Healthy Indiana Plan Operations and Evaluation

Office of Medicaid Policy and Planning
July 27, 2022

Agenda

- HIP Operations Update
- HIP Enrollment Update
- HIP Summative Evaluation 2018-2020

Healthy Indiana Plan Operations Update

HIP Operations Update

- Who is eligible?
  - Indiana Residents ages 19-64
  - Income under 138% of the federal poverty level
  - Not eligible for Medicare
- New for 2022 post-partum coverage will extend to 12 months

HIP Operations Update

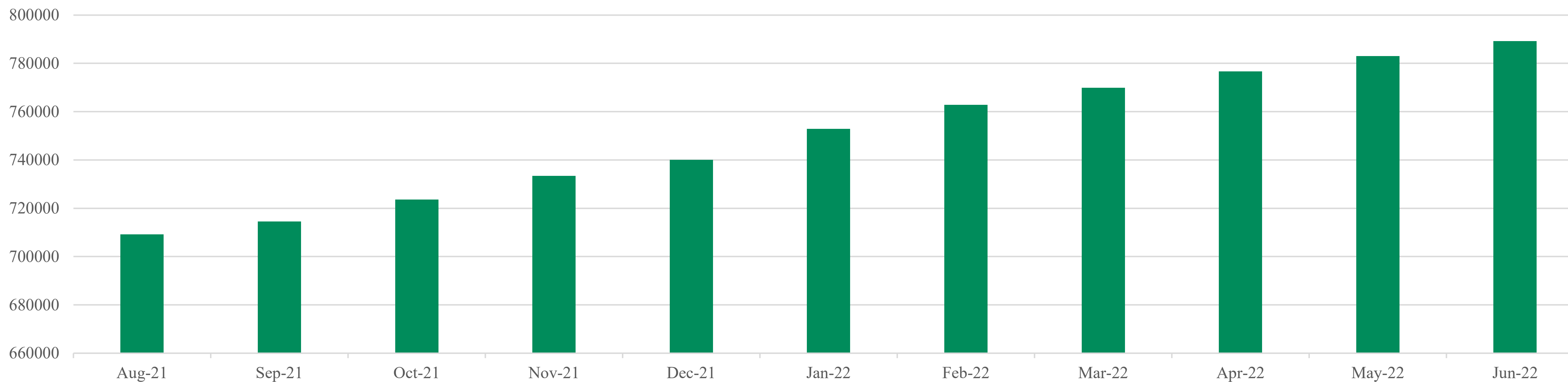
- Public Health Emergency Impacts
  - During the public health emergency, health coverage cannot be terminated except for death, moving out of the state, or voluntary withdraw
  - All cost sharing has been suspended for the duration of the public health emergency. This includes co-payments and POWER Account Contributions (PAC)

Community engagement requirement

The Community Engagement Program Gateway to Work was halted October 2019, and the program was paused in April 2020. In June 2021, CMS withdrew its conditional approval for the requirement and the program is no longer in effect.

Healthy Indiana Plan Enrollment Update

12 Month HIP Enrollment



HIP Enrollment Breakdown

Excluding HIP Maternity 74,400

FPL	State Basic	Regular Basic	Total Basic	State Plus	Regular Plus	Total Plus	Total Enrollment
<5%	53,336	244	53,580	213,471	156,511	369,982	423,562
5%-22%	1,654	3	1,657	6,664	4,539	11,203	12,860
23%-50%	3,170	6	3,176	10,176	16,411	26,587	29,763
51%-75%	3,567	10	3,577	14,081	24,561	38,642	42,219
76%-100%	3,121	9	3,130	15,200	28,718	43,918	47,048
101%-138%	3,389	20	3,409	24,131	45,788	69,919	73,328
>138%	2,005	32	2,037	14,254	22,018	36,272	38,309
>138% TMA	96	0	96	9,407	8	9,415	9,511
Total	70,338	324	70,662	307,384	298,554	605,938	676,600

HIP Summative Evaluation

Years 2018-2020

Overview

Summative Evaluations are required by the Centers for Medicare and Medicaid Services (CMS) to document findings from the HIP program during the waiver demonstration period. This evaluation covers the 3-year demonstration period running from February 1, 2018 to December 31, 2020. To fulfill our reporting duties, FSSA contracted the Lewin Group to complete the evaluation as well as Milliman to conduct a number of analyses within it. In addition to statistical analyses, Lewin conducted numerous surveys and interviews with key stakeholders to perform this assessment. The report adheres to strict CMS guidelines and was submitted to CMS on June 30, 2022 and is awaiting final approval.

Goals

1. Improve health care access, appropriate utilization, and health outcomes among HIP members
2. Increase community engagement leading to sustainable employment and improved health outcomes among HIP members
3. Discourage tobacco use among HIP members through a premium surcharge and the utilization of tobacco cessation services
4. Promote member understanding and increase compliance with payment requirements by changing the monthly POWER Account requirement to a tiered structure
5. Ensure HIP program policies align with commercial policies, are understood by members, and promote positive member experience and minimize gaps in coverage
6. Assess the costs to implement and operate HIP and other non-cost outcomes of the demonstration

Goal 1: Improve health care access, appropriate utilization, and health outcomes among HIP members

Enrollment in HIP will

- ✓ Promote member use of preventative, primary & urgent care, needed prescription drugs, and chronic disease care management
- ✓ Diminish unnecessary member use of emergency department services
- ✓ Prompt members to report positive health outcomes
- ✓ Prompt members to report satisfaction with health care access
- ✓ Compare to enrollment in other Medicaid expansion states

Use of services

Preventative Care

- Basic members utilize less healthcare services
- Basic & Plus members' use decreased 2015-2020
- Vision & Dental: All members' participation fell 38.2% 2015-2020, utilization fell 42.9% (mostly 2020)

Primary Care

- All members' utilization up 75.1% 2015-2020
- Overall utilization and participation peaked in 2019 at 75.6%, 3,541 visits per 1,000

Specialty Care

- 2015-2020 trends highly variable
- Overall decrease in both participation & utilization rates
- Basic members participate & utilize at much lower rates

Urgent Care

- Participation up 67%, utilization up 48% for all members 2015-2020
- Basic members participate & utilize at lower rates

Emergency Department

- Little change until 2020 when rates dropped ~10% -
- Plus members participate, utilize less
- "Avoidable" visits down 16% 2015-2020; likely due to "non-emergent" visits dropping 18%

Member feedback & Enrollment rates

Members report on health outcomes

- About 2/3 of respondents report Good/Very Good/Excellent overall health, higher for mental health
- MCE 2 respondents report higher shares of Very Good/Excellent health, lower shares of Fair/Poor health
- No discernable time trends

Members report on access to care

- 2019: 86.6% of respondents reported usually or always getting necessary care; 83.4% said same for getting care quickly; no MCE/time trends
- 2017-2019: About 1/3 of enrollees used Fast Track; members using PE or FT are staying enrolled longer than before

Enrollment rates

- 2015-2016: 19% increase in enrollment rate attributed to expansion; comparison states grew 6.5%
- 2018-2019: 7% increase in enrollment rate while comparison states fell 2%

Goal 2: Increase community engagement leading to sustainable employment and improved health outcomes among HIP members

The Gateway to Work program was designed to incentivize able-bodied HIP members to attain employment or engage in other community activities correlated with improved health and wellness. Members were required to report their hours of community involvement in at least eight months of each coverage year. **Reporting requirements were halted October 2019, and the program was paused indefinitely in April 2020 due to the PHE and federal lawsuit. In June 2021, CMS withdrew its conditional approval for the requirement and the program is no longer in effect.**

Goal 3: Discourage tobacco use among HIP members through a premium surcharge and the utilization of tobacco cessation benefits

The tobacco premium surcharge will

- ✓ Increase the use of tobacco cessation services among HIP members
- ✓ In conjunction with tobacco cessation services, decrease tobacco use

Increasing the use of tobacco cessation services through implementation of the tobacco premium surcharge

Tobacco cessation services participation rate

↑ 75%

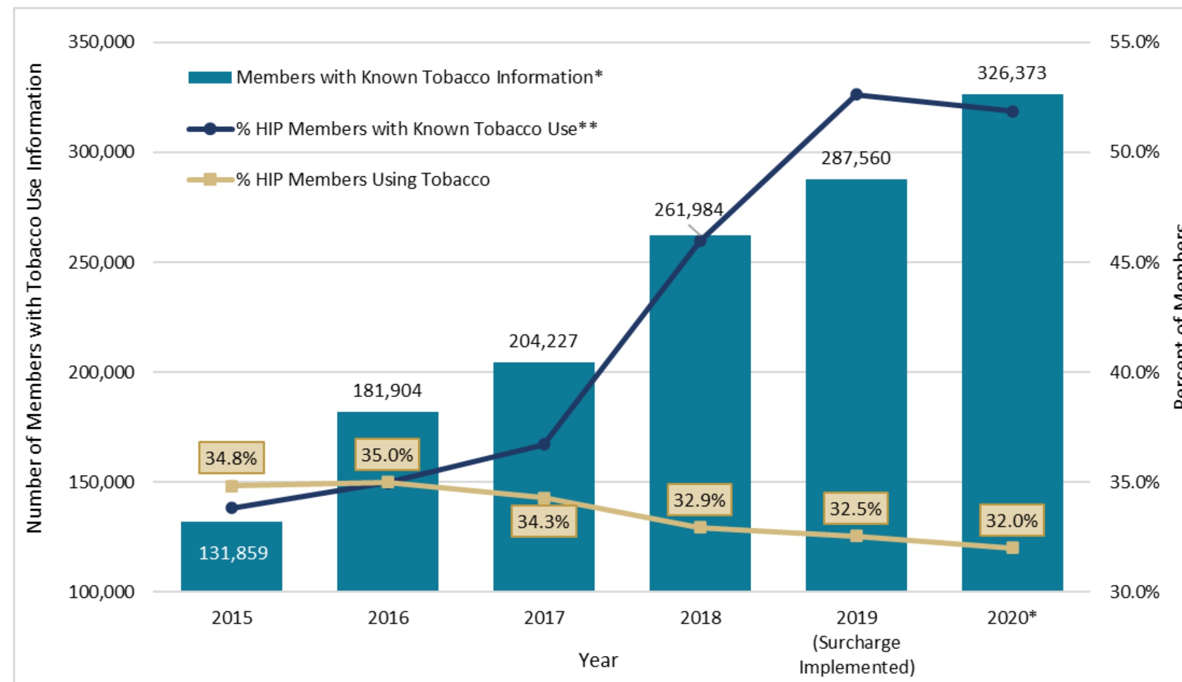
among HIP members 2017-2019. Decrease in 2020 under PHE policies.

Nicotine Replacement Therapy is the most common treatment.

↑ 150%

among all HIP members 2015-2019. Increases in all tobacco treatments.

Effect of tobacco premium surcharge and availability of tobacco cessation services on member tobacco use



* Number of HIP members who self-reported tobacco use information (response options: yes, no, or prefer not to answer) during enrollment (defined as known tobacco use information).
** % of HIP members with known tobacco use information who reported using tobacco.
Source: Data for member self-reported use of tobacco was collected by the State from new applications (new HIP members or members switching MCEs) during enrollment. The subset of members with available tobacco information (used or did not use tobacco) is not based on a random sample of members.
*Due to COVID-19 PHE, HIP suspended policies related to tobacco surcharge. MCEs continued collecting information on tobacco use.

Goal 4: Promote member understanding and increase compliance with payment requirements by changing the monthly POWER Account requirement to a tiered structure

- ✓ HIP's POWER Account tiered structure will be clear to HIP members
- ✓ Enrollment and enrollment continuity will vary by POWER Account payment tier

Member understanding of new POWER Account tier system

2019-member survey:

Among non-payers, 51% reduction in those reporting inability to afford payments as the reason; 45% in 2017 to 22% in 2019

Among non-payers, 62% decrease in members reporting they did not know why or how they had to make payments; 21% in 2017 to 8% in 2019

Goal 4 HIP Plus member disenrollment with nonpayment as a reason was low and decreased from 2.2% in 2016 to 1.4% in 2019

"Overall, providers reported that the ability to pay the required amount is not the main challenge for members; rather; the main challenge is knowing what the payment amount is and when to make those payments." – Lewin Group

Enrollment continuity

Percent of HIP Plus Only Population

Time Period (N=)	1-3 Months	4-6 Months	7-9 Months	10-12 Months
Feb 2015 - Dec 2015 (N = 224,195)	21.3%	21.2%	27.0%	30.5%
Jan 2016-Dec 2016 (N = 305,904)	17.0%	17.2%	15.4%	50.5%
Jan 2017-Dec 2017 (N = 312,229)	16.6%	16.2%	14.0%	53.2%
Jan 2018-Dec 2018 (N = 326,811)	17.2%	18.2%	14.7%	49.9%
Jan 2019-Dec 2019 (N = 331,458)	15.7%	17.5%	14.7%	52.2%
Jan 2020-Dec 2020 (N = 446,943)	14.0%	11.7%	12.8%	61.5%

Source: HIP monthly enrollment files, February 2015 – December 2020.

Goal 5: Ensure HIP program policies align with commercial policies, are understood by members, and promote positive member experience and minimize gaps in coverage

- ✓ Members will understand program policies
- ✓ Members will be satisfied with HIP
- ✓ Members subject to non-eligibility periods and retroactive eligibility are similar to commercially insured individuals
- ✓ Cutting retroactive eligibility will not reduce member enrollment or access to care; decrease health status; or have adverse financial impact

Similarity of HIP & commercially insured populations

- CMS requires an evaluation of how the HIP population differs from the Indiana commercially insured population
  - HIP members are slightly older (45 on average vs. 43 for commercial)
  - Greater percentage of HIP members had less than high school education
  - HIP member are more likely to be Black or African American and less likely to be Asian or Hispanic than the Indiana commercially insured population

Goal 6: Assess the costs to implement and operate HIP and other non-cost outcomes of the demonstration

- ✓ Costs and non-costs to implement and operate HIP are sustainable

HIP program economic feasibility

Per Member Per Month Costs for Expansion Programs

$800.00
$700.00
$600.00
$500.00
$400.00
$300.00
$200.00
$100.00
$0.00

2016
2017
2018
2019
2020

Indiana
Ohio
Kentucky

HIP Summative Evaluation

- The draft HIP Summative Evaluation will be posted publicly on the FSSA HIP Website
  - https://www.in.gov/fssa/hip/about-hip/hip-documents-and-resources/
- The draft version will be replaced by the final version after CMS approval

Comments

- Future comments can be submitted in writing to Meredith Edwards, Director of Care Programs
  - Meredith.Edwards@fssa.in.gov

Questions?

Indiana Family and Social Services Administration
Office of Medicaid Policy and Planning
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