Healthy Indiana Plan (HIP 2.0)

HIP Interim Evaluation Overview

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

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

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

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

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

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

January – June 2015:
The State developed a comprehensive evaluation strategy for HIP.

June 1, 2015:
The State submitted a Draft Evaluation Plan to CMS.

December 28, 2015:
The State submitted a Final Evaluation Plan to CMS, based on extensive discussions with CMS, and input from Lewin. CMS approved the plan.
**Key Methods**

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

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

**MCE Data:** Contains data from MCEs on member behavior (e.g., POWER account payments).
Goals of HIP 2.0 and Study

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

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

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

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

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

<table>
<thead>
<tr>
<th>Estimates</th>
<th>Observations</th>
</tr>
</thead>
</table>
| The State’s actuary, Milliman, estimated that **nearly 559,000** Indiana residents would be eligible for HIP. | **As of January 2016:**  
| **At the end of the demonstration year:**  
| • Over 60% of eligible Indiana residents between ages 19 and 64 with family income at or below 138% of the FPL may have had HIP 2.0 coverage. | • Over 345,000 actively enrolled members.  
| • More than 30,000 conditionally approved members. |
### Results: Enrollment

<table>
<thead>
<tr>
<th>Percent FPL</th>
<th>Basic</th>
<th></th>
<th>Plus</th>
<th></th>
<th>Total HIP Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>State</td>
<td>Regular</td>
<td>Basic Total</td>
<td></td>
<td>State</td>
</tr>
<tr>
<td>0%-50%</td>
<td>56,072</td>
<td>35,165</td>
<td>91,237</td>
<td>40.0%</td>
<td>64,150</td>
</tr>
<tr>
<td>51%-100%</td>
<td>4,839</td>
<td>19,968</td>
<td>24,807</td>
<td>30.9%</td>
<td>9,185</td>
</tr>
<tr>
<td>101%-138%</td>
<td>1,424</td>
<td>2,603</td>
<td>4,027</td>
<td>11.9%</td>
<td>4,922</td>
</tr>
<tr>
<td>&gt;138%*</td>
<td>1,264</td>
<td>53</td>
<td>1,317</td>
<td>36.6%</td>
<td>1,926</td>
</tr>
<tr>
<td>Total*</td>
<td>63,599</td>
<td>57,789</td>
<td>121,388</td>
<td>35.1%</td>
<td>80,183</td>
</tr>
</tbody>
</table>

**Source:** The Lewin Group

**KEY RESULT:** “A greater proportion of individuals both above and below the poverty level enroll in HIP Plus than in HIP Basic. Thus, it appears that POWER Account contributions do not constitute a barrier to enrollment in the HIP program.”
Nearly 89% of HIP 2.0 enrollees in January 2016 had a family income at or below the federal poverty level (FPL).

<table>
<thead>
<tr>
<th>Percent FPL</th>
<th>Total HIP Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%-50%</td>
<td>227,958</td>
</tr>
<tr>
<td>51%-100%</td>
<td>80,324</td>
</tr>
<tr>
<td>101%-138%</td>
<td>33,778</td>
</tr>
<tr>
<td>&gt;138%*</td>
<td>3,596</td>
</tr>
<tr>
<td><strong>Total</strong>*</td>
<td><strong>345,656</strong></td>
</tr>
</tbody>
</table>

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

*Source: The Lewin Group*
Results: Enrollment

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

Source: FSSA
Results: Enrollment

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

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

Source: The Lewin Group
KEY RESULT: HIP Plus members:
- About 65% of all enrollees
- About 62% of enrollees with income under the federal poverty level

Plus Plan Membership as of January 2016 by Federal Poverty Level

- Less than 23% FPL: 52%
- 23-50% FPL: 13%
- 51-75% FPL: 13%
- 76-100% FPL: 12%
- 101-138% FPL: 9%
- More than 138% FPL: 1%

Source: The Lewin Group
Results: Affordability (continued)

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

<table>
<thead>
<tr>
<th>Average POWER Account Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>For those Making Monthly Contribution</td>
</tr>
<tr>
<td>All HIP Plus Members</td>
</tr>
<tr>
<td>Average: $15.89 (N=239)</td>
</tr>
<tr>
<td>Less than or Equal to 100 Percent of the FPL</td>
</tr>
<tr>
<td>$13.17 (N=184)</td>
</tr>
<tr>
<td>Greater than 100 Percent of the FPL</td>
</tr>
<tr>
<td>$28.48 (N=55)</td>
</tr>
</tbody>
</table>

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

• Reported monthly PACs by family income:
  – Less than or equal to 100% FPL: Average contribution of $13.17 per month.
  – More than 100% FPL: Average contribution of $28.48 per month.
Results: Affordability (continued)

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

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

<table>
<thead>
<tr>
<th>Employer Contributions</th>
<th>YTD Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Employers Participating</td>
<td>124</td>
</tr>
<tr>
<td>Number of Members on Whose Behalf an Employer Makes a Contribution</td>
<td>131</td>
</tr>
<tr>
<td>Total Amount of Employer Contributions</td>
<td>$5,563.69</td>
</tr>
<tr>
<td>Average Amount of Employer Contributions</td>
<td>$42.47</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Non-profit Organization Contributions</th>
<th>YTD Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Non-Profit Organizations Participating</td>
<td>75</td>
</tr>
<tr>
<td>Number of Members on Whose Behalf a Non-Profit Makes a Contribution</td>
<td>1,244</td>
</tr>
<tr>
<td>Total Amount of Non-Profit Contributions</td>
<td>$17,482.29</td>
</tr>
<tr>
<td>Average Amount of Non-Profit Contributions</td>
<td>$14.05</td>
</tr>
</tbody>
</table>

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

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

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

<table>
<thead>
<tr>
<th>Source of Assistance</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Member</td>
<td>86%</td>
</tr>
<tr>
<td>Friend</td>
<td>25%</td>
</tr>
</tbody>
</table>

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

Worries about Ability to Pay the POWER Account Contribution

- Never: 38%
- Rarely: 14%
- Sometimes: 22%
- Usually: 7%
- Always: 3%
- Don't Know: 16%

Source: The Lewin Group

- Always or usually worried about PAC, and very satisfied: 50%
- Rarely or never worried about PAC, and very satisfied: 73%
Results: Affordability (continued)

<table>
<thead>
<tr>
<th>HIP Plus</th>
<th>HIP Basic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Yes (%)</strong></td>
<td><strong>No (%)</strong></td>
</tr>
<tr>
<td>Continue to Stay Enrolled if Required to Pay $5 More</td>
<td></td>
</tr>
<tr>
<td>80%</td>
<td>10%</td>
</tr>
<tr>
<td>Continue to Stay Enrolled if Required to Pay $10 More</td>
<td></td>
</tr>
<tr>
<td>59%</td>
<td>23%</td>
</tr>
</tbody>
</table>

Note: Remaining responses are “Don’t Know”.

Source: The Lewin Group

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

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

Non-payment of PAC:

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

Reasons for Non-payment of PAC

- Administrative issue (3%)
- Affordability (10%)
- Did not need services (16%)
- Confusion about plan and membership/plan type (26%)
- Confusion regarding payment process (30%)
- Forgot (2%)
- Don't know/No reason (13%)

Source: The Lewin Group
Results: Non-Payment

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

**Below 100% FPL:**
- **Policy:** Movement to HIP Basic
- **Awareness of the policy:** 78%

**Above 100% FPL:**
- **Policy:** 6 month disenrollment period
- **Awareness of the policy:** 97%
Results: Disenrollment (PAC)

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

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

Source: The Lewin Group
Results: Disenrollment (continued)

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

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

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

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

<table>
<thead>
<tr>
<th>HIP Members Applied for Waiver/Exemption</th>
<th>Granted Waiver/Exemption</th>
<th>Denied</th>
<th>Pending</th>
</tr>
</thead>
<tbody>
<tr>
<td>176</td>
<td>166</td>
<td>6</td>
<td>4</td>
</tr>
</tbody>
</table>

Source: FSSA
Members leaving HIP in the first year:
- Approximately 61,500 members (15%) disenrolled (for any reason)
- About 16% of disenrolled members were served in another Medicaid program

Common reasons for leaving HIP:
- *Income exceeds program eligibility standards.*
- Failing to comply with redetermination
- Failing to provide required supporting documentation.

*Source: The Lewin Group*
The survey also asked whether respondents had health insurance coverage after they had left the program. Approximately 55 percent of the respondents (n=71) responded that they did. 36% of members who leave HIP obtain health coverage through their employer, and 24% of members who leave HIP obtain health coverage through their spouse’s employer.
Results: Fast Track

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

**Unique Members Making Fast Track Payment**
- 30,856 enrollees
- 11% of Plus members

**Members Making Fast Track Payments Since Policy Began**
- 18% of ever enrolled members
- 26% of Plus members

**Presumptive Eligibility (PE) Members Making Fast Track Payments**
- 6,365 members
- Represents 22% of all previously PE members & 40% of all previously PE Plus members.
- Higher than Fast Track payment rates for non-PE members, which suggests that PE members may be taking advantage of the Fast Track policy to gain coverage sooner.
- Members with income above 100% FPL are particularly likely to make a Fast Track payment; about 60% of previously-PE members make a Fast Track payment.

**Using Care Within First Month of Enrollment**
- Fast Track members are not using more care in their first month of enrollment than members who do not make Fast Track payments.

*Source: The Lewin Group*
## Results: Network Adequacy & Access

<table>
<thead>
<tr>
<th>Member Access Requirement</th>
<th>Outcome Achieved?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care provider within 30 miles</td>
<td>✅</td>
</tr>
<tr>
<td>At least 90% of members have access to at least one vision provider within 60 miles</td>
<td>✅</td>
</tr>
<tr>
<td>At least 90% of members have access to at least one dental provider within 60 miles of their home</td>
<td>✅</td>
</tr>
</tbody>
</table>

*Source: The Lewin Group*
Results: Member Perspective on Access

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

<table>
<thead>
<tr>
<th></th>
<th>Adult Medicaid CAHPS Survey</th>
<th>HIP Enrollees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always or usually acquired routine appointments as soon as needed</td>
<td>79%</td>
<td>74%</td>
</tr>
<tr>
<td>Always or usually acquired appointment with specialists as soon as needed</td>
<td>80%</td>
<td>79%</td>
</tr>
</tbody>
</table>

Source: The Lewin Group
Results: Satisfaction

Overall Experience with HIP in Past Six Months

- Very Satisfied: 58%
- Somewhat Satisfied: 22%
- Neither: 6%
- Somewhat Dissatisfied: 7%
- Very Dissatisfied: 4%

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

- Yes: 93%
- No: 3%
- Don’t Know: 4%

Source: The Lewin Group
Results: Provider Impact

Provider Responses Regarding Change in Requests for Charity Cases
- Decline in number of charity care requests: 39%
- No change in number of charity cases: 36%
- Increase in number of charity cases: 16%
- Don't know: 8%

Provider Responses Regarding Change in Instances of Bad Debt
- Decline in instances of bad debt: 27%
- No change in instances of bad debt: 16%
- Increase in instances of bad debt: 13%
- Don't know: 44%

Source: The Lewin Group
Results: Non-emergency Medical Transportation

Proportion of members identifying specific types of transportation most often used for medical visits

- I drive myself, using my own vehicle
- Someone else drives me, using my own vehicle
- Someone else drives me, using their vehicle
- I take a taxi cab/Uber
- I take the bus
- I walk
- I drive myself, using another vehicle
- Medical/insurance-covered transportation
- Don’t Know

Source: The Lewin Group
Results: Non-emergency Medical Transportation (continued)

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

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

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

In summary, a relatively small number of HIP 2.0 members missed appointments due to transportation-related issues.
Results: POWER Account and Cost-conscious Behavior

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

<table>
<thead>
<tr>
<th></th>
<th>HIP Plus Respondents</th>
<th>HIP Basic Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heard of the HIP POWER account</td>
<td>66%</td>
<td>46%</td>
</tr>
<tr>
<td>...and report having a POWER account</td>
<td>72%</td>
<td>76%</td>
</tr>
<tr>
<td>...and report checking the POWER account balance monthly</td>
<td>40%</td>
<td>30%</td>
</tr>
<tr>
<td>Ask provider about cost of care</td>
<td>27%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Source: The Lewin Group

*Sample sizes too small to be reliable*
Results: Co-payments

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

Providers understand how to identify HIP members with a co-payment obligation and collect payment as appropriate

<table>
<thead>
<tr>
<th>Providers who know how to identify if HIP members are required to pay co-payments</th>
<th>88%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers who report using the Eligibility Verification System to identify co-payment requirements</td>
<td>83%</td>
</tr>
<tr>
<td>Providers who report charging co-payments to HIP members</td>
<td>84%</td>
</tr>
<tr>
<td>Providers who report collecting co-payments at the point of service</td>
<td>80%</td>
</tr>
</tbody>
</table>

Source: The Lewin Group
## Results: Member Knowledge of the Program

### No cost sharing for preventive services
- Survey data suggest that a large majority of HIP 2.0 members may not be aware of the HIP 2.0 policy that would allow them to get no-cost preventive care.
- 39% of HIP Plus and 40% of HIP Basic survey respondents reported “Don’t Know.”
- Members surveyed were not enrolled for a full year.

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

### Table: Member Understanding of Key Program Policies

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

**Source:** The Lewin Group
Results: Health Status

For members with at least 6 months enrollment:
- 37% had one to two chronic conditions and an additional
- 24% had more than two

Percent of Reported Chronic Conditions

<table>
<thead>
<tr>
<th>Psychiatric</th>
<th>Cardiovascular</th>
<th>Skeletal</th>
<th>Gastrointestinal</th>
</tr>
</thead>
<tbody>
<tr>
<td>22.2%</td>
<td>20.5%</td>
<td>14.2%</td>
<td>12.0%</td>
</tr>
</tbody>
</table>

Source: The Lewin Group

HIP Plus members have higher morbidity than HIP Basic Members
- Out of all HIP members, HIP Plus members with income up to 100% FPL are the most likely to have chronic conditions and the most likely to be medically frail
Results: Health Status (continued)

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

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

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

Source: The Lewin Group
Results: Utilization of Services

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

<table>
<thead>
<tr>
<th>Utilization Statistic</th>
<th>HIP Plus</th>
<th>HIP Basic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Primary Care Visits</td>
<td>Specialty Care Visits</td>
</tr>
<tr>
<td>Percent of unique Members who used the Service/Visit</td>
<td>31%</td>
<td>46%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Plan</th>
<th>Adherence</th>
<th>Generic fill rate</th>
<th>Brand fill rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Total</td>
</tr>
<tr>
<td>HIP Basic</td>
<td>67.1%</td>
<td>84.3%</td>
<td>15.7%</td>
</tr>
<tr>
<td>HIP Plus</td>
<td>84.0%</td>
<td>82.0%</td>
<td>18.0%</td>
</tr>
</tbody>
</table>

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

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

![Graph showing percentage of qualified services received over months enrolled.](chart.png)

Source: The Lewin Group
Preventative Care (continued)

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

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

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

<table>
<thead>
<tr>
<th></th>
<th>ED Utilization (per 1,000)</th>
<th>Non-Emergency Use of ED (per 1,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIP Plus</td>
<td>775.4</td>
<td>183.6</td>
</tr>
<tr>
<td>HIP Basic</td>
<td>1,033.6</td>
<td>262.6</td>
</tr>
</tbody>
</table>

Source: The Lewin Group

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

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

2. Future Evaluation Planned
   – Future evaluation activities include:
     • Evaluating the effectiveness in the program at increasing the proportion of low-income residents covered by employer-sponsored insurance
     • Analyzing the effects of HIP Link on employers and employees
Gateway to Work is a voluntary referral program that connects HIP members who are unemployed or working less than 20 hours per week to available employment, work search and job training programs.

- As of January 31, 2016, a total of 307,156 letters were mailed to inform HIP members of the Gateway to Work program.
- 3,277 calls have been received from interested HIP 2.0 members.
- A total of 1,196 Gateway to Work orientations have been scheduled, with a total of 551 orientations attended.
In the first year, 208 Presumptive Eligibility (PE) providers (about 6% of potentially qualifying providers) made a PE eligibility determination.

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

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

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

Source: FSSA
Other State Findings: Presumptive Eligibility

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

Source: FSSA
405 IAC 2-3.3-3

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

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

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

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

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

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

No Qualified providers have meet the standard for (C) above.
Hospital PE Performance Standards (cont.)

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

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

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

Corrective Action Plan letters to hospitals will be sent out starting in August 2016.
Next Steps and Q&A

**KEY DATE**

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

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