insurance for Indiana's Families Summary* (August 2003).

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eligibility thresholds in the nation and only covered non-disabled caretakers up to 23% of FPL. There was reluctance to expand the State's traditional Medicaid program as an open-ended entitlement. Traditional Medicaid had the potential to strain the State's budget, a questionable ability to significantly improve the health status of individuals, a lack of incentives for participants to utilize health care appropriately, and the structure did not promote personal responsibility. While consumer driven health plans and HSAs were used in the commercial marketplace, they had not been used for low-income populations. Based on input from numerous stakeholder meetings, Governor Mitch Daniels instructed his staff to design a health care plan that incorporated health care consumerism and private market principles. This ensured the maintenance of a balanced State budget by not creating an open-ended entitlement program, and promoted health for Hoosiers.

Governor Daniels presented the design of the HIP program to the public in November of 2006. Once proposed, Republican State Senator Pat Miller and Democrat State Representative Charlie Brown championed the effort and sponsored House Bill 1678 during the 2007 session of the General Assembly. Through their leadership, the Indiana Check-Up plan, which contained the enabling legislation for HIP, passed with bipartisan support with votes of 70-29 in the House of Representatives and 37-12 in the Senate. HIP's enabling legislation only permits the State to enroll as many individuals as its funding can support to ensure long term budget sustainability. HIP enrollment is constrained by the number of dollars generated through a cigarette tax increase included in the enabling legislation that funds the program; this tax increase simultaneously discourages smoking.

After the bill was passed in April 2007, the Family and Social Services Administration (FSSA) moved immediately to develop an implementation plan. They began negotiations with CMS to obtain federal waiver approval. HIP began enrolling working-age, uninsured adults on January 1, 2008, seven months after passage of the enabling legislation and less than a month after receiving approval for the program from the CMS. HIP was the first, and is still the sole, Medicaid program that harnesses the powers of consumerism through an HSA model to promote responsible health care consumption. It marries the best intentions of the Medicaid program with more modern features of a high deductible health plan (HDHP) containing an HSA model, while creating a plan for long term financial sustainability.

HIP was created to serve the needs and improve the health of low income Hoosiers who did not have access to health insurance coverage. Concurrently, it aligned with the State's commitment to consumerism and high deductible plans, as these types of plans are also offered to state employees.

In traditional Medicaid programs, participants have minimal incentive to utilize health care services appropriately or to be responsible for their health. HIP sought to give its enrollees affordable coverage and include incentives and tools to be cost conscious consumers of health

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care. Since 2008, the program has demonstrated that an HSA model can effectively serve a low income population.

An unforeseen challenge of HIP was the pent-up demand for services in the uninsured population. Initially, the HIP population used services at a greater rate than the traditional Medicaid population, likely due to untreated disease in this previously uninsured population. However, since inception, HIP members have taken advantage of preventive services, lowered their ER use, and learned to manage their chronic conditions through the use of prescription medications. Over the course of HIP, the program has met and exceeded the State's performance expectations. The State remains committed to HIP as a program that provides quality care to low income individuals while embracing the principals of consumerism.

3.1 Contract Modifications

HIP has evolved over the course of the demonstration. At the beginning of the program, HIP contracted with two managed care entities (MCE), Anthem and MDwise and had a third Enhanced Services Plan (ESP) that is separate but is operated by the State's high risk pool, the Indiana Comprehensive Health Insurance Association (ICHIA), to provide coordinated coverage for HIP members with high risk conditions. During the first three and a half years of the program, the contracts governing the State's relationship with Anthem and MDwise were modified to contain costs, better serve members, streamline ESP, and ensure the MCEs remained on stable financial footing.

The initial contracting period in 2007 selected two managed care plans Anthem and MDwise in collaboration with AmeriChoice that leveraged commercial experience and HSA experience. However, in the 2009 contract year, MDwise changed subcontractors to ACS which handles MDwise claims processing and member billing. Acting in some capacity as a third health plan option ESP is administered on an ASO basis through ICHIA.

In 2008 both Anthem and MDwise ended the year with significant losses due to the pent-up demand for services and high disease burden of the population. Non-caretakers in general had higher costs than caretakers. The State amended the risk-sharing arrangements in their 2009 HIP contracts. The amended contracts included higher monthly capitated rates for caretakers and a stop-loss provision for non-caretakers (effective retroactively to January 2009), and new criteria for the high risk pool. CMS approved the amended contracts in mid-December 2009. The losses were due to the high morbidity of a previously uninsured population and pent-up demand of the early entrants, especially amongst the non-caretaker population where no Medicaid coverage existed. Milliman analysis conducted on the first year of program claims experience showed that caretakers had a 25% higher risk adjusted relative morbidity than the commercial population and non-caretakers had an even higher morbidity at 65% greater than a comparable commercial population. These populations also initially used services at a much higher rate, compared to a commercial population. Caretakers initially had 38% more inpatient hospital days and 181%

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more ER visits and non-caretakers had 155% more inpatient hospital days and 269% more ER visits. Over the course of the first year of enrollment, HIP members increased use of pharmacy services and decreased use of all other services, with the decline in utilization beginning in approximately the third month of enrollment⁸. This pent-up demand for services has been challenging for health plans to manage. However, over the three year life of the program, the health plans have seen high inpatient costs replaced with more outpatient visits and use of prescription drugs, which has decreased costs.

The 2010 HIP contracts included a carve-out for most pharmacy services. The carve-out for pharmacy costs helped the State meet and exceed the budget neutrality requirements. The State consolidated into one contract all the pharmacy purchasing for Medicaid programs. This consolidation was done to maximize rebate savings available to the State, as well as to achieve administrative simplifications, and thus savings, on prescribing, dispensing, claims submission, program analytics, and prior authorization for pharmaceuticals. For members, this new arrangement provides access to an expanded list of pharmaceuticals, including brand-name pharmaceuticals. For providers, it streamlines the prescribing system, moving from multiple distinct lists of preferred drugs for different public programs and plans, to one list. This shift utilizes one set of prior authorization requirements, one claims processing methodology, and one help desk. Thus far, both vendors are working closely with the State and the State has established a good working relationship with these vendors.

The negotiations for the 2011 health plan contracts addressed the costs of care and the final contracts included risk corridors to allow the State and the plans to share in any cost savings or losses the plans may experience. This risk corridor program began in 2009 and has been continued. As of May 2011, both Anthem and MDwise were reviewing calculated stop-loss payment against their claims experience to assure accordance with State calculation. Both plans are reporting declines in utilization and more predictable costs now that the population has access to routine and preventive health care services.

The 2011 contracts represented the first time the State combined HIP and Hoosier Healthwise (HHW) into one contract. HHW serves the State's non-waiver Medicaid managed care populations. The State wanted integrated contracts to gain some program efficiencies and to make the programs seamless for families who have some members in HHW and others in HIP. As a result, the State views both programs as more family friendly. The new contract developed this integration and requires plans to maintain one call center for both programs, a way of offering 'one stop shopping' to families with members in both the HIP and HHW programs. Unifying the programs also brings administrative simplification for providers, as the new contract aligns all policies and procedures in the two programs (although provider

⁸ Damler, R. *Experience Under the Health Indiana Plan: The short-term cost challenges of expanding coverage to the uninsured*. Milliman Inc. (August, 2009).

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reimbursement remains based on Medicare rates in the HIP). The State believes the new contracts will bring a focus on family health to both programs.

During the 2010 process the State selected three plans to serve the HIP population. Anthem and MDwise continue to serve HIP, and the State added Managed Health Services (MHS), which has traditionally served Indiana's Medicaid Hoosier Healthwise population. Under the new contracts, the plans must implement a debit swipe card for HIP members. The cards are to be used at the point-of-service to verify eligibility, whether the service is covered, and whether the provider is participating in the HIP. The card is linked to their POWER accounts, and members should be able to assess at the point of service what their contribution to the costs of the services will be (i.e., what will be deducted from their POWER accounts). The debit card is intended to enhance the experience of using the POWER account and promote consumer driven healthcare. MHS has operationalized the card as of January 1, 2011 and the other plans will implement the card in 2011. All debit cards were required to have the capability for eligibility determination and cost estimation as of July 1, 2011, with full implementation of the debit card in place by January 1, 2012.

3.2 Enhanced Services Plan (ESP)

The ESP was designed to reduce risk for the health plans and to lower capitation rates to the health plans. Initially ESP participants were to represent the top 1% of risk in the HIP population, through modifications to the ESP program this population currently represents the top 3% to 5% of risk in the HIP population. While receiving all the same HIP services and benefits, these high risk individuals are managed by the State's high risk plan, Indiana Comprehensive Health Insurance Association (ICHIA), with experience in managing high cost health conditions. The HIP population is separate from the State's high risk pool.

HIP's higher than expected initial cost of care, which partly result from pent-up demand and enrollees higher morbidity and co-morbidities, drove the State to identify ways of reducing the risk to the health plans. One means of attaining this goal was to expand the list of conditions that would qualify an individual to participate in the ESP and simplify referral processes to make ESP determinations timelier. Originally, ESP was accessed when a high risk condition was reported and verified and the State contracted with a vendor to interview the patient to determine if the ESP placement was appropriate. To make access to the ESP more convenient, the State altered several enrollment policies and expanded the list of qualifying conditions in July 2009. When HIP applicants check one of the qualifying conditions on the application, they are now automatically enrolled in the ESP and stay enrolled until their eligibility is redetermined. If their claims history at redetermination confirms the information reported on the application, they will stay with the ESP; otherwise, they will be transitioned to one of the other health plans. In addition, the plans now have six months to refer a member to the ESP, as opposed to 60 days in 2008. In July 2009, when the new policies took effect, Anthem and MDwise reviewed their claims records, applied Milliman's underwriting guidelines, and scored their members. Those

members found to have an ESP qualifying condition and a risk score at or above a certain threshold were transferred to the ESP at that time. This process is expected to continue for the life of the waiver and no changes are requested.

3.3 Application Processing

At two different times during the first year of program operations, the State's vendor struggled to keep up with the flow of applications—more than 120,000 were submitted in CY 2008 (yielding more than 35,000 enrollees). At program initiation, high enthusiasm for the program, assertive outreach and advertising and pent-up demand led to more than 18,000 applications being submitted in just the first month. The State's vendor adjusted staffing to accommodate this initial surge in interest, but the queue again lengthened during the second half of 2008. Part of the challenge in managing applications may have been that HIP's launch coincided with a major initiative to upgrade enrollment and eligibility business processes affecting all public assistance programs operated by the Family and Social Services Administration (FSSA). To address the issue, additional eligibility staff was hired in January 2009. The application processing delays seen in the first demonstration year did not substantially slow enrollment. For example, by March 2009 HIP was approaching the enrollment cap (34,000) for non-caretaker adults, a level that the State had not expected to reach until the third or fourth year of the demonstration. To manage enrollment levels, and to ensure the State could maintain budget neutrality, the State closed enrollment for non-caretakers in March 2009.

The State also made significant progress in 2009 with the HIP application backlog. HIP operations staff worked to resolve various issues and have identified approaches to expedite their resolution. In late 2009, the State hired an additional 18 state eligibility consultants (SECs), who were brought on in January 2010. They have increased the percentage of applications processed in a timely manner from 71% in May 2009 to 88% as of December 2010. In the second quarter of 2009, the State developed a revised dashboard to include more information on the HIP application processing and to showcase different aspects of the HIP program.

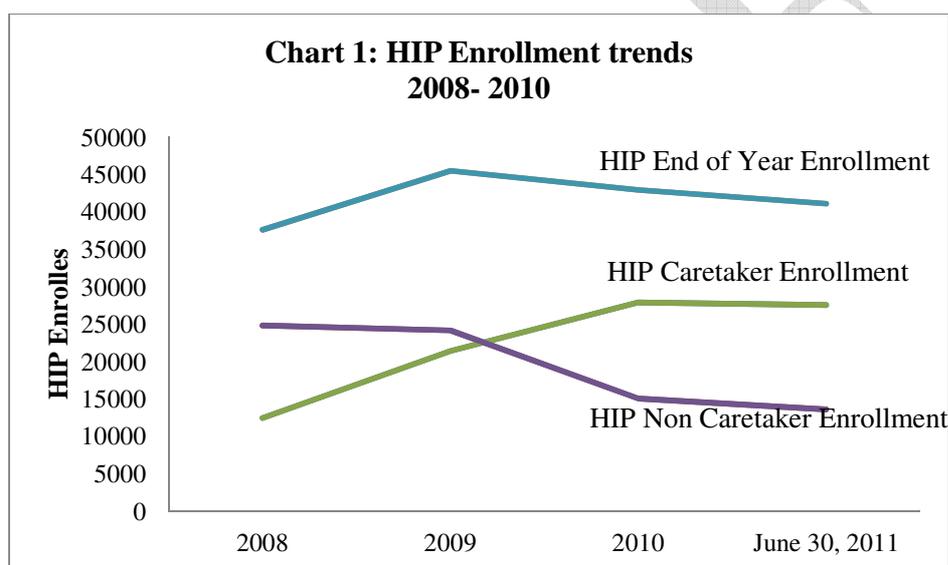
3.4 Non-caretaker Waitlist

The waiver agreement imposed a cap on the number of non-caretakers who could enroll in the program. On March 12, 2009, HIP closed enrollment to non-caretakers. At that time, the number of non-caretakers members had reached 32,000, just below the 34,000 cap established in the Special Terms and Conditions (STC). Enrollment for non-caretakers was closed before the cap was reached to ensure that applicants in the eligibility determination process or appealing denied applications and any pregnant woman who after delivering lost HHW eligibility could be enrolled in HIP without exceeding the cap. At the same time, all new applications from non-caretakers were reviewed for eligibility and placed on a waiting list if determined eligible. CMS agreed to raise the cap by 2,500 individuals for an overall limit of 36,500 non-caretakers. The State opened 5,000 non-caretaker slots in the fall of 2009 and sent letters to the first 5,000 applicants on the waitlist in November 2009. The invited

applicants started the enrollment process by reapplying for HIP and having their eligibility for the program redetermined. With the passage of the Affordable Care Act in March 2010, HIP enrollment of non-caretaker adults remained closed due to the Maintenance of Effort (MOE) provisions contained in this legislation and concern that since the program could not be closed to caretakers, the State could be forced to cover costs beyond the funds that were available from the cigarette tax fund. Based on declining enrollment of non-caretakers, the State initiated the opening of an additional 8,000 slots to individuals on the waitlist in August 2011. The waitlist for non-caretakers was 50,155 as of June 30th, 2011.

3.5 Enrollment Trends

In the first three years of the HIP program, the State received a total of 309,847 applications and 77,466 people had been enrolled. In 2008, the first year of program operations, the State received 120,313 applications. Submitted applications dropped off in 2009 with 72,282 being submitted but picked back up again in 2010 with 117,252 submissions. As of June 30th, 2011 17,490 applications have been received in 2011.



The chart above shows the end of year enrollment trends for the first three years of the HIP program. The decline in non-caretaker enrollment and the increase in caretaker enrollment is apparent. HIP enrollment was 37,568 at the end of 2008, 45,460 at the end of 2009, 42,872 at the end of 2010 and current enrollment as of June, 30th 2011 is 41,062. The program's population is divided into caretaker and non-caretaker groups. As the program has progressed the percentage of caretakers ever enrolled has increased in comparison to the non-caretakers enrolled. For those ever enrolled in HIP in 2010 56% were caretakers and 44% were non-caretakers. By comparison, at the end of 2008 67% of enrollees were non-caretakers and 33% of

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enrollees were caretakers. As of June 2011, 67% (27,364) of enrollees were caretakers and 33% (13,698) were non-caretakers.⁹

Over the course of the HIP program the majority of members have been under 100% FPL. Member distribution by FPL in June 2011 is consistent with the previous trend: 69% of HIP enrollees are currently at or under 100% FPL. HIP has only had 10% to 15% of enrollees on an annual basis that are over 150% FPL.

Table 1: HIP Enrollee Distribution by FPL: Members ever enrolled¹⁰

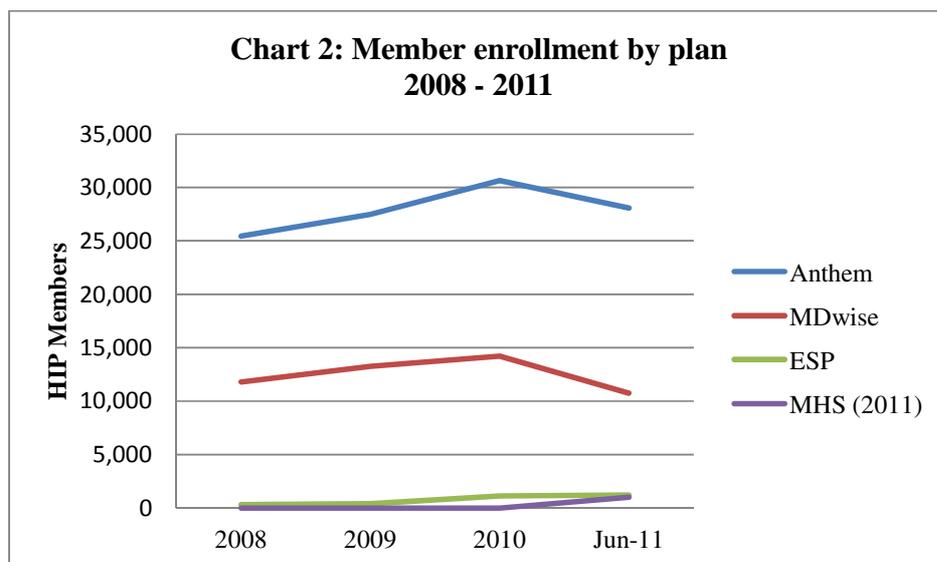
| FPL | 2008 | 2009 | 2010 |
|-----------------------|------------------------------|------------------------------|------------------------------|
| <100% FPL | 26,969 72% | 41,795 71% | 37,061 62% |
| 101 – 150% FPL | 6955 19% | 11,432 19% | 13,849 23.1% |
| >150% FPL | 3,620 10% | 6,079 10% | 9,015 15% |
| TOTAL | 37,544 100% | 59,306 100% | 59,945 100% |

When found eligible HIP members are able to select Anthem, MDwise or MHS as their plan, or they are placed into ESP if they identify that they have a high risk condition. Over the first three years of the program (2008 to 2010) between 68% and 70% of members have enrolled in Anthem, and 30% to 32% have enrolled in MDwise. With the changes to the ESP assignment process the percentage of HIP members enrolled in ESP increased from 1% to 3% between 2009 and 2010. This rate has held steady and in June of 2011 3% of HIP members were enrolled in ESP. The current demonstration year (2011) is the first year of the HIP program that has had a third managed care option for members to choose from. As of June 2011 approximately 3% of HIP enrollees were enrolled in MHS. Anthem maintained 68% of HIP enrollment and the percent of members enrolled in MDwise dropped to 26%.

⁹ Annual data from annual HIP reports. June data from June HIP Dashboard.

¹⁰ Data from HIP Annual Reports 2008-2010.

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Over the course of the HIP program, member distribution by gender has been steady though one gender has been predominant. Sixty-three percent (63%) of enrollees are female and 37% of enrollees are male. Geographically, HIP members are distributed throughout the state, with higher concentrations in Indiana's population centers and overall enrollment reflects the population density of the state¹². Similarly, member distribution by race has, over the course of the program, closely aligned with the distribution of working age uninsured adults under 200% FPL in Indiana¹³. From January 2008 to June 2011 the percentage of enrollees who identified as white varied from 82% to 84% and the members who identified as black varied from 10% to 13% with Hispanic, Native American and others making up the remainder. Age distribution has also been relatively steady throughout the course of the program. From 2008 to June 2011 member age distribution has skewed towards more aged individuals with those under 30 representing the smallest proportion of HIP members.

Table 2: Percentage Member distribution by age

| Age | 2008 | 2009 | 2010 | June 2011 |
|-------|-------|------|------|-----------|
| <30 | 19.3% | 20% | 15% | 13.9% |
| 30-39 | 21.4% | 25% | 29% | 29.8% |
| 40-49 | 26.6% | 27% | 28% | 29.9% |
| 50+ | 32.9% | 28% | 28% | 26.4% |

*Data from HIP Annual Reports 2008 – 2010 and HIP June dashboard

¹¹ Data from Years 1, 2 and 3 annual HIP reports and OMPP Data request 10/12/11.

¹² HIP Year 3 Annual Report, Pg. 29-30

¹³ HIP Year 1 Annual Report, pg. 20

3.6 Benefit Limit

HIP includes an annual limit of \$300,000 in benefits and a lifetime benefit maximum of \$1,000,000. Over the course of the program few members have reached or come close to reaching these limits. The HIP program monitors members to ensure that members are able to be transferred to another program if they are close to reaching \$300,000 in annual limits or \$1,000,000 in lifetime limits. This monitoring is to ensure that members are not denied needed services. If a member does reach, or come close to reaching these limits, an attempt is made at determining eligibility for traditional Medicaid. All members who have come within \$100,000 of or reached the \$300,000 annual benefit limit were transferred to ESP, Medicaid or other programs. The number of members that met these criteria in each demonstration year are displayed below.

Table 3: HIP Members at Benefit Limit

| Year | Members at \$200,000 | Members at \$300,000 | Total |
|-------|----------------------|----------------------|-------|
| 2008 | 1 | | 1 |
| 2009 | 17 | 2 | 19 |
| 2010 | 1 | 0 | 1 |
| 2011 | 3 | 0 | 0 |
| Total | 22 | 2 | 24 |

3.7 POWER Account Contributions

The POWER account, a unique feature of the HIP program, requires members to make upfront contributions to their health care costs. Contributions range from 2% to 5% of enrollee income and can be reduced by payments from an enrollee's employer. Over the course of HIP, there have been a percentage of individuals who do not contribute to their POWER accounts due to the way income is counted. For these members accounts are 100% state funded. The State did not intend for there to be any members who did not contribute to their POWER account, nor was this part of the waiver negotiations. For 2008, approximately 35% of HIP enrollees did not contribute to their POWER account. Over the course of the program this percentage has been decreasing, in December 2010 only 21% of HIP enrollees did not contribute to their POWER account, and in June 2011 20% of members did not contribute to their POWER account. Indiana's waiver renewal request includes modification to the POWER account contributions.

3.8 Disenrollments

Enrollees can disenroll from HIP at any time or be terminated from HIP for failing to pay a POWER account contribution, for failing to complete the redetermination process, or if it is found that the individual no longer meets eligibility requirements. Between 2008 and 2010 a total of 35,323 members left HIP. It was most common for enrollees to leave during the redetermination period approximately 12 months after being enrolled; 57% or 20,015 enrollees left the program within a month of the redetermination period. Of the remaining disenrollments, 6,199 (1,835 in 2008 and 2009 and 4,364 in 2010 and) members were disenrolled because they

failed to pay a POWER account contribution. This represents 8% of HIP members ever enrolled in the program. The remaining disenrollments would include pregnant women who are transferred to traditional Medicaid for the duration of their pregnancy, and then may reenter HIP afterwards.¹⁴

Section 4: Summary of Quality Reports

As required under the STCs, the State has conducted an evaluation of the HIP program and has developed annual reports on the program. Mathematica Policy Research and Milliman have been contracted with to independently evaluate the quality of the HIP program. The 2010 annual report submitted June 2011 discussed in detail the results of Mathematica’s monitoring activities. The program shows interesting variations in care seeking behavior between contributors and non-contributors and caretakers and non-caretakers. While all of these groups respond to HIP incentives they have different ways of seeking care which the program continually investigates. A summary of these analyses are included in this waiver renewal application.

Improves Access To Care:

- The HIP program appears to be meeting its goal to improve access to care for low-income Hoosiers enrolled in the plan. HIP provider networks are adequate. If there are any shortages with particular types of specialty (such as neurosurgeons), plans allow access to out-of-network providers. Data from Mathematica’s 2010 survey of HIP members indicate that access to care improves after Hoosiers enroll in the HIP program, they are more likely to receive preventive care and get prescription medications and they report fewer unmet health care needs. In addition, the proportion reporting the ER as their usual source of care declines dramatically after enrollment in HIP. Mathematica surveyed the use of care in the last six months of new and established HIP members. The table below shows the difference in care utilization between new enrollees and established enrollees. Established enrollees use more primary and preventive services, prescription drugs, are less likely to use the ER and less likely to report the ER as their main source of care.

Table 4: Care Utilization between new enrollees and established enrollees¹⁵

| Care Utilized: | New Enrollees | Established Enrollees |
|-----------------|---------------|-----------------------|
| Primary Care | 60% | 90% |
| Preventive Care | 28% | 69% |

¹⁴ Data from Year 3 (2010) Annual Report, submitted June, 2011.

¹⁵ Healthy Indiana Plan Section 1115 Annual Report: Demonstration Year 3 (2010), pg. 38. Submitted June, 2011.

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| | | |
|----------------------------------|-----|------|
| Prescription drugs | 54% | 80% |
| ER | 38% | 32% |
| ER as main source of care | 30% | 9.2% |

- Mathematica continues to document that 90 percent of HIP members have a physician visit within 12 months of enrolling.
- A Milliman analysis of HIP enrollee service utilization for the first 18 months of the program compared HIP enrollees to comparable Medicaid and commercial populations. HIP incentives for members to seek preventive care have demonstrated success. Individuals enrolled in HIP had higher preventive care visits than Indiana’s HoosierHealthWise (HHW) Medicaid population. The HIP Caretaker population had 445.4 well-care visits per 1,000 enrollees, and the non-caretaker population had 281.8 well-care visits per 1,000 enrollees compared to HHW adults 195.3 visits per 1,000 enrollees. This analysis indicates that HIP Caretakers seek preventive care more frequently than comparable commercial populations and non-caretakers seek preventive care at rates similar to comparable commercial populations.

Table 5: Preventive Care Utilization (January 2008-June 2009)

| Population | Well Care Visit (utilization rate per 1,000) |
|------------------------------------|---|
| HHW- Adults | 195.2 |
| HIP-Caretakers | 445.4 |
| HIP- Non-Caretakers | 281.8 |
| Commercial (Adult only) (1) | 354.8 |
| Commercial (Adult only) (2) | 306.2 |
| Ohio Medicaid Adults | 352.7 |

(1) Age / Gender adjusted to HIP – Caretaker population

(2) Age / Gender adjusted to HIP – Non Caretaker population

- The State monitors member access on a monthly basis including evaluating health plans primary and specialty care networks. Member access is examined on distance from primary and specialty care providers, access to hospital care, and appointment wait times. Mathematica reports that with enrollment in HIP utilization of health care services increased and unmet need declined.

Increases Knowledge of Health Care Spending:

- Data from Mathematica's 2010 survey of HIP members indicate that most survey respondents were aware of their POWER account, believed that they had been given adequate information about the account, and knew where to look for more information if they needed it. Approximately 60 percent reported knowing the balance of their POWER account and 45 percent reported checking their account at least monthly, important first steps of cost conscious consumers¹⁶.
- A 2009 Product Acceptance Research (PAR) telephone survey of HIP members found that six in ten respondents now think differently about how or where they get health care since enrolling in HIP and that one-third have asked the cost of a medical procedure or service before receiving treatment.

POWER Account/Consumer Directed Plan Does not Discourage Participants from Seeking Needed Care:

- Mathematica's analysis of utilization shows that members are accessing services and that the POWER account contributions do not discourage participants from seeking needed healthcare. As individuals remain enrolled in HIP, they move away from seeking routine care in the ER and begin seeking care in physicians' offices. Over 12 months of enrollment, on average HIP enrollees show a 14.8% decline in non-emergent ER use and a 25% increase in physician office visits. No evidence was found suggesting that HIPs consumer based structure discourages enrollees from seeking needed care. Additionally, a Mathematica survey of HIP members found that approximately 70% of enrollees indicated that the monthly contribution was just the right amount and something they could afford. Another 7% thought they could afford a monthly contribution that was a little higher than the current amount. In contrast, approximately eight percent thought the monthly contribution was far too high.
- At its conception the HIP program intended to have all members contribute to their POWER account; however, due to the way income is calculated and the lack of a program requirement for a minimum contribution for 2008 to June 2011 between 20% and 35% of enrollees have not been required to contribute to their POWER account. This has led to an opportunity to analyze possible differences in care seeking behavior between contributors and non-contributors. Contributors have lower rates of ER use from the beginning of their enrollment in HIP. Over 12 months of continuous enrollment 35% of contributors visit the ER with 24% visiting the ER at least once for a non-emergent visit. Non-contributors visit the ER more frequently;

¹⁶ Healthy Indiana Plan Section 1115 Annual Report: Demonstration Year 3

57% visited the ER and 34% of non-contributors enrolled for 12 months continuously had a non-emergency ER visit. Non-contributors also experience fewer gains in than contributors in physician office visits, for contributors physician office visits increase by 26% over 12 months of enrollment and for non-contributors it increases by 22%¹⁷.

Table 6: HIP Members Service Utilization

| Over 12 Months of continuous enrollment: | Contributors | Non-Contributors |
|---|---------------------|-------------------------|
| Any ER Visit | 35% | 53% |
| Any Non-Emergency ER Visit | 25% | 34% |
| Increase in Physician Office Use | 26% | 22% |

Whether contributing to a POWER account has a direct effect on care seeking behavior remains under investigation. Non-contributors have unique care seeking behavior and are overall more likely to visit an ER than contributors. This may be influenced by their contributor status, though the structure of the HIP program works over the course of enrollment for all enrollees decrease non-emergency ER use and increase physician office use.¹⁸

- A Milliman analysis of the first year of Anthem’s experience with HIP showed that after adjusting for morbidity differences non-contributors have higher expenditures than contributors. The non-contributor caretaker population had 3.5% increased expenditures over the contributor caretaker population and the non-contributor non-caretaker population had expenditures 13% higher than the non-contributor non-caretaker population.¹⁹

By the end of calendar year 2010, HIP was a fully functioning program that was achieving several of its goals including: improving access to care for low-income Hoosiers; promoting preventive care among most HIP members; providing quality of care; achieving high levels of member satisfaction; and maintaining the program’s fiscal soundness. Monthly HIP enrollment in 2010 remained steady throughout most of the year and enrollment patterns continued to indicate that upon entry to the HIP program, most members remained enrolled for a full year or more. Steady enrollment provides opportunities for HIP and the health plans to (1) give members guidance on how to use health care services appropriately and (2) reap the benefits of initiatives

¹⁷ Mathematica Data Preview, December 2nd, 2010

¹⁸ Data in this paragraph: Mathematica data supplement for the HIP Year 3 Annual Report: December 2, 2010.

¹⁹ Milliman report to HIP Taskforce: August 7th, 2009.

that promote the use of preventive care, disease management programs, and case management services. It also means that members have an opportunity to benefit from responding to program incentives.

4.1 Progress on Program Goals

Goal 1: Reducing the number of uninsured low-income Hoosiers

- HIP program seeks to reduce the number of uninsured low-income Hoosiers. HIP program has been providing an important safety net for its members who would have been uninsured otherwise. Given the expected limited revenue from the State cigarette tax, HIP was not intended to cover all Hoosiers below 200% of FPL. After three years, HIP has served 77,466 Hoosiers.
- Although the overall uninsured rate among low-income working-age Hoosiers did not change between 2008 and 2009, data suggest that uninsured rates among caretakers declined by 4 percentage points. At the same time, Medicaid coverage rates among low-income caretakers increased by 7.1 percentage points. Those with income below 150 percent of the FPL experienced declines in their uninsured rates. For example, working-age adults with income between 101 and 150 percent of FPL saw their uninsured rate decline by 2.6 percentage point between 2008 and 2009 while their Medicaid coverage rate increased by 4.3 percentage points. The increase in Medicaid coverage rates among low-income adults who are typically not eligible for Medicaid unless they have a disability, suggest that during the economic downturn, Medicaid, including the HIP program, was moderating any increase in uninsured rates.

Goal 2: Reduce barriers and improve statewide access to health care services for low-income Hoosiers

- Plans report that all HIP members, in all health plans, have access to a primary medical provider (PMP) within 30 miles of their homes.
- All plans continue to work on their specialty networks; deficiencies are few, and plan administrators think problems with certain specialties are due to general medical shortage areas, or inadequate numbers of providers for the population as a whole in some regions of Indiana.
- A 2010 Mathematica survey of HIP members suggests that access to care improves after enrollment into HIP. Using respondents who had only enrolled in HIP in the previous month and their access to care while uninsured as the counterfactual against which the success of HIP is judged, the survey data indicate that HIP members are:
 - More likely to have a PMP and more likely to use a doctor's office or clinic as their usual source of care rather than the ER,
 - More likely to receive preventive care, acute care, specialty care, and prescription medications,
 - Less likely to have an unmet need for care.

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- All plans are required to submit access reporting annually along with a geo-access map of provider locations. If a plan does not have the necessary access as outlined in the scope of work, the plan must submit the reporting on a monthly basis and outline efforts to increase access. At this time, all plans are meeting the access requirements.

Goal 3: Promote value-based decisions making and personal health responsibility

- HIP uses several financial incentives to encourage members to become thoughtful health care purchasers and active participants in maintaining or improving their health. These incentives begin upon enrollment, when most HIP members are required to contribute to the cost of their care by making monthly payments to their POWER accounts. Findings to date suggest that:
 - As of the end of 2010, nearly four of every five HIP members made a contribution to their POWER account.
 - Utilization differences have been noted between contributors and non-contributors. Non-contributors have 66.8 non-emergent ER visits per 1,000 members while contributors have 34.7 non-emergent ER visits per 1,000 members. The non-contributing population in general suffers from higher morbidity, however, the POWER account contributions and the influence of consumerism cannot be ruled out as factors contributing to this vast difference in utilization²⁰.
 - Survey data collected by Mathematica in 2010 suggest that the majority of respondents knew key features of the program. For example, most HIP members were aware of their POWER account, believed that they had been given adequate information about the accounts, and knew where to look for more information if they needed it.
 - Over the first two years of the HIP program only 3% of enrollees were disenrolled for failing to pay their POWER account contribution. The disenrollment rate increased over the third year with 4,364 individuals being disenrolled in year three. This was more than twice the number of individuals disenrolled for failure to pay a POWER account contribution for the first two years of the program. At the end of 2010, the disenrollment rate for failure to pay a POWER account contribution over the program history was 8%. Currently, the rate for 2011 seems more consistent with the nonpayment rate for the first two years, out of 43,220 enrollees at the start of 2011 only 611 were disenrolled for failure to pay their POWER account through June 2011.
 - HIP members eligibility is redetermined annually. Enrollees are required to complete a redetermination packet and return it in a timely manner. A Mathematica analysis for the first two years of the program showed that 85%

²⁰ Data from Mathematica Data Enclosure, December 2010.

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of HIP enrollees returned redetermination packets on time. For the third year of the demonstration, 2010, 96% of enrollees submitted their redetermination packet on time.

Goal 4: Promote primary prevention

- A large proportion of HIP members obtain primary care services. Given that most HIP members stay enrolled in the program, and only some are cycling on and off, HIP and its health plans should see benefits in promoting the receipt of appropriate preventive care. HIP encourages the use of preventive services by providing first dollar coverage for preventive services. Preventive services up to \$500 are not subject to the deductible and members do not have to draw on their POWER account funds. HIP also ties POWER account rollovers, and reductions in future monthly contributions, to the completion of required preventive care.
 - Roughly 90% of HIP members who started eligibility periods in 2008 and 2009 and stayed continuously enrolled for 12 or more months had a physician office visit of any type²¹.
 - Service records for the seven different preventive services the Office of Medicaid Policy and Planning (OMPP) required for full rollovers in 2009 and 2010 indicate that the majority of HIP members received some type of preventive care during their first year of enrollment.
 - Analysis of POWER account rollover data shows that for members who had effective coverage dates beginning between January and June 2009 and were still enrolled in June 2010 during the POWER account rollover process that 80% had received the preventive services required to make them eligible for a full POWER account rollover. Not all members that were eligible for a rollover had remaining POWER account balances but analysis of the rollover process indicates that HIP is encouraging members to seek preventive services.²²
 - Analysis of the first 18 months of HIP shows that members have greater rates of preventive care use than the HHW Medicaid population. For every 1,000 enrollees HIP had 445.4 caretaker preventive visits and 281.8 non caretaker preventive visits while the HHW population had 195.2 preventive visits per 1,000 enrollees. HIP preventive use in caretakers is greater than similar commercially insured populations and the use in non-caretakers is comparable to a similar commercially insured population.²³

²¹ HIP Year 3 Annual Report, (June 2, 2011).

²² Rollover Report May 2011

²³ Milliman Data, Presentation to Governor March 23, 2010

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- Considering only services obtained in the first six months after enrollment in the HIP program, encounter claims records indicate that 2009 members obtained preventive care more quickly. For example, within the first six months, 41% of young (ages 19-34) female 2008 members had received at least one recommended preventive service. Among 2009 members, 46% of females met this criterion within the first six months.
- To promote preventive care, the health plans are pursuing a number of different strategies, including member mailings, newsletters, telephone outreach, and support. The ESP administrator implemented a new care coordination program in 2010.

Goal 5: Prevent chronic disease progression with secondary prevention

- By lowering cost and access barriers to care and activating members to be more engaged patients, HIP aims to slow disease progression among members with chronic conditions. Analyses to date indicate that:
 - Chronic disease is prevalent among members. More than a quarter of those enrolled from January 2008 through June 2010 have been diagnosed with pulmonary, skeletal and connective tissue, cardiovascular, metabolic, or skin diseases. In addition, more than 40 percent of members have been diagnosed with or treated for psychiatric conditions, including non-chronic depression.
 - Non-caretakers were more likely than caretakers to be diagnosed with chronic diseases and are nearly twice as likely to be diagnosed with conditions that are considered to be medium or high cost (24 versus 13 percent), which is consistent with the age differences between these two groups.
 - The health plans continued to use several strategies to manage the chronic conditions of their members, including telephone support, disease management programs, and online tools.
 - Analysis conducted by Milliman shows that while HIP enrollees experience significant chronic disease burden, that during enrollment in the program use of prescription medication increases and inpatient, outpatient, and physician services decline. This suggests that HIP members are managing their chronic conditions with prescription medication and need fewer direct health services as a result.

Goal 6: Provide appropriate and quality-based health care services

- A critical goal for HIP is to provide appropriate and quality-based health care services and HIP appears to be achieving this goal.

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- Overall satisfaction appears to be high among HIP members. Respondents to the CAHPS surveys administered by the health plans report high levels of satisfaction with their plans—levels that, in most cases, are comparable to or higher than national averages for Medicaid plans. For example, Anthem’s plan average composite score for customer service (which includes the percent reporting they always or usually got information they needed from the plan’s customer service line, and the percent reporting they always or usually were treated with respect by customer service staff) was 85.1%, a statistically significant difference from the 2009 Quality Compass Medicaid adult average plan score of 76.2%. Likewise, 84.2% of MDwise members were always or usually satisfied with their experiences with receiving care and getting appointments in a reasonable time, a statistically significant difference from the 2009 Quality Compass Medicaid adult average plan score of 80.9%.
- Mathematica’s 2010 survey of HIP members also indicates high levels of satisfaction with the HIP program overall. Approximately 87% of respondents who were new to HIP and 97% of respondents who were established were “Very Satisfied” or “Somewhat Satisfied” with the HIP Program.
- A Product Acceptance Research Survey in 2009 of HIP members enrolled at least 6 months showed that 94% of HIP enrollees were satisfied with the program and 99% would re-enroll in the program. Seventy-six percent (76%) of individuals surveyed indicated they liked their POWER account, three-fourths of surveyed individuals said they are now more likely to seek preventive care and four in ten indicate that their health is better than it was a year previous.
- Data from the State’s Intranet Quorum, the State’s issue management system, are consistent with the CAHPS data and do not indicate that members have any serious concerns about the performance of the plans.

Goal 7: Assure State fiscal responsibility and efficient management of the program

- The enabling state legislation requires HIP to be a fiscally sound program. As of the end of calendar year 2010, the HIP program appeared to be achieving this goal. State documentation indicates that:
 - The HIP program continued to meet its budget neutrality goals as of the end of 2010.
 - The 2010 negotiations with the health plans addressed the costs of care and the final contracts included risk corridors to allow the State and the plans to share in any cost savings or losses the plans may experience.
 - Analysis of the funding mechanisms for HIP finds that state funding was adequate during the program’s first three years. Hospitals continued to support the redistribution of DSH funds. Cigarette tax revenues, while declining, were

sufficient to meet the program's needs, and the proportion of HIP members contributing to their POWER accounts rose steadily throughout 2010.

4.2 Future Goals of the Demonstration

If the program continues, the State will continue to pursue the goals identified above and will continue study of these areas. Additional study and time to collect additional data will help the State understand the long term impact of HIP. HIP intends to continue to investigate the effects of value-based purchasing on enrollee care seeking behavior. The State expects that changes to HIP due to modifications to IC 12-15-44.2 that allow plans to make payments to POWER accounts may be used as disease management incentives. The impact of these contributions on enrollee care seeking behavior will be studied. The State will also study the impact of the required minimum contribution on enrollment and care seeking behavior.

4.3 Health Plan Performance-External Quality Review

In 2010, Burns & Associates, Inc. conducted an external quality review (EQR) of Anthem and MDwise for calendar year 2010. The EQR assessed the performance of the health plans in six areas: (1) cultural competency initiatives, (2) program integrity, (3) accessibility and availability of providers, (4) retrospective authorizations, claim denials, and claim disputes, (5) validation of performance measures, and (6) validation of performance improvement projects. Plans were assessed independently, and assessments were made for both HIP and HHW programs.

Overall, the EQR found that both plans were fully compliant in the areas assessed. The following outlines some important findings and recommendations:

- Both Anthem and MDwise have undertaken numerous initiatives related to cultural competency, but the EQR recommended that the plans utilize the U.S. Department of Health and Human Service's Office of Minority Health's Culturally and Linguistically Appropriate Services (CLAS) standards as a tool to ensure that their cultural competency work plans follow these recommended guidelines. In addition, the EQR recommended that Anthem make more materials available in Spanish, and that both plans better use the race and ethnicity data from OMPP in conjunction with claims data to better target health disparities within the HIP population. Anthem has submitted and OMPP has approved additional materials in a Spanish format. All plans have reported that they maintain race and ethnicity data in their respective systems. The Culturally and Linguistically Appropriate Services (CLAS) standards have been implemented with re-bid in 2011. The plans have done internal gap analysis to identify and meet the standards.
- Both plans are following credentialing and recredentialing policies and procedures for HIP, and in early 2010, both plans placed a renewed emphasis on investigating fraud and abuse cases. For example, the plans expanded staff assigned to investigations, and increased the number of investigations they conducted in 2010.

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They also recommended that since the investigations team is newer at MDwise, that MDwise adopt an ongoing training schedule, similar to what Anthem uses.

- Few clinical issues were disputed in either retroactive authorization or claims disputes, except in ER cases where the ‘prudent layperson’ rule was cited (and in those cases, the EQR agreed that these denials were made appropriately in cases where they had adequate records to assess this). In addition, most claims denials occurred for administrative reasons, usually because the service was out-of-network or the provider submitted the claim dispute too late (both HIP plans use a “60 day” rule for filing a claim dispute, which complies with the State’s administrative rule [405 IAC 1-1.6]). Although the EQR recognized that ‘out-of-network’ and untimely filing of claims are legitimate reasons for a denial, they suggested that more education, aimed at members about the differences between in- and out-of-network services, and at providers on the timeframe required to dispute claims, is needed. The use of in-network services and the importance of a PMP has been further highlighted throughout the updated member handbooks. Provider education on claims submission is offered by the plans as well as the State’s fiscal agent.
- Reviews of the validity of the processes used to report four performance measures in HIP found the data used by the plans appeared to be valid, but the EQR did suggest that improvements could be made. For example, the data reported in Anthem’s and MDwise’s provider claims dispute reports appeared to be valid, but there were different interpretations between the plans as to what information to provide in the report, so that the results cannot be compared between the plans. OMPP has updated the reporting manual for 2011 to further identify and define the needed information for this report. OMPP has been working with the plans to ensure that the information is comparable across plans.

The EQR report does not suggest the plans have any systematic issues related to their performance. The recommendations and suggestions made to the plans recognized a level of competency at the plans, citing several items as best practices. For example, Anthem’s newly hired staff to investigate fraud and abuse was cited as having a very strong process for handling investigations, and among the HHW and HIP plans, “...best illustrated to the EQR how the results from Special Investigations Unit investigations often get fed back as improved processes on the front end to other parts of the organization to prevent fraud and abuse.” MDwise was cited for its cultural competency programs, including that MDwise “releases all of its materials in English and Spanish, avoiding the need for Spanish-speaking members to have to specifically request these materials.”

After the release of the EQR report in November 2010, the plans took steps to address EQR recommendations regarding provider education. For example, MDwise is providing additional provider education through one-on-one contact and through newsletters. In 2011, Anthem will

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distribute a new member handbook for the HIP and HHW programs, and the plan also began sending letters to any provider treating an Anthem member who is in the plan's case management or disease management program, to try to improve care coordination.

Section 5: Requested Program Changes

During the 2010 legislative session the Indiana legislature passed IC 12-15-44.2 and made changes to HIP. To this end, the State seeks waiver authority to implement these changes which include:

- Requirement for HIP enrollees to make a minimum contribution of \$160 annually, or \$13.33 per month. This requirement is limited by income and no enrollee will pay more than 5% of income towards health costs.
- Ability for non-profits not affiliated with a health plan to pay up to 75% of the minimum contribution.
- Ability for health plans to contribute towards members' POWER accounts as incentives for healthy behavior.
- Changes related to the ACA:
 - HIP as the program to serve the Medicaid Expansion population.
 - Effective in 2014, reduction of the eligibility level to 133% FPL to coincide with ACA Medicaid eligibility.
 - Removal of the annual and lifetime maximum limits, effective with waiver extension approval.

In addition, the State seeks modification to its budget neutrality agreement based on its experience to date and the changes in the ACA.

5.1 Minimum Contribution

The original goal of the HIP program was to move away from the concept of "free health care," to educate members about the cost of the health care services, and to give members "skin in the game." The concept behind the POWER account requires individuals to make contributions so that they have a stake in considering how their health care dollars are spent. The legislative intent of the original HIP legislation was that all individuals would make a POWER account contribution. During the original negotiations with the CMS, it was also presumed that all individuals would be making a contribution, and the amount of the sliding scale was adjusted to ensure that no individual exceeded the 5% of income limit on cost-sharing, including consideration of CHIP premiums. It was a surprise to the State, when after applying the rules of how income is counted, that there were individuals who did not make contributions. During the 2011 session, the Indiana General Assembly passed legislation to correct this error. Currently, HIP has 21% of participants that are not making contributions to their POWER account and this number has been as high as 35%. The principles behind the POWER account suggest that it cannot be effective without individuals making contributions.

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While there was never any intention for a free program, this error has provided the State with an opportunity to compare the behavior of individuals making contribution versus those that do not. While further study is needed to account for the relative health risk, as discussed earlier, there are key differences between those individuals that make contributions and those that do not.

- For individuals enrolled for 12 consecutive months those that contribute to their POWER account (contributors) have 34.7 non-emergent ER visits for every 1000 enrollees while those who do not contribute (non-contributors) have 66.8 non-emergent ER visits for every 1000 enrollees²⁴.
- Required POWER account contributions do not demonstrate a prohibitive effect on the use of needed services. However, indications are emerging that they may change how users consume services. For contributors enrolled for 12 consecutive months the ratio of physician office visits to non-emergent ER visits increased steadily. In the first month of enrollment members had 17.7 physician visits for every non-emergent ER visit and in the 12th month of enrollment members had 26.2 physician visit for every non-emergent ER visits. This represents a 48% increase in the physician visit to ER ratio over 12 months²⁵.

With these guiding principles and research, IC 12-15-44.2 institutes a minimum POWER account contribution of \$160 annually. The sliding scale to calculate member contributions will still be in place, and the legislation limits the minimum contribution to not be more than the percentages stated below. Members will be required to contribute their minimum monthly contribution (\$13.33 a month) until they meet the limiting percentage of income present in Indiana code. Once the limiting percentage is met the State will fund the account. Indiana expects that the vast majority of HIP enrollees will be able to meet the minimum contribution requirement without the state intervening. Please see the cost sharing section for detailed plans to ensure these individuals do not exceed the applicable percentage of income limiting their contributions.

Table 7: Limiting contribution percentage and Minimum contribution

| FPL | Limiting Contribution Percentage | Income Single | \$160 Minimum Contribution % of Income | Income Family of 4 | \$160 Minimum Contribution % of Income |
|------------|----------------------------------|---------------------|--|----------------------|--|
| <25% | 2% | <\$2,723 | >5.9% | <\$5,588 | >2.9% |
| 25 to 50% | 2% | \$2723 to \$5,445 | 2.9% to 5.9% | \$5,588 to \$11,175 | 2.9% to 1.4% |
| 50 to 75% | 2% | \$5445 to \$8,168 | 2% to 3% | \$11,175 to \$16,763 | .95% to 1.4% |
| 75 to 100% | 2% | \$8,168 to \$10,890 | 1.5% to 2% | \$16,763 to \$22,350 | .6% to .95% |
| 100 to | 3% | \$10,890 to | 1.2% to 1.5% | \$22,350 to | .57% to. 6% |

²⁴ Mathematica Data Analysis Supplement, December 2010.

²⁵ *Ibid.*

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| | | | | | |
|--------------------|----|----------------------|------------|----------------------|--------------|
| 125% | | \$13,613 | | \$27,938 | |
| 125 to 150% | 4% | \$13,613 to \$16,335 | 1% to 1.2% | \$27,938 to \$33,525 | .48% to .57% |
| 150 to 200% | 5% | \$16,335 to \$21,780 | 0.7% to 1% | \$33,525 to \$44,700 | .35% to .48% |

\$160 annually is approximately 5% of income for an individual at 30% of FPL. The State will work to ensure individuals do not contribute more than the HIP enabling legislation IC 12-15-44.2-11 specifies. Currently, the process for ensuring that individuals do not contribute more than 5% of their income is manual and relies on member reporting; however, a plan is in progress to electronically track member contributions and to stop collecting contributions as the member nears the limiting percentage of income. The goal of the minimum contribution is to harness the power of value conscious consumerism for all enrollees while leveling the playing field for all HIP members. Instituting a minimum POWER account contribution requirement returns the program to the original vision of all enrollees contributing towards their care and gives all HIP members the same consumer responsibility and accountability. Additionally, the State has not experienced problems with affordability of contributions for HIP enrollees and over the course of the program between 92% and 97% of enrollees have consistently paid their POWER account contribution on time. For HIP members that do not currently pay a POWER account contribution the State has developed a plan to transition them to contributing enrollees. Please see the transition plan for more detail. HIP contains a process to ensure that members do not pay more than 5% of their income towards health care costs, please see the cost sharing section for more details.

5.2 Not-for-profit Contributions

The original authorizing language for HIP, indicated that only the State, employers, and individuals can make contributions to the POWER account. IC 12-15-44.2 allows for more flexibility, so that not-for-profit organizations can assist with contributions and contribute up to 75% of the enrollee’s contribution requirement. Not-for-profits are not allowed to contribute 100% of the member’s minimum POWER account contribution because a central tenant of the HIP program is for all individuals to contribute to their care. HIP currently allows employers to contribute up to 50% of an individual’s contribution to the POWER accounts and extending this option to not-for-profit organizations fits with the program’s goals to provide affordable consumer directed coverage.

5.3 Managed Care Entity Contributions

IC 12-15-44.2 allows for the HIP contracted MCEs to contribute to the individual’s POWER account. Contributions must be linked to an incentive. Again, the original drafters had intended to allow the MCEs to provide health related incentives to individuals through the POWER account. However, the legislation did not specify this and therefore all health related incentives have been paid or given directly to individuals outside the POWER account. Allowing MCEs to

pay health incentives to the POWER account aligns with HIP's philosophy and should strengthen the incentive for individuals to invest in health promotion efforts. The new legislation indicates that MCE contributions cannot reduce the individual's required minimum contribution or be greater than HIP's \$1100 deductible. However, this option allows MCEs to offer financial incentives through the POWER account to members for positive health behaviors. Allowing MCEs to contribute to the POWER account is in line with program goals of harnessing consumerism to improve health behaviors and allows members the chance to earn additional subsidies to their POWER account.

5.4 Affordable Care Act (ACA) Related Program Changes

5.4.1 Eligibility

IC 12-15-44.2 calls for HIP to be the coverage vehicle for the new Medicaid population authorized under the ACA. It is the State's intent and desire to enroll individuals under 133% FPL (with 5% income disregard), that are not eligible for Medicaid under another category (such as aged, blind, or disabled populations, pregnant women, children, etc.) into the HIP program under the HIP 1115 demonstration project as of January 2014. Please see the Eligibility section for more details on Medicaid and HIP eligibility and the transition plan for more details on the process of enrolling these newly eligible individuals in HIP.

To bring HIP in line with ACA requirements, IC 12-15-44.2 changes HIP eligibility from 200% FPL to 133% FPL (138% with 5% income disregard) effective January 1, 2014. Eligibility would be maintained to 200% through 2013 and begin the transition to 133% FPL in October 2013 at the time of Exchange open enrollment, with coverage beginning in January 2014 for non-caretaker adults (see Transition Plan). This change was instituted because the ACA extends Medicaid eligibility to all individuals under 133% FPL and creates premium tax credits and cost sharing subsidies for individuals between 133% and 200% FPL.

In 2010, 15% (9,015) of HIP members were over 150% FPL and 23% (13,849) are between 100% and 150% FPL; the vast majority of HIP members are under 133% FPL and will not be affected by this change. For those members who will be transferred from HIP to subsidized commercial products the State has developed a plan to aid HIP enrollees in this transition. Please see the transition plan for more details.

5.4.2 Benefits

In 2013, HIP also intends to remove the lifetime \$300,000 and annual \$1,000,000 maximum limits on coverage to comply with the ACA. Since the program's start in 2008 only 2 HIP enrollees have reached the \$300,000 annual or \$1,000,000 lifetime maximum limit. These enrollees were transferred out of HIP to the programs high risk pool, ESP, or to Medicaid to continue their coverage. Removal of the annual and lifetime limits will affect few HIP members and have little effect on the overall program and brings HIP in line with ACA requirements.

5.5 Budget Neutrality

The original HIP demonstration project included a budget neutrality agreement since HIP extended coverage to non-caretakers that are not currently eligible for Medicaid. The State based its budget neutrality agreement on diverted Disproportionate Share Hospital (DSH) funding, savings projects, and limited expenditure growth in the HHW population. As a result, CMS agreed to allow the State to cover 34,000 non-caretakers. This number was adjusted in 2009 to 36,5000.

The HIP program continues to meet and exceed its budget neutrality requirements and therefore the State requests an adjustment to reflect the current scenario, and also to adjust for the ACA changes. Due to the savings projects the State implemented in the last three years, the waiver margin has far exceeded projections and requires adjustment. In addition, since non-caretakers are now eligible for Medicaid, the State requests bringing non-caretakers to the "without waiver" side of the equation, starting in 2014. We have prepared the budget neutrality documents to reflect a scenario in 2013, before full implementation of the ACA, and then 2014-2015 scenario.

The State had a waiver margin of \$94 million during the first year of the demonstration which exceeded the projected waiver margin of roughly \$28 million for that year. HIP achieved this margin despite enrolling more non-caretakers than had been projected. The large margin resulted from the savings achieved for the HHW populations, 3% to 6% over the projected per member per month (PMPM) rates for this group, and the substantial savings achieved for the HIP caretakers, 16% over the projected per member per month rate.

During the second demonstration year (CY 2009), the State implemented a carve out of pharmacy services to avail the rebates not afforded to Medicaid managed care plans. Representing state and federal dollars, waiver documents estimated a waiver margin of just over \$76 million, well above the CMS-approved waiver margin for the year. The most current cost-effectiveness review through December 31, 2010, indicated that the waiver margin for the third year of the demonstration would be substantially higher and just over \$364 million state and federal dollars. This margin is based on falling PMPM rates for HHW groups, which fell between 8% for children and 13% for pregnant women, presumably because of the pharmacy carve out. Projections for the last two years of the demonstration indicate that the State will continue to maintain program costs far exceeding the budget neutrality requirements of the waiver.

Indiana has been highly successful in its additional savings projects; the projects that have been running for three years include (1) third party liability, (2) estate recovery, and (3) fraud. Additionally, the State has begun two new projects to save additional funds, covering incontinence supplies, and hemophilia blood factor. The table below shows savings to date and anticipated savings for the period of the waiver demonstration.

Table 8: Savings Projects²⁶

| Project | FFY 2007 Baseline | Total Savings To Date | Anticipated Savings |
|--|----------------------|--------------------------|--|
| | | | Jan. 1 st , 2013- Dec. 31 st , 2015 |
| Third Party Liability | \$19,614,846 | \$322,048 | \$11,055,462 |
| Estate Recovery | \$9,532,345 | \$9,040,728 | \$10,396,837 |
| Fraud and Abuse Collections | \$4,295,099 | \$14,529,037 | \$16,708,392 |
| Blood Factor Savings | | \$25,620,766 | \$24,000,000 |
| Incontinence Supplies | | \$30,853,523 | \$36,000,000 |
| TOTAL | \$33,442,290 | \$80,366,102 | \$98,160,691 |

Due to the State’s great success in these projects as part of the State's renewal application, the State requests the following changes to its budget neutrality agreement:

- 1) Removal of the additional savings projects from the budget neutrality agreement.** The original requirement was for savings of \$15 million, or \$3 million per year. The State has saved over \$80 million to date and expects savings to grow to \$98.1 million between January 1st, 2013 and December 31st, 2015.
- 2) Moving the non-caretaker population to the without waiver side in 2014.** As of January 1, 2014 all individuals under 133% FPL will become eligible for Medicaid, regardless of caretaker status, therefore the State requests that non-caretaker adults be treated similar to the caretaker adults, in the budget neutrality agreement starting in 2014 and not subject to an enrollment cap. In 2013, the State will maintain non-caretakers in the budget neutrality agreement as they are today.
- 3) Return of DSH funding.** Due to the collective success of the State's management of the HHW program and its savings projects, the State requests that for the period of January 1, 2013 to December 31, 2013 that the DSH dollars be reallocated to the hospitals, as the budget neutrality agreement can be achieved without the DSH diversion. After 2014, with non-caretakers adults on the without waiver side of the budget neutrality agreement the State will have no further need for diversion of DSH dollars. The State requests that DSH dollars be reallocated to hospitals for the entire waiver extension period.

Indiana proposes to continue the agreed trend from the original demonstration project for the HHW population through the waiver demonstration period.

²⁶ OMPP Data Request: E-mail 9-30-11

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Please see the financing attachments for the specifics on the requested changes to the budget neutrality agreement.

Section 6: Eligibility

For the demonstration extension period from January 1, 2013 to December 1, 2013 HIP eligibility will continue to extend to 200% FPL and the State requests no changes to eligibility during the first year of the renewal. Individuals will be HIP eligible if they are between 19 and 64 years of age, not otherwise eligible for Medicaid, and do not have access to employer sponsored insurance. In order to prepare for the ACA, as directed by IC 12-15-44.2, the State proposes to begin to make eligibility changes to coordinate with the ACA provisions starting on 10/1/2013. From 1/1/2013 to 9/30/2013 income for new applicants and redeterminations will be calculated using the current income calculation process. The proposed eligibility regulation states that it is considering allowing states to convert to modified adjusted gross income (MAGI) prior to 2014 using an 1115 demonstration. The HIP demonstration would like to take advantage of this opportunity. To coordinate with Exchange open enrollment periods, income for new HIP applicants will be calculated as of 10/1/2013 based on MAGI. IC 12-15-44.2 changes eligibility to 133% FPL as of January 1, 2014, from 10/1/2013 to 12/31/2013 HIP applicants will continue to be eligible to 200% FPL based on MAGI. The regulation also prevents individuals from being excluded for coverage due to a MAGI calculation prior to March 31, 2014. Indiana believes that implementing MAGI for HIP consistent with the open enrollment period increases operational effectiveness; however, to maintain consistency with the proposed regulation Indiana will allow individuals found ineligible, to also be reviewed based on the current eligibility process between October 1, 2013 and March 31, 2014.

The State will prepare to transition HIP members that are above 133% FPL to the Exchange (federal or state). Indiana proposes to schedule a special redetermination period for all HIP enrollees that current eligibility information indicates are over 133% FPL in January, 2014. At this point all enrollees will have their eligibility redetermined based on MAGI; please see the transition plan for more details.

Section 6.1 Populations Ineligible for HIP

Individuals eligible for services under traditional Medicaid are described below. None of these populations will participate in HIP and therefore, none of these populations will have POWER accounts.

Table 9: Current Medicaid Populations Ineligible for HIP

| |
|---|
| 1. Mandatory categorically needy low-income families and children eligible under section 1925 for Transitional Medical Assistance |
| 2. Mandatory categorically needy poverty level infants eligible under 1902(a)(10)(A)(i)(IV) |
| 3. Mandatory categorically needy poverty level children aged 1 up to age 6 eligible under 1902(a)(10)(A)(i)(VI) |

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| |
|--|
| 4. Mandatory categorically needy poverty level children aged 6 up to age 19 eligible under 1902(a)(10)(A)(i)(VII) |
| 5. Optional categorically needy poverty level pregnant women eligible under 1902(a)(10)(A)(ii)(IX) |
| 6. Optional categorically needy poverty level infants eligible under 1902(a)(10)(A)(ii)(IX) |
| 7. Optional categorically needy AFDC-related families and children eligible under 1902(a)(10)(A)(ii)(I) |
| 8. Mandatory categorically needy low-income parents eligible under 1931 of the Act |
| 9. Mandatory categorically needy pregnant women eligible under 1902(a)(10)(A)(i)(IV) or another section under 1902(a)(10)(A)(i): |
| 10. Individuals qualifying for Medicaid on the basis of blindness |
| 11. Individuals qualifying for Medicaid on the basis of disability |
| 12. Institutionalized individuals assessed a patient contribution towards the cost of care 1902 (f) |
| 13. Individuals dually eligible for Medicare and Medicaid (42 CFR §440.315) |
| 14. Children receiving foster care or adoption assistance under title IV-E of the Act |
| 15. Women needing treatment for breast or cervical cancer who are eligible under 1902(a)(10)(A)(ii)(XVIII) |
| 16. Illegal or otherwise ineligible aliens who are only covered for emergency medical services under section 1903(v) |

Section 6.2 Populations Eligible for HIP

The populations described below in Table 10 are the current HIP eligible populations that will be covered through October 2013. Due to ACA implementation and changes to IC 12-15-44.2 eligibility for HIP will change between 2013 and 2014. Table 11 notes the revised eligibility that will be effective 1/1/2014. Details about how these eligibility changes will be implemented can be found in the transition plan.

Table 10: Healthy Indiana Plan (HIP) Program Eligibility January 1, 2013 to December 31, 2013.

| Description | FPL and/or other qualifying criteria | Demonstration Eligibility Group |
|---|---|--|
| Demonstration Eligible Groups January 1, 2013 to December 31, 2013 | | |
| Custodial parents and caretaker relatives currently excluded from | Income up to the AFDC income limit for the particular family size as indicated in the State Plan with | Parents and Caretakers |

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| | | |
|---|---|------------------------|
| the Medicaid State plan who have been uninsured for at least 6 months, and who are not otherwise eligible for Medicaid or Medicare | resources in excess of \$1,000 | |
| Custodial parents and caretaker relatives of children eligible for Medicaid or CHIP who have been uninsured for at least 6 months, and who are not otherwise eligible for Medicaid or Medicare | Income above the AFDC income limit for the particular family size as indicated in the State Plan and up to and including 200% FPL; no resource limit. | Parents and Caretakers |
| Non-custodial parents and childless adults (19-64) who do not meet the criteria of HIP Caretakers, who have been uninsured for at least 6 months, and who are not otherwise eligible for Medicaid or Medicare | 0% FPL through 200% FPL; no resource limit. At no point in time may the number of individuals exceed 36,500. | Non-caretaker Adults |

October 1, 2013 the State will begin to determine eligibility based on MAGI. Non-caretakers who meet the criteria for Medicaid eligibility under the ACA, but who cannot enroll directly in HIP due to the non-caretaker enrollment cap will be enrolled in HIP coverage effective January 1, 2014 and be placed on a waitlist. The requirements that an individual have been uninsured for at least six months and not have access to employer sponsored insurance are removed from the HIP eligibility criteria effective January 1, 2014. Individuals who apply between October 1, 2013 and December 31st, 2014 and are otherwise eligible but ineligible due to these criteria will be granted coverage effective January 1, 2013.

Table 11: Healthy Indiana Plan (HIP) Program Eligibility January 1, 2014 to December 31, 2015

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| Description | FPL and/or other qualifying criteria | Demonstration Eligibility Group(s) | Consistent with below group(s) prior to January 1, 2014 |
|---|--|---|---|
| Demonstration Eligible Groups January 1, 2014 to December 31, 2015 | | | |
| Adults ages 18 to 64 who are not otherwise eligible for Medicaid or Medicare. | Income under 133% FPL per the Modified Adjusted Gross Income (MAGI) guidelines with 5% disregard, payment of POWER account contribution, no resource limit | Adults (As described in the noticed of proposed rulemaking at 435.119 “the adult group”, parents/caretakers below 23% FPL will not be in HIP.) | Parents and Caretakers, Non-Caretaker Adults |

6.3 Eligibility Exclusions

Between January 1, 2013 and December 31, 2013, the State will maintain eligibility as in the current waiver. As such, individuals are excluded from HIP eligibility if:

- They are eligible for Medicaid under the State Plan (see Table 9)
- They are eligible for Medicare
- They have income in excess of 200% FPL
- They have access to an employer-sponsored health plan
- They are currently enrolled in a health insurance program
- They are excluded from HIP eligibility for 12 months if they fail to pay a POWER account contribution within 60 days; not inclusive of the first POWER account contribution

To align with the Exchange enrollment period, starting October 1, 2013 HIP will begin to use MAGI income calculation. Between October 1, 2013 and December 31, 2013 HIP applicants disqualified from HIP coverage due to access to employer-sponsored health plans, insurance in the last six months, or enrollment in a health insurance program but otherwise eligible for HIP will be enrolled in HIP coverage effective January 1, 2014. During this same period, non-caretakers who cannot be immediately enrolled due to the enrollment cap will be granted coverage effective January 1, 2014 and placed on the waitlist.

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Starting January 1, 2014 the income qualification for HIP will change to be consistent with the requirements in IC 12-15-44.2. Formerly HIP eligible individuals over 133% FPL will be eligible for tax-credits in the Exchange as of January 1, 2014. From January 1, 2014 to December 31, 2015 individuals will be excluded from HIP eligibility if:

- They are eligible for another Medicaid category under the State Plan (see Table 9)
- They are eligible for Medicare
- They have MAGI in excess of 133% FPL (138% with 5% disregard)
- They are excluded from HIP eligibility for 12 months if they fail to pay a POWER account contribution within 60 days; not inclusive of the first POWER account contribution

6.4 Special Redetermination Period

Based on Indiana Code, the income standards for HIP change January 1, 2014. HIP will initiate a special redetermination period starting January 1, 2014 for all individuals that current eligibility information shows may have income in excess of 133% FPL based on MAGI. Individuals who are determined ineligible for HIP based on income will be screened for eligibility for Exchange coverage. Please see the transition plan for more details.

Section 7: Benefits

The benefits provided by HIP are described below.

HIP offers the following coverage:

- 1) A basic commercial benefits package once annual medical costs exceed \$1,100.
- 2) A POWER account valued at \$1,100 per adult to pay for initial medical costs. The POWER accounts provide incentives for participants to utilize services in a cost-efficient manner. HIP members make monthly contributions to their POWER accounts depending on their income level and the State funds the remainder of the account.
- 3) \$500 in “first dollar” preventive benefits; these benefits are at no cost to HIP members and will not deplete their POWER account. **Proposed change:** To comply with ACA requirements HIP will offer all required preventive services outside of the deductible.
- 4) **Proposed Change:** Removal of \$300,000 annual and \$1,000,000 lifetime limit after which individuals are transferred to HIP’s high risk pool or another Medicaid program. For the waiver renewal period the State has requested that this limit be removed to comply with ACA requirements.

Table 12: HIP Benefits

| Benefit | Limits/Inclusions (as applicable) |
|---------|-----------------------------------|
|---------|-----------------------------------|

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| | |
|---|---|
| Inpatient Facility | |
| Medical/Surgical | |
| Mental Health/Substance Abuse | Covered same as any other service |
| Skilled Nursing Facilities | Subject to a 60-day maximum |
| Outpatient Facility | |
| Surgery | |
| Emergency Room | Co-payment for services determined to be non-emergency : \$6 for adults 100% FPL to 133% FPL, \$3 for adults up to 100% FPL |
| Urgent Care | |
| Physical/Occupational/Speech Therapy | 25-visit annual maximum for each type of therapy |
| Radiology/Pathology | |
| Pharmacy and Blood | Generic preference, brands allowed when no generic is available |
| Professional Services | |
| Inpatient/Outpatient Surgery | |
| Inpatient/Outpatient ER Visits | |
| Office Visits/Consults | |
| Preventive Services | At least \$500 annual first dollar coverage |
| Physical/Occupational/Speech Therapy | 25-visit annual maximum for each type of therapy |
| Radiology/Pathology | |
| Outpatient Mental Health/ Substance Abuse | Covered the same as any other illness |
| Ancillary Services | |

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| | |
|---|---|
| Prescription Drug | Brand name drugs are not covered where a generic substitute is available |
| Home Health | Excludes long term care. |
| Hospice | |
| Emergency Transportation | |
| Durable Medical Equipment/Supplies/Prosthetics | |
| Family Planning Services | Excludes abortion or abortifacients. Includes contraceptives and sexually transmitted disease testing as described in Medicaid law (42 USC 1396). |
| Lead Screening Services | Under 21 Years of Age |
| Hearing Aids | |
| Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services | Subject to the HIP benefit coverage limits |
| Disease Management Services | |

The benefits package for HIP has not been a benchmark equivalent health plan, as it does not cover dental, or vision services, maternity and non-emergency transportation. Milliman Inc conducted an analysis comparing HIP to a benchmark benefit plan included an attachment. Currently, HIP has waivers for the requirement to offer these services and seeks continuation of these waivers. Milliman has certified that with the addition of these benefits and the removal of the HIP annual and lifetime coverage limits that HIP is a benchmark equivalent health plan.

Additional guidance is needed around maternity coverage. Currently, when an individual in HIP becomes pregnant they are transferred out of HIP to Medicaid for the duration of their pregnancy and afterwards they can reenroll in HIP. The ACA lists maternity coverage and newborn care as a required essential benefits in §1302(b)(1)(D). However, when defining those eligible for Medicaid's benchmark coverage plan in §2001(a)(1)(C) the provision excludes those who are pregnant as they are already eligible for Pregnancy Medicaid. Indiana would be willing to include pregnant women in the HIP program to maintain continuity of coverage under one program and to suspend cost sharing requirements for the duration of the pregnancy. The state seeks guidance from CMS on this provision and what program pregnant women under 133% FPL with the 5% income disregard will qualify for.

Section 8: Cost-Sharing

Currently, HIP utilizes two forms of cost sharing. First it requires copayments for non-emergency ER visits. Second it requires individuals to contribute to their POWER accounts. Contributions to POWER accounts are used to pay for health care services received before the deductible is met. POWER account contributions are made on a sliding fee scale basis and are detailed below. Caretakers, consistent with the CMS standard, do not pay more than 5% of their annual income in combined cost sharing (POWER account contributions and ER copays). Caretakers make required POWER account contributions on a sliding scale up to only 4.5% of their income, leaving room for any potential ER copays. Non-caretakers in the current HIP program have up to 5% for their required POWER account contribution and pay a flat \$25 for all non-emergency ER visits.

Independent legal analysis of the HIP POWER account contributions indicates that POWER account contributions should not be classified as premiums. Section 1916A of the Social Security Act defines “premium” to include “any enrollment fee or similar charge.” The enrollee contribution to the POWER account is not an “enrollment fee;” rather, it is a contribution towards the \$1,100 amount in the account. In that way, it is closer to either a deductible or co-insurance (although, unlike those two, it does not relate to a particular service at the time it is paid). Unlike a premium payment, HIP enrollees continue to own their required contributions and in the event of disenrollment from the program any of their remaining contributions are returned to them.

Per CMS rules for HIP caretakers, the total aggregate amount of (1) POWER account contributions, (2) HIP copayments, (3) Medicaid cost sharing requirements, and (4) CHIP cost sharing requirements may not exceed 5% of family income. If a member approaches the cost sharing limit, the health plan verifies the member’s cost-sharing documentation, and then notifies the HIP program manager that the member has reached the 5% maximum contribution amount and the date it occurred. The member is not required to pay any further POWER account contributions or ER co-payments for the rest of the 12-month benefit period. Member handbooks were modified in 2009 to clarify that members must maintain their receipts and document their out-of-pocket costs. Members self-monitor and report to the program that they have reached 5% of their income in cost-sharing requirements. Going forward OMPP is working on an automated process that will monitor and verify members spending on POWER account contributions, CHIP premiums and copayments and ensure that these payments do not exceed 5% of income.

8.1 Copayments

Overall, copayments will change to accommodate the new status of non-caretakers as indicated by the ACA. Since HIP eligibility will align with the ACA Medicaid expansion group in 2014, those over 133% FPL will no longer be eligible for HIP as of January 1, 2014. Copayments for non-emergency use of the ER are displayed below, after 2014 and ACA implementation the

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higher copayment for HIP Adults will be eliminated, as at that time they become a categorically eligible Medicaid group.

Table 13: Waiver Extension Demonstration Year 6 Cost Sharing January 1, 2013 to December 31, 2013 (current requirements)

| Population | Non-Emergency ER Use Co-Payment Amount | Power Account Contribution |
|---|--|-----------------------------------|
| HIP Caretakers With Incomes Above the AFDC Income Limit as Indicated in the State Plan through 100% FPL | \$3 per visit | Not more than 2% of income |
| HIP Caretakers Above 100 % through 150% FPL | \$6 per visit | 3% to 4% of income |
| HIP Caretakers Above 150 % through 200% FPL | Lower of 20 percent of the cost of the services provided during the visit, or \$25 | Not more than 4.5% of income |
| HIP Adults | \$25 per visit | 2% to 5% of income based on FPL |

Table 14: Waiver Extension Demonstration Year 7 & 8 Cost Sharing January 1, 2014 to December 31, 2015

| Population | Non-Emergency ER Use Co-Payment Amount | Power Account Contribution |
|---|---|-----------------------------------|
| Adults With Incomes Above the AFDC Income Limit as Indicated in the State Plan through 100% FPL based on MAGI | \$3 per visit | Not more than 2% of income |
| Adults Above 100 % through 133% FPL based on MAGI | \$6 per visit | 3% to 4% of income |

8.2 POWER Account

The POWER account is an HSA styled account that HIP enrollees use to cover HIP's \$1,100 deductible and is the centerpiece of the HIP plan. In the majority of cases both enrollees and the State contribute to the POWER account. Since the beginning of the HIP program between 20% and 35% of POWER accounts have been fully funded by the State as the individuals were not required to pay a POWER Account contribution. The cornerstone of the HIP program is to promote personal responsibility and consumerism in healthcare and including non-contributors in the program is contrary to the program's goals; these individuals have no "skin in the game" or incentive to be cost conscious consumers.

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The HIP program emphasizes personal responsibility, and the vast majority (92%) of POWER account contributors pay their POWER account contributions on time. HIP enrollees who do not pay any contributions are not expected to have the same degree of personal responsibility as they cannot be disenrolled for failure to pay a contribution. Potentially related to the paying of contributions, these non-contributors have higher non-emergency use of the ER (66.8 visits per 1000 enrollees vs. 34.7 visits per 1,000 enrollees for contributors). The utilization differences between contributors and non-contributors suggest that paying a contribution may impact care seeking behavior.

As discussed previously, HIP has not experienced problems with affordability, and a Mathematica survey of HIP members found that 70% of contributors consider the amount of their POWER account contribution to be ‘just right’, while 7% indicate they could pay an even greater contribution; only 8% of HIP enrollees felt their contribution was far too much. Under HIP, employers are also able to contribute 50% of an individual’s required contribution.

During the 2010 legislative session, the Indiana legislature modified IC 12-15-44.2. These modifications include language that requires members to contribute a minimum amount to their POWER account to ensure that all individuals are making contributions and have the appropriate consumer incentives, or “skin in the game.” The minimum amount required is an annual contribution of \$160 but not more than 2% of income for an enrollee under 100% FPL, 3% of income for an enrollee from 100% to 125% FPL and 4% of income for an enrollee 125% to 150% FPL. The percentage limits in the enabling legislation may prevent very low income adults from making the full minimum contribution. Table 15 indicates the proposed POWER account contributions. Individuals will contribute the required minimum monthly contribution until they meet their income limit and then required contributions for those individuals will be suspended.

Table 15: POWER Account Contributions

| Annual Household Income | Minimum POWER Account Contribution | Maximum POWER Account Contribution | Estimated maximum annual/monthly contribution Individual | Estimated maximum annual /monthly contribution Family of 4 |
|---------------------------------------|--|---|---|---|
| All enrollees less than 25% FPL | \$160 annually but not more than 2% of annual income | Not more than 2% of income | \$54.46/ \$13.33 | \$111.76/ \$13.33 |
| All enrollees between 25% and 50% FPL | \$160 annually but not more than 2% of income | Not more than 2% of income | \$108.90/ \$13.33 | \$223.50/ \$18.63 |
| All enrollees between 50% and 75% FPL | \$160 annually | Not more than 2% of income | \$163.36/ \$13.61 | \$335.26/ \$27.94 |

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| | | | | |
|---|----------------|-------------------------------|-------------------|-------------------|
| All enrollees between 75% and 100% percent FPL | \$160 annually | Not more than 2% of income | \$217.80/ \$18.15 | \$447.00/ \$37.25 |
| All enrollees above 100 through 125 percent FPL | \$160 annually | Not more than 3% of income. | \$408.39/ \$34.03 | \$838.14/ \$69.85 |
| All enrollees above 125 through 133 percent FPL | \$160 annually | Not more than 4% of income. | \$579.35/ \$48.28 | \$1,100/ \$91.67 |
| <i>Year 1: January 1, 2013 to 2014 redetermination for below populations on HIP (below populations will be transitioned to the Exchange in 2014 please see transition plan for details).</i> | | | | |
| All enrollees above 133 through 150 percent FPL | \$160 annually | Not more than 4% of income. | \$653.4/ \$54.45 | \$1,100/ \$91.67 |
| HIP Caretakers above 150 through 200 percent FPL | \$160 annually | Not more than 4.5% of income. | N/A | \$1,100/ \$91.67 |
| HIP Adults above 150 through 200 percent FPL | \$160 annually | Not more than 5% of income | \$1,089/ \$90.75 | N/A |

The new legislation also allows not-for-profit entities to make up to 75% of an individual's required contribution. Individuals who receive sponsorship from not-for-profits may pay less than the displayed minimum contributions. Enrollees pay their contributions in equal monthly installments, and are also permitted to pay the entire sum up front.

For those members who do not currently contribute, and who will be required to start contributing on their first redetermination period after January 1, 2013 the State has developed a transition plan described in detail in the next section.

The State will continue to ensure that the POWER account is fully funded from the beginning of individual enrollment and will continue to make contributions to ensure that the deductible can be met if expenses occur at the beginning of the enrollment period. Health plans are required to collect the POWER account contribution from individuals, and individuals will not receive HIP

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coverage until the first day of the coverage month after the first contribution. This is the current policy and the State requests no changes to this.

Employers can pay 50% of a members required contribution, and not-for-profits can pay 75% of a member's minimum contribution. HIP members that struggle to pay the required minimum contribution will be able to seek employer or non-profit support.

The required minimum contribution of \$160 represents 5% of income for an individual making \$3200 a year, or 29% FPL. IC 12-15-44.2-11 that contains the language instituting the minimum contribution also contains language that limits maximum contributions. The language from the IC 12-15-44.2-11 surrounding the minimum contribution requirements and limiting maximum amounts is excerpted below.

At least one hundred sixty dollars (\$160) per year and not more than the following applicable percentage of the individual's annual household income per year, less any amounts paid by the individual under the Medicaid program under IC 12-15, the children's health insurance program under IC 12-17.6, and the Medicare program (42 U.S.C. 1395 et seq.) as determined by the office:

- *Two percent (2%) of the individual's annual household income per year if the individual has an annual household income of not more than one hundred percent (100%) of the federal income poverty level.*
- *Three percent (3%) of the individual's annual household income per year if the individual has an annual household income of more than one hundred percent (100%) and not more than one hundred twenty-five percent (125%) of the federal income poverty level.*
- *Four percent (4%) of the individual's annual household income per year if the individual has an annual household income of more than one hundred twenty-five percent (125%) and not more than one hundred fifty percent (150%) of the federal income poverty level.*
- *Five percent (5%) of the individual's annual household income per year if the individual has an annual household income of more than one hundred fifty percent (150%) and not more than two hundred percent (200%) of the federal income poverty level.*

To track entire family spending on Medicaid services, FSSA is implementing a process to automatically monitor member expenditures and ensure that POWER account contributions, CHIP premium payments, and copayments never exceed 5% of a member's income in line with CMS guidelines. Currently, members must track their own spending and report when they have reached the 5% limit. In the event that a HIP member has exceed 5% of their income but has not met the minimum contribution requirement the State will suspend the POWER account contribution requirement and ensure the POWER account is fully funded.

Section 9: HIP 1115 Waiver Renewal Transition Plan

OMPP has developed a transition plan for two scenarios, based upon CMS' approval or denial of the HIP 1115 demonstration waiver extension. Should the State not receive approval to continue the 1115 waiver for the **full three year period**, 2013-2015, the State will begin dismantling the HIP program in June of 2012 as described in Plan B. If the waiver is approved, the State will proceed with Plan A.

Plan A: 1115 receives approval for three year extension (2013, 2014 & 2015)

The changes addressed in this transition plan, which directly affect HIP members, are (1) the reduction of the upper eligibility threshold from 200% FPL to 133% effective January 1, 2014, (2) the requirement of a minimum member POWER account contribution of \$160 annually (subject to a 5% income limit) or approximately \$13/month, and (3) the option for not-for-profit entities to contribute up to 75% of an individual's monthly POWER account contribution. "Plan A" addresses the continuation of the waiver and is subdivided to address several populations affected by changes to the 1115 waiver from its original demonstration to the proposed structure in this waiver extension. "Plan A" populations are:

- (1) Per IC 12-15-44.2 and the Affordable Care Act, current HIP members between 133% FPL and 200% FPL who will no longer be eligible for HIP coverage in 2014, but will be eligible for an Exchange product.
- (2) HIP currently operates a waitlist for approximately 50,000 non-caretaker adults. It is assumed that these individuals will be eligible for enrollment in HIP or an Exchange product and tax subsidy in 2014.
- (3) HIP members who currently make no contributions to their HIP POWER accounts ("zero contributors") due to current income counting requirements, but will be required to contribute \$160 annually beginning at the start of their renewal period in 2013, as required by State statute.
- (4) HIP members under 133% who will maintain HIP eligibility, but may be affected by the \$160 annual contribution to the POWER account. These members are currently contributing less than \$160 annually.

Once the State receives approval from CMS, trainings will take place with the MCEs: Anthem, MDwise, and MHS. The goal of the trainings is to prepare the MCEs for the upcoming changes so they may begin planning, as necessary, to best assist HIP members in the transition.

Information will be available on FSSA's HIP website (www.HIP.in.gov). FSSA will publish a press release and notify all legislators of the waiver approval and the plan for the program going forward.

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(1) Current HIP members between 133% FPL and 200% FPL

A waiver extension for three years will result in program changes at the end of demonstration year six/renewal year one for current members between 133% FPL and 200% FPL. These individuals will become eligible for Exchange subsidies beginning January 1, 2014 and per Indiana code would no longer be eligible for the HIP, pending CMS approval of the eligibility threshold. The September release of the notice of proposed rulemaking for 42 CFR Parts 431, 433, 435, and 457 *Medicaid Program: Eligibility Changes under the Affordable Care Act of 2010* relating to modified adjusted gross income (MAGI), state the following:

“Proposed §435.603(a)(1) and (2) set forth the basis and scope of this section. At proposed §435.603(a)(3), we implement 1902(e)(14)(D)(v) of the Act, as added by section 2002(a) of the Affordable Care Act, which specifies that, in determining ongoing eligibility of individuals enrolled in the Medicaid program as of January 1, 2014, the financial methodologies based on MAGI shall not be applied until the next regularly-scheduled redetermination of eligibility after December 31, 2013 or March 31, 2014, if such individual otherwise would lose eligibility as a result of the shift to MAGI-based methodologies before such date.”

As of January 1, 2014 individuals between 133% and 200% FPL will no longer be eligible for HIP eligibility as a result of the HIP change in the eligibility threshold effective on that day, not as a result of a change to MAGI calculation. The following is proposed for individuals between 133% and 200% FPL, who are enrolled in HIP. In keeping with the philosophy that those under 133% FPL will be enrolled in Medicaid and over 133% FPL will be enrolled in a Qualified Health Plan with tax subsidies, the transition plan modifies the redetermination period, such that individuals enroll in a QHP early in 2014. This plan reduces duplication of services offered through multiple programs. The plan for transitioning individuals between 133% and 200% FPL is as follows:

- Prior to July 2012 - Upon waiver extension approval from CMS and no later than July 1, 2012, FSSA will commence putting together a change package for the Indiana Client Eligibility System (ICES) and the claims system, MMIS, to reflect the eligibility threshold change, effective January 1, 2014.
- For individuals enrolled in HIP above 133% FPL under current eligibility standards, a special redetermination period will commence January 1, 2014. Letters will be sent to individuals identified as between 133% and 200% FPL, by October 2013, notifying them of the special redetermination date and of their potential eligibility for coverage through the Exchange. This process aligns the redetermination dates with Exchange enrollment periods.
- October 1, 2013 - A letter regarding changes to the HIP program will be mailed no later than October 2013 to HIP members between 133% and 200% FPL notifying the member that based on the income information the State has, s/he may lose HIP

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eligibility if, at redetermination, their income remains over 133% FPL. The letter will note that a second letter will be mailed by January 1 advising them to complete their redetermination, how to complete their redetermination, and if found ineligible for HIP but eligible for a tax subsidy, how to enroll in an Exchange product.

- October 1, 2013 - A letter will be sent to all enrollment centers informing them of the changes to the program for individuals between 133% FPL and 200% FPL and how to assist an individual in enrolling in an Exchange product.
- January 1, 2014 – Redetermination letters will be mailed to individuals above 133% FPL. Individuals will have 60 days to complete their redetermination. If found eligible for HIP, they will remain enrolled in HIP. If income remains above 133% FPL at redetermination, these individuals will be referred for tax subsidy screening.
 - Phone numbers will be provided in the letters for each MCE as well as the Exchange, such that individuals could begin selecting products once they receive their eligibility determination from the State. It is anticipated that each MCE may offer a comparable product to HIP on the Exchange. Currently, the HIP program requires that MCEs have a commercial product similar to HIP. If the waiver is approved, the State may consider a requirement of MCEs to provide a plan on the Exchange. Information on other available Medicaid products and where to obtain and submit an application will be included in the letter.
 - The State will track the progress of the population and may also consider outbound phone calls to members that have not responded.
 - For individuals who are found eligible for a tax subsidy, remaining non-state contribution balances in POWER account contributions will be rolled over to health savings accounts (HSAs) if the member selects a high-deductible health plan (HDHP), or the balance will be returned to member as is the current process. The MCEs will hold any balance for six months after reconciliation of the POWER account. Thus, contributions to the HSAs will be made mid-year 2014.
- March 15, 2014 – Termination letters will be sent to HIP members who did not complete their redetermination. These letters will include information on how to enroll in an Exchange product or reapply for HIP.

(2) Individuals currently on the HIP waitlist

The State will take steps necessary to inform individuals on the HIP wait list that they will be eligible for HIP or an Exchange product in January 2014.

- October 2013 – At the time of the Exchange open enrollment, ICES will issue letters to individuals on the HIP waitlist, in batches, stating that they may be eligible for HIP and that

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there will no longer be a wait list for the program. Individuals will need to reapply for the program in order to prove they are still eligible and will need to file this application no later than 45 days from the date of the letter. A phone number will be provided on the letter for individuals to call should they have questions or need assistance. The enrollment broker would be leveraged to assist with any returned letters and subsequent outreach to clients, as noted in the prior section.

- Case numbers of individuals who are sent application invitation letters will be flagged in ICES so DFR will know who to process as waitlist applicants.
- In processing eligibility, access to employer sponsored insurance and insurance within the last 6 months will only disqualify individuals through December 31st, 2013. Individuals with these disqualifications but otherwise eligible for HIP will be granted coverage effective January 1, 2014.
- If application is received by DFR by the due date (within 45 days), but without all required documentation to determine eligibility, they will complete the same follow up to obtain verification.
- All applicants over 133% FPL will be screened for tax subsidy eligibility, in coordination the Exchange's open enrollment period. From October 1, 2013 to December 31, 2013 HIP will maintain eligibility levels to 200% FPL; however, tax subsidy screening for the eligible portion of the HIP population will promote streamlined transitions to Exchange coverage for this population.
- Coverage would not begin for non-caretakers determined eligible for HIP until January 1, 2014.

(3) Current members who currently make no contributions to HIP POWER accounts (“zero contributors”)

- As soon as waiver approval is received from CMS, FSSA will run a data query to identify all HIP members who currently do not make POWER account contributions. A letter will be sent to these HIP members informing them that they will be required to make POWER account contributions beginning on their first redetermination after January 1, 2013 and that employers may contribute up to 50% and not-for-profit groups may contribute up to 75% of their monthly payment. Individual required contributions will not be phased in until their redetermination period.
- The State will meet with the MCEs to walk staff through the program changes. MCEs will be asked to help coordinate the effort and to be prepared to work with their members to make the transition.
- Changes will be made to FSSA's eligibility and claims management systems (MMIS). It will be particularly important to ensure that no one has a zero contribution and that the default contribution is never zero, but is at least \$160 annually or approximately \$13/month subject to the income limits present in statute.

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- After January 1, 2013- At each individual's appointed redetermination period, s/he will be given information regarding their new POWER account and how to appeal the decision.

(4) Those under 133% who will maintain eligibility but may be affected by the changes to the POWER account rules, as their POWER account contribution may increase.

The same process as described in item (3) will be followed, the difference being that the letters will be tailored to those who may have a change in the amount of their POWER account contribution due to the minimum contribution. The letters will continue to describe the opportunity for not-for-profit participation.

Plan B: 1115 does not receive approval for 3 year extension & the program is dismantled

Should the State not receive approval to continue the 1115 waiver for the full three year period, 2013-2015, the State will begin dismantling the HIP program. The State will require at least six months of preparation to ensure the transition runs smoothly. The last day of the program will be December 31, 2012. Appropriate steps will be taken to ensure all members are aware of the closure of the program and of other options that might be available to them.

- Upon denial from CMS:
 - FSSA will publish a press release and notify all State and Federal Indiana legislators of the denial and the subsequent termination of the program.
 - Letters will be sent to all HIP members informing them that the program will end on December 31, 2012, per CMS's denial. The letters will note that HIP members may continue to receive coverage for healthcare services through December 31, 2012, should they continue to meet eligibility requirements. The letters will also contain information on other products that could be available to these members upon the closure of the program, such as other Medicaid categories, ICHIA, the PCIP, and commercial insurance.
 - Letters will also go out to individuals on the HIP wait list notifying them of the closure of the program and the subsequent discontinuance of the waitlist. The waitlist will close and no additional individuals will be placed on the waitlist.
 - The above process will be repeated, to ensure that communication is received.
 - The State will begin negotiations with the three MCEs to amend their contracts to terminate the HIP portion of their combined HHW and HIP contracts.
 - The State will develop a plan for the remaining dollars in the HIP fund.

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- Letters and bulletins will be sent to Medicaid providers and enrollment centers informing them of the end of the program.
- FSSA will commence making necessary changes to its eligibility and claims management system to ensure that members are terminated and that no capitation payments are made to health plans.
- July 2012 - FSSA will stop processing new HIP applications. Any application in process will be denied. Redeterminations will cease, and individuals will be left in the HIP program until the end of the year. DFR staff will be trained to inform clients that HIP is no longer an option, and applications will be removed from the website and local offices.
- December 2012 – Letters will go out to each HIP member informing them that their coverage was terminated; there will be no appeal rights associated with this termination as the program will have ended. The letters will detail the options that will be available beginning in 2014 via the Exchange, other Medicaid programs, and the commercial market.

Section 10: Evaluation reports

Mathematica developed an evaluation plan for HIP during the HIP initial demonstration period. HIP is meeting its program goals and providing quality care to clients. During the extension period Indiana expects to continue to make some modification to the evaluation design and to focus on new areas of study. Evaluation reports address HIP's progress on program goals in addition to the evaluation questions present in the STCs.

Evaluation reports will include evaluation on the below HIP goals:

1. Reduce the number of uninsured low income Hoosiers.
2. Reduce barriers and improve statewide access to health care services for low income Hoosiers.
3. Promote value-based decision making and personal health responsibility.
4. Promote primary prevention.
5. Prevent chronic disease progression with secondary prevention.
6. Provide appropriate quality-based health care services.
7. Assure State fiscal responsibility and efficient management of the program.

During the waiver extension period evaluation reports will continue to include responses to the below STC evaluation questions:

1. What percentage of the potentially eligible population enrolls in HIP? How does the percentage vary by major population subgroups (HIP Caretakers, HIP Adults) and income level?
2. What are the consequences of requiring HIP participants with family income less than 150 percent of the FPL to pay monthly premiums? How many of these participants fail to make their first POWER account contribution? How many of these participants are disenrolled for failure to pay their premiums?

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3. To what extent has HIP impacted the uninsurance rate in Indiana?
4. To what extent has HIP reduced uncompensated care provided by Indiana's federally funded health clinics?
5. How many enrollees exhaust their POWER account each year? How many enrollees are able to roll-over a sufficient POWER account balance to reduce their subsequent contributions?

During the waiver extension period the State also intends to investigate if the minimum contribution requirement effectively changes the care seeking behavior on current non-contributors and encourages more cost conscious consumption of health care services.

Section 11: Public Comment Period

This 1115 demonstration extension application follows the proposed rule for 1115 demonstration applications and includes a public comment period. The notice below was included in the Indiana Register October 12, 2011 and public comment sessions were conducted November 14 and 16, 2011.

11.1 Public Comment Notice

Notice of Public Hearing

Under 42 CFR Part 431 and the rules proposed under PART 431 in the September 17, 2010 issue of the Federal Register, 75 FR 56946 – 56961, notice is hereby given that (1) on November 14, 2011 at 1:30 p.m. in conference rooms 1 and 2, and (2) on November 16, 2011 at 1:30 p.m. in conference room 4, at the Indiana Government Center South, Conference Center, 402 West Washington Street, Indianapolis, Indiana, the Family and Social Services Administration will hold a public hearing on a Medicaid 1115 waiver renewal submission to the Centers for Medicare and Medicaid Services to extend the demonstration for the Healthy Indiana Plan (HIP) for calendar years 2013-2015. The current 1115 waiver is set to expire on December 31, 2012. As a result of the recent changes to Medicaid eligibility initiated by the Patient Protection and Affordable Care Act (ACA) and changes authorized by the Indiana General Assembly at I.C. 12-15-44.2, the waiver renewal application includes the authorized modifications to HIP, as well as a request for HIP to serve as the coverage vehicle for newly-eligible individuals under the ACA Medicaid expansion.

The HIP demonstration project was approved in December 2007, and the program began on January 1, 2008. HIP currently covers non-disabled adults between the ages of 19-65 who meet the following qualifying criteria: income less than 200% of federal poverty level (FPL), no access to employer-sponsored insurance, and no health coverage within the six month period prior to application. The program includes a \$1,100 deductible and creates Personal Wellness and Responsibility (POWER) accounts to fund the deductible. Individuals are required to make monthly contributions to the POWER account, and the state funds the remainder of the account to ensure the \$1,100 deductible can be met. Minimal copayments of \$3, \$6 or \$25 are charged

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for non-emergent utilization of the emergency room, per the current HIP program. In 2014, the \$25 copayment will be eliminated. HIP is delivered via risk-based managed care and provides a basic commercial benefit package once medical costs exceed \$1,100. Additionally, \$500 in first dollar preventive benefits are provided at no cost to the individual.

There are seven program goals in the proposed 1115 waiver application: (1) reduce the number of uninsured low-income Hoosiers, (2) reduce barriers and improve statewide access to health care services for low-income Hoosiers, (3) promote value-based decisions making and personal health responsibility, (4) promote primary prevention, (5) prevent chronic disease progression with secondary prevention, (6) provide appropriate and quality-based health care services, and (7) assure State fiscal responsibility and efficient management of the program. HIP will be evaluated based on progress towards these goals.

HIP currently covers approximately 41,000 individuals. The purpose of this 1115 waiver renewal is to continue HIP for three years, the maximum allowable time period, to use HIP to cover the individuals newly eligible for Medicaid in 2014, and to make other ACA-related changes. Changes to the program in this waiver extension, authorized in I.C. 12-15-44.2, include:

- A requirement for enrollees to make a minimum contribution to their POWER Account of \$160 annually (but guarantees that individuals will not pay more than 5% of their income towards health costs).
- An allowance for not-for-profits to make up to 75% of a member's required contribution to the POWER Account and authorization for health plans to contribute to the POWER Account to incentivize positive health habits. Currently, employers can make up to 50% of an individual's contribution; this remains in place with the addition of the aforementioned provisions.
- Changes HIP eligibility levels to align with the ACA expansion limit of 133% of federal poverty level (FPL) starting on January 1, 2014. The current eligibility threshold is 200% FPL.

In the first three years of the 1115 demonstration project, HIP covered 77,466 individuals. Current enrollment for the program is approximately 41,000 individuals. With waiver approval it is anticipated that, beginning in 2014 with the ACA provisions taking effect, a total of 192,000 parents and 164,000 adults will be enrolled in HIP. Changes to the budget neutrality agreement have been made to reflect the Affordable Care Act changes. Per the memorandum included in this waiver application, "1115 Waiver – Renewal Budget Neutrality Filing," expected expenditures are \$2.3B, \$3.9B and \$4.2B (state and federal) in 2013, 2014 and 2015 respectively. The expected savings, respectively, via the waiver for each of those years, are \$150.1M, \$487.5M, and \$538.0M (state and federal).

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The state will identify individuals under 21 years of age who qualify for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services and assure that EPSDT services will be provided to those individuals who qualify. In addition, if an individual is recognized as part of a Tribal Nation, the State assures that required services will be provided to qualified individuals. The methods and standards for payment are consistent with the current program: not less than the federal Medicare reimbursement rate for the services provided or at a rate of 130% of the Medicaid reimbursement rate for a service that does not have a Medicare reimbursement rate.

Copies of the HIP waiver renewal documents are now on file at the Indiana Family & Social Services Administration, Office of the General Counsel, 402 W. Washington Street, Room 451, Indianapolis, Indiana 46204 and are open for public inspection. The documents may also be viewed at www.in.gov/activecalendar by selecting the date(s) of the public hearing. Written comments may be sent to the aforementioned address to the attention of Bobbi Nardi or to Barbara.nardi@fssa.in.gov through second hearing on November 16, 2011.

11.2 Public Comment Feedback

[This section will include a summary of the feedback received in the public comment period.]

Section 12: Types of waivers being requested

The State is requesting the below waivers.

Title XIX Waivers

1. Amount, Duration, and Scope and Comparability Section 1902(a)(10)(B)

To the extent necessary to enable Indiana to vary the services offered to individuals, within eligibility groups or within the categorical eligible population, based on differing managed care arrangements or on the absence of managed care arrangements. Individuals enrolled in the Hoosier Healthwise program receive additional benefits such as case management and health education that may not be available to other Medicaid beneficiaries not enrolled in Hoosier Healthwise.

2. Freedom of Choice Section 1902(a)(23)

To the extent necessary to enable Indiana to restrict the freedom of choice of providers for the demonstration eligibility groups.

3. Reasonable Promptness Section 1902(a)(3)
Section 1902(a)(8)

To the extent necessary to enable Indiana to prohibit reenrollment for 12 months for individuals in Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults) who are disenrolled for failure to make POWER account contributions.

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To the extent necessary to enable Indiana to delay provision of medical assistance until the first day of the month following an individual's first contribution to the POWER account.

- 4. Methods of Administration: Transportation** Section 1902(a)(4)
insofar as it incorporates
42 CFR 431.53

To the extent necessary to enable Indiana to not assure transportation to and from providers for Demonstration Population 4 (HIP Caretakers) or Demonstration Population 5 (HIP Adults).

- 5. Eligibility Section** Section 1902(a)(10)(A)
To the extent necessary to allow Indiana not to provide medical assistance for Demonstration Population 4 (HIP Caretakers) or Demonstration Population 5 (HIP Adults) until the first day of the month following an individual's first contribution to the POWER account.

- 6. Amount, Duration, and Scope of Services** Section 1902(a)(10)(B)
To the extent necessary to permit Indiana to offer to Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults), known as "the adult group" in the proposed rule at 435.119, benefits that differ from the benefits offered to the categorically needy group.

- 7. Income and Resource Test** Section 1902(a)(10)(C)(i)
To the extent necessary to enable Indiana to exclude funds in the POWER account from the income and resource tests established under State and Federal law for purposes of determining Medicaid eligibility for Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults).

- 8. Freedom of Choice** Section 1902(a)(23)
insofar as it incorporates
42 CFR 438.52(a)

To the extent necessary to enable Indiana to provide only one choice of plan for individuals in Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults) who are identified as having certain high-risk conditions.

- 9. Retroactive Eligibility** Section 1902(a)(34)
To the extent necessary to allow Indiana to not provide medical assistance to Demonstration Population 4 (HIP Caretakers) or to Demonstration Population 5 (HIP Adults) for any time prior to the first of the month following an individual's first contribution to the POWER account.

- 10. Prepayment Review** Section

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1902(a)(37)(B)

To the extent necessary to allow Indiana to not ensure that prepayment review be available for disbursements by members of Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults) to their providers.

11. Cost-Sharing

Section 1916A

To the extent necessary to enable Indiana to charge require POWER account contributions up to 5% of family income for Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults).

12. Dental and Vision Coverage for Certain HIP Caretakers

Section

1902(a)(43)

and HIP Adults

To the extent necessary to enable Indiana not to cover certain vision and dental services described in sections 1905(r)(2) and 1905(r)(3) of the Act to 19 and 20 year-old members of Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults).

The current STCs grant HIP the below waivers. The State believes that these waivers are no longer necessary for the HIP program and does not request that their inclusion in the waiver renewal.

1. Statewideness/Uniformity

Section

1902(a)(1)

To the extent necessary to enable Indiana to operate the Demonstration and provide managed care plans or certain types of managed care plans, including provider-sponsored networks, only in certain geographical areas.

2. Disproportionate Share Hospital (DSH) Payments

Section

1902(a)(13)(A)

insofar as it incorporates Section 1923(c)(1)

To the extent necessary to allow Indiana to divert of a portion of DSH payments made to hospitals to cover the demonstration population.

Section 13: Financing Reports

Please see attached financing report prepared by Milliman Inc.