HEALTHY INDIANA PLAN DEMONSTRATION

PROJECT NUMBER: 11-W-00237/5

SECTION 1115 ANNUAL REPORT

Centers for Medicare and Medicaid Services

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SECTION 1: EXECUTIVE SUMMARY

Seven months after the Indiana General Assembly passed bipartisan legislation to create the program, the Healthy Indiana Plan (HIP) began to enroll working-age, uninsured adults on January 1, 2008. HIP is the nation's first high-deductible health plan with health savings accounts (HSA) model for Medicaid recipients. The State and HIP beneficiaries jointly make monthly contributions to a Personal Wellness and Responsibility (POWER) account, which funds an eleven hundred dollar deductible (the amounts of member contributions vary by income level).

The HIP program targets uninsured adults between ages 19 and 64 that have income under 200 percent of the federal poverty level (FPL). They must also have been uninsured and not have access to employer-sponsored health coverage during the six months before they apply for the program to discourage crowd-out of private insurance. The HIP program is not intended to cover all of the eligible population, but per the legislation only the number of individuals that revenue sources (cigarette taxes and DSH payments) can support.

Most HIP members are required to make a monthly contribution to their HSA-styled Personal Wellness and Responsibility (POWER) account (between two to five percent of their family income). The monthly contributions and POWER accounts are designed to encourage HIP members to take responsibility for their health care. Covered services are initially paid by the POWER account funds. To encourage the use of preventive health care, the first $500 in preventive care services are not charged against the POWER account.[1]

As of December 31, 2012, and after 60 months (5 years) of program operations:

- The State had received 411,568 HIP applications; of those, 75,172 (18 percent) were submitted in 2012.
- 105,197 unique individuals had ever been enrolled in HIP.
- In 2012, 68.9% of those enrolled in HIP were caretaker adults, and 31.1% were non-caretaker adults. The HIP population mix of caretakers and non-caretakers has shifted since 2009 when the non-caretaker cap was imposed (at the end of 2009, 47.8% of those enrolled in HIP were caretakers and 52.2% were non-caretakers).

A number of indicators suggest that HIP is valued by its members, and that the program's design effectively promotes conscious consumption of healthcare services. In 2012, 94 percent of individuals that were determined eligible for HIP made their first required monthly contribution

[1] During the first year of the demonstration, the health plans did not charge any preventive service use against the POWER accounts. Starting in mid-2009, Anthem imposed the $500 limit on preventive care and services above that limit were charged to the member's POWER account. MDwise and MHS continued to offer unlimited preventive services through 2012.

to their POWER accounts and became full members, and 93 percent made subsequent contributions to remain enrolled. This indicates that contributions are affordable for members. The majority of HIP beneficiaries indicate willingness and ability to contribute to the cost of their health care coverage, and that they value having it. Analysis of the 2013 Mathematica Policy Research HIP member survey indicates that the majority of HIP beneficiaries believe that the amount of their monthly POWER account contributions is the right amount or in fact, too low, and that they would be willing to pay more to remain enrolled in the program. The required POWER account contributions do not appear to impose financial burden on beneficiaries, either. Only 14 percent of former HIP members reported that cost-sharing was their reason for leaving the program—they were much more likely to report other reasons, such as gaining other insurance coverage, an increase in income, or not returning enrollment paperwork. Most HIP members (83 percent) prefer making up-front monthly payments with the opportunity to have unspent funds returned instead of making a payment each time they visited a health professional, pharmacy, or hospital. The survey also found that 96 percent of HIP members were either somewhat or very satisfied with their overall experience with the program.

HIP uses incentives to promote appropriate healthcare utilization, and in 2012, 60 percent of members received at least one recommended preventive service for their age and gender. To discourage inappropriate ER usage, the program charges co-payments for non-emergent visits. In 2012, only 31 percent of HIP members visited the ER, compared to 38 percent of adult Hoosier Healthwise members (traditional managed care Medicaid). Additionally, 5 percent of members reported deciding to seek care at an urgent care center or their regular doctor instead of the emergency room because of the co-payment.

HIP continues to meet budget neutrality requirements and state costs do not exceed the funding available for the program. These fiscal results are partially due to the cost containment measures taken in earlier years, but also reflect the state's closure of the program to non-caretakers who tend to be older and have more chronic conditions compared to caretakers. This closure was implemented in March 2009.

The HIP program has experienced a variety of successes to date, discussed in detail throughout the rest of the report. These successes lend strong evidence to the effectiveness of using a consumer-driven health plan model to insure a low-income population. Evaluation results demonstrated that this model can effectively promote appropriate healthcare utilization while staying well within budget neutrality limits and protecting some of the most vulnerable citizens from unmanageable medical costs.

SECTION 2: INTRODUCTION

HIP was designed to provide health insurance coverage to low-income Hoosiers who do not have access to health insurance and are not eligible for Medicaid. On December 14, 2007, HIP was approved as the Indiana Section 1115 Medicaid Demonstration Project (11-W-00237/5) for a five-year period – January 1, 2008, through December 31, 2012 – in accordance with section 1115(a) of the Social Security Act., Indiana has been granted two waiver extensions and the demonstration is currently set to end on December 31, 2013. This demonstration provides health insurance coverage to working-age adults who are not eligible for Medicaid and who have a household income below 200 percent of the federal poverty level (FPL).
This demonstration is the first of its kind in the United States and uniquely empowers members to be cost- and value-conscious health care consumers. It also has a uniquely strong emphasis on personal responsibility and consumer value-based purchasing. HIP members:

- Make monthly contributions to their Personal Wellness and Responsibility (POWER) accounts ranging from two to five percent of gross family income[2]
- Manage their POWER accounts through debit cards and monthly statements
- Incur penalties when they do not submit their monthly contribution within 60 days or do not submit information needed for the redetermination process in a timely manner, which includes disenrollment from the program and remaining ineligible for 12 months
- Have financial incentives to obtain yearly preventive services (as specified by the State and based on age and gender)
- Lower their monthly contributions when unused POWER account funds are rolled over from one year to the next; and maximize the size of the rollover if they receive the preventive services specified by the program.
- Do not have to make co-payments for services, except for non-emergent emergency room (ER) visits.[3]

All Section 1115 Medicaid research and demonstration waivers are required to be budget neutral—the demonstration may not cost more to the federal government than it would have cost had it not been implemented. The estimated total computable budget neutrality limit for the five years of the demonstration is $10,451,800,822. Over the past five years of the demonstration, the HIP program has cost just over $1 billion (just under $465 million for caretakers and about $539 million for non-caretakers). When this figure is added to the five years of expenditures for the

[2] Monthly contributions are not required if a member does not have any income or if the family is already spending 5 percent of its income on premiums and cost-sharing requirements for family members covered by Medicaid of the State Children's Health Insurance Program.

[3] ER co-payments are refunded to caretaker adults if the ER visit results in a hospital admission or is determined to be emergent. Non-caretaker adults do not receive refunds under these circumstances.

XIX Mandatory Populations ($8.4 billion), the cumulative waiver margin is $1.1 billion[4]. The Special Terms and Conditions (STCs) that govern the demonstration allow Indiana to use a portion of its Disproportionate Share Hospital (DSH) funds and managed care savings in the program's budget neutrality calculations. The HIP is also funded by a portion of a cigarette tax which was implemented July 1, 2007.[5] This report evaluates the fifth year of operations, calendar year 2012. An overall summary of the year is provided, followed by an evaluation of the goals of the program as listed in the original 1115 waiver. The State of Indiana respectfully submits its Fifth Annual Healthy Indiana Plan Section 1115 Demonstration report to Centers for Medicare & Medicaid Services (CMS).

[4]Source: Milliman Budget Neutrality Waiver Renewal Report to the Family and Social Services Administration, July 2013.

[5] At that time, the cigarette tax rose 81 percent, from $0.550 to $0.995 per pack.

SECTION 3: ACCOMPLISHMENTS

In 2012 the HIP program had accomplishments in all areas.

Enrollment and Program Take-Up Rates/Impact on Uninsurance

- By December 2012 - the close of the fifth demonstration year - the HIP program had served a total of 105,197 Hoosiers. On average, 40,721 Hoosiers were enrolled in HIP each month between January 2008 and December 2012. Total enrollment peaked in September 2009 at 50,339 members.
- The uninsured rate for Hoosiers with incomes under 50 percent of FPL has *decreased* from about 47 percent in 2005-2007 (prior to HIP implementation) and held steady at approximately 43 percent between 2008 and 2012. Uninsured rates for other income groups HIP covers above 50 percent of FPL (up to 200 percent of FPL) have increased since before HIP was implemented. The increase in the uninsurance rate among other income groups is likely due to external factors such as the national economic recession and high unemployment rates during the HIP implementation period. It likely would have been higher without HIP.

Fiscal Conditions

- As in previous years, the State took steps in 2012 to ensure that HIP meets federal budget neutrality and legislative requirements dictating that funding would be adequate to support enrollment. One step included keeping the program closed to new non-caretakers (also known as childless adults) throughout 2012.

- By the end of 2012, the HIP program had cost approximately $1 billion over the course of its five years, staying below the five-year waiver margin.

Operational Accomplishments

Operationally, the HIP program was in a steady state and no notable operational changes were implemented due to the uncertainty associated with HIP's future.

POWER Accounts

- In 2012, most HIP members (77 percent) were required to contribute to their POWER accounts. Of those who received a full subsidy, 95 percent had incomes under 100 percent of the FPL.

- Through the end of 2012, about 35 percent of member POWER accounts contained funds after 18 months of member enrollment. Sixty-five percent of these accounts received partial rollovers (member-contributed funds only), and 35 percent received full rollovers (member and State-contributed funds).

Evaluation/Program Design Accomplishments

HIP has demonstrated successes in using the model of a consumer-driven health plan for a low-income population. In addition, HIP has effectively promoted preventive care utilization and discouraged inappropriate emergency room use.

- The majority of HIP members report that they prefer to make a fixed monthly payment to the POWER account with the opportunity to receive unspent funds back over making copayments each time they seek medical care. In Mathematica's 2013 survey of HIP enrollees, 83 percent of survey respondents said they preferred to pay up front each month over paying each time they visited a health professional, pharmacy, or hospital. This finding lends support to the HIP contribution approach (funding POWER accounts based on income) as opposed to co-payments.
- Most HIP members feel that their POWER account contributions were reasonable. According to Mathematica's 2013 survey, among those who made a monthly contribution to their HIP POWER accounts, approximately three quarters of current HIP members felt that their monthly contributions were "the right amount," and nearly 85 percent believed the amount was either right or below the right amount. Overwhelmingly, members reported that they would be willing to pay more to remain in HIP. In 2012, 94 percent of members made the first required contribution to the POWER account and 93 percent made subsequent contributions.
- HIP is effective at promoting the receipt of preventive care. In 2012, 69 percent of female HIP beneficiaries and 39 percent of male HIP beneficiaries (60 percent of the overall HIP population) received at least one age-appropriate recommended preventive service, according to a claims analysis. Members who were required to contribute to their POWER accounts used preventive care at higher rates than non-contributors, perhaps because of the incentive to receive a full rollover and reduce required contributions in the next year if services were obtained.
- HIP is effective at reducing inappropriate emergency room usage among beneficiaries. Only 31 percent of HIP enrollees visited the ER in 2012, as opposed to 38 percent of adult Hoosier Healthwise (managed care Medicaid) enrollees. In the 2013 Mathematica survey, 5 percent of HIP beneficiaries decided to go to an urgent care center or their regular doctor to seek care because of the co-pay required for non-emergency use of the emergency room.

SECTION 4: POLICY AND ADMINISTRATIVE DIFFICULTIES AND SOLUTIONS

The effect of Affordable Care Act on HIP continued to be a significant policy and operational challenge in 2012. Since the passage of the ACA, Indiana has repeatedly sought guidance regarding the future of HIP. In September 2012, the State received notice of a one-year extension of the waiver, which served as a short-term reprieve but maintained the long-term uncertainty about the program's existence. The uncertainty has impacted enrollment and all operational improvement and maintenance projects have continued to be on hold.

The original 1115 demonstration waiver authorizing HIP was approved for five years, with an expiration date of December 31, 2012. The Indiana Family and Social Services Administration submitted an 1115 waiver renewal request on December 28, 2011 and requested the renewal for the maximum three-year allowable time. In September 2012, Indiana was granted a one-year extension of the program. A new waiver application was submitted in early 2013, and in September, Indiana was granted permission to extend the HIP program for an additional year (through December 2014). The Special Terms and Conditions mandated a decrease in the income level at which Hoosiers are eligible for HIP, due to federal subsidies that will be available for those over 100 percent of the FPL to purchase coverage on the federal Marketplace.

SECTION 5: PROJECT STATUS

5.1 OUTREACH AND PLAN ACTIVITIES

A. OUTREACH

The three Managed Care Entities (MCEs) that contract with the state (Anthem, MDwise, and MHS) continue to conduct outreach and marketing activities for the HIP program. All three MCEs have active marketing programs, and regularly organize and participate in community events to raise awareness of the HIP.

Anthem

In 2012, Anthem's outreach staff participated in over 375 events to provide information on HIP and HHW (Hoosier Healthwise, Indiana's Medicaid risk-based managed care program for pregnant women, very low-income parents, and children). Outreach activities seek to promote the HIP program by educating members on HIP benefits and the POWER account, and by promoting cost-conscious health care decision-making and preventive care among members. Further, Anthem utilizes HHW outreach events as an opportunity to promote HIP. During Anthem's 34 Clinic Days, held throughout the state to promote preventive health services for children enrolled in HHW, applications for HIP were distributed to caregivers.

Anthem utilizes partnerships with faith-based organizations, minority health organizations, government agencies, Work Force One, Covering Kids and Families participants, public libraries, retail stores, pharmacies, and community health organizations to reach its target populations. Outreach specialists have traveled to food pantries to educate members about HIP transportation benefits and emergency room (ER) usage; participated in Men's Health Week at Federally Qualified Health Centers (FQHC) to raise awareness of preventable health issues and encourage early detection and treatment for diabetes, HIV, and other conditions; and presented at college health fairs. Outreach Specialists have built relationships with local Family and Social Services Administration's Division of Family Resources throughout the state, allowing them to present during monthly IMPACT classes (job training and education for TANF and SNAP recipients) During these presentations, Outreach Specialists provide an overview of the HIP program, including the application process, POWER account requirements, and the availability of transportation. Anthem also works with medical providers to offer individualized member outreach. Providers can refer members who miss appointments or who might benefit from health education classes, connection to community resources, or an explanation of member benefits.

Anthem staff has made efforts to specifically reach out to Allen County's Burmese community. Recognizing the cultural and language barriers faced by this population, Anthem developed alternate processes for access to customer services and provided specialized assistance in accessing preventive health services and education. Anthem has collaborated with the other MCEs to conduct open houses for members from Burma/Myanmar. These open houses offered

education on how to schedule doctor's appointments, secure transportation, manage their health care, and understand their HIP plan benefits.

Each new HIP member who enrolls in Anthem receives a welcome call from a Health Needs Specialist to inform them about plan benefits, including access to preventive care, coverage for doctor's visits and hospitalizations, and the POWER account. During the call, the member is given the opportunity to select a primary medical provider (PMP) and to complete a health risk assessment. HIP members also receive customized MyHealth Notes, which remind members to get regular preventive care, encourage the correct use of prescription drugs, and promote overall wellness.

MDwise

During 2012, MDWise staff conducted outreach at over 100 school events (including after-school programs, parent-teacher conferences, and school registration days); held 197 "Q&A" chats with individuals seeking services at local Department of Family Resources (DFR) offices, health departments, FQHCs, and other agencies; provided education on HIP at 29 IMPACT community presentations; distributed information on how to apply for HIP after pregnancy to 25 pregnancy support groups and 15 community baby showers; partnered with community centers, food pantries, public libraries, and Covering Kids and Families to educate community members about HIP benefits; worked with School Based Health Centers to promote HIP among uninsured parents; offered presentations on the HIP program to seven Human Resources Departments at companies where insurance was not offered to employees; and conducted various education and health promotion efforts among members. Overall, MDwise staff distributed 200 HIP applications at various community events and presentations, and provided direct assistance to community members on the HIP online enrollment process. MDwise also distributed educational pieces on "How to Stay Enrolled on HHW & HIP," and "Where to Enroll for HHW & HIP" at over 500 community events and presentations.

MDwise publishes a member newsletter, and uses this as a platform to promote and provide education about HIP. It also conducts outreach to members to encourage them to see a doctor within the first 90 days of becoming a HIP member. Further, during 2012, MDwise promoted its "HIP Employer Contribution" inserts to small businesses, disseminated its "Use the Emergency Room Wisely" brochure to members, updated and promoted materials on its Smoke Free program, and disseminated materials on its INControl Disease Management program.

MDwise mails letters to all new members explaining the importance of preventive care and the need to complete the preventive care requirements to realize a full POWER account rollover. MDwise also mails monthly POWER Account invoices and statements that provide a listing of all health care services the member has used in the past year. To assist members during their redetermination period, MDwise sends redetermination reminders and calls members to help them with the process. During the outbound call, MDwise completes a redetermination assessment.

In 2012, MDwise also conducted outreach specifically to providers by offering workshops and/or individual education to all HIP physicians, providing HIP providers with lists of members who had not yet received their required preventive care, publicizing HIP's pay-for-performance opportunities, and participating in multiple provider associations and organizations. In 2010, MDwise piloted its Community Advisory Council program, an initiative involving open forums during which MDwise solicits community and member feedback. MDwise continued this program through 2012, and conducted five Councils in different regions of the state over the course of the year to understand member concerns about health and access to care.

MHS

MHS participated in over 150 member outreach events during 2012, including educational events on nutrition, physical activity, and tobacco use prevention and cessation; community health fairs; healthy lifestyle events at faith-based organizations; health fairs for students and employees at community colleges; events targeting men's and women's health issues; the Indiana Black Expo-Summer Celebration; and the Indiana State Fair. During its Madison County Health Center Diabetic Day/Health Check Health Day, MHS encouraged HIP and HHW members to see their PMP and get the required preventive care. For the event, MHS contacted members whose claims history indicated they were due for one or more recommended preventive services, and invited those members to see their PMP for a check-up and needed screenings.

MHS has also partnered with the Indiana Minority Health Coalition in an effort to help members better understand their POWER accounts and HIP benefits. In addition, it has created a Member Ombudsman Program in partnership with Mental Health America of Indiana to provide personal assistance to members who have difficulty navigating HIP systems. MHS is also currently implementing a program to conduct outreach to HIP members before their redetermination period.

In addition, MHS conducts online marketing. In 2012, the plan posted 65 news items that were approved by the state and published online to educate members and build on the information available in the plan's member handbook and the benefit quick reference guide. The news items covered nutrition, fitness, and general benefit information. For HIP members, these news items included a series of posts called "Quick Tips for HIP," which reminded members about the benefits of receiving preventive care, the meaning of "conditional eligibility," and the importance of making timely POWER account payments. Each news item was posted on the MHS Web site, as well as on Facebook and Twitter.

To help retain members, MHS rewards Member Services staff for accuracy and timeliness in interactions with members.

Enhanced Services Plan (ESP)

The ESP Program (administered by ACS) does not have a formal marketing requirement, but it does have a program to promote preventive care and utilization of lower cost services. The program includes bi-monthly mailings and an annual newsletter that outlines all the preventive care benefits covered by the program, as well as the health consequences of not receiving preventive care.[6] The mailings in 2012 focused on depression, situations when urgent care or discussions with a regular doctor are more appropriate than a trip to the ER, and the importance of getting a flu shot.

Maximus

Maximus, the State's enrollment broker, provides general information and applications for HIP, but continues to focus its efforts, as contracted, on pre-enrollment member information, plan selections, and plan changes.

B. HEALTH PLAN INCENTIVE PROGRAMS FOR MEMBER AND PROVIDERS

Member Incentives

Anthem

In 2012, Anthem introduced a new incentive program to encourage its members to receive preventive services. For this program, Anthem identifies members who are approaching the end of their benefit period without having received the required preventive care, and offers these members a $50 gift card if they secure these services. Mailers were sent to qualifying members encouraging diabetes, breast cancer, and cervical cancer screenings. Breast cancer screening mailers were sent to 2,119 HIP members, 11 percent of whom returned the form to claim the gift card, with a 10 percent return rate for incorrect addresses. Diabetes screening mailers were sent to 1,840 members with 10 percent claiming the reward, and an 9 percent return rate for wrong addresses. Cervical cancer screening mailers were sent to 4,880 members, with 8 percent receiving the incentive and a 7 percent return rate for incorrect addresses. Anthem's 2012 HEDIS results demonstrate the percentage of members who received these preventive services after this campaign, as applicable to their gender and disease state. These rates are comparable to rates in private managed care plans.

Table 5.1: Anthem's 2012 HEDIS Results for Preventive Care Services

Preventive Services	2012 HEDIS Rates	2011 HEDIS Rates
Breast Cancer Screening	58.5%	54.7%
Cervical Cancer Screening	70.2%	65.3%
Diabetes HbAc1	84.5%	86.1%

[6] ESP members are not required to get specific preventive services to obtain a rollover, so there are no financial incentives for them to obtain preventive care as there are for other, non-ESP HIP members.

Anthem also offers incentives for members who complete a Health Risk Assessment (HRA). Those who complete the assessment online or over the phone receive an incentive gift card (with a limit of one per household). In 2012, 9.8 percent of the total HIP Anthem membership earned an incentive gift card as a result of completing the HRA.

MDwise

The MDwise REWARDS program uses incentives to encourage members to seek preventive care. Members earn points for completing an HRA, visiting the doctor for annual exams and health screenings, and registering to receive monthly statements online. Earned points can be redeemed for gift cards. MDwise promoted the incentive program in its main brochure, member handbook, on its Web site, and through postcards mailed to all members. Several of these promotion efforts proved successful in increasing the program's reach. In December of 2012, a mailing was sent to all HIP/HHW households, after which the REWARDS Web site saw a 206 percent increase in unique page views, and there was a 313 percent increase in HIP member gift card redemption. MDwise also created a business card-sized promotional card for providers to hand out to members. After use of the card began, MDwise REWARDS saw a 50 to 100 percent increase in gift card redemptions in the following months.

MHS

MHS has created the CENT-Account Rewards program, through which members receive incentives for various activities. Incentive money is loaded directly onto the member's HIP debit card and can be used to purchase health supplies.. Members can receive a gift card for visiting their assigned PMP within the first 90 days of MHS membership. In 2012, a new incentive was added that pays members a gift card for completing a telephone health risk assessment within the first 90 days of enrollment in the plan.

Provider Incentives

The Indiana Office of Medical Policy and Planning (OMPP) has instituted a Pay for Performance program which utilizes a selection of Healthcare Effectiveness Data and Information Set (HEDIS) measures to track the performance of HIP and HHW providers. In 2011, (the most recent data available at the time of this report—data is reported with almost a two-year delay) the three HEDIS pay-for performance bonus measures pertaining to HIP members were: Follow-up after Hospitalization for Mental Illness; 30-day return rate to the ER; Comprehensive Diabetes Care: LDL Screening. Another pay-for-performance measure was chosen from the CAHPS survey (Consumer Assessment of Healthcare Providers and Systems Survey): the number of smokers advised to quit. There were also two "bonus" measures that pertained to HIP in 2011: Generic Dispensing of Medications rate and Medical Utilization Trend rate.

MDwise and MHS met pay-for-outcomes bonus rates for the Follow-up after Hospitalization for Mental Illness HEDIS measure in 2011. Anthem did not meet pay-for outcomes bonus rates for any of the HEDIS measures pertaining to HIP in 2011; however, Anthem did meet the incentive

rate for the CAHPS measure (smokers advised to quit), whereas MDWise and MHS did not meet the incentive level for this CAHPS measure. All three of the MCE's achieved the bonus rate results for the Generic Dispensing of Medication and the Medical Utilization Trend Rate. It is important to note that this data includes both Hoosier Healthwise and HIP populations and providers.

Anthem and MDwise do not have any additional provider incentives, but MHS continued its Physician Summit Awards in 2012. These awards are given annually to three PMPs. Honorees receive an engraved crystal award and a catered lunch for their staff, and are featured on the MHS Web site and in provider newsletters.

5.2 OPERATIONAL AND POLICY DEVELOPMENTS

A. CONTRACTING

No substantial changes occurred during 2012 MCE contract negotiations; these negotiations focused primarily on rates[7]. In the initial years of the demonstration, the management of plan risk had to be adjusted to account for unforeseen pent-up demand for services, as well as multiple co-morbidities that had been previously untreated. As a result, the State amended the risk-sharing arrangements to include higher monthly capitation rates and a stop-loss provision for non-caretakers (effective retroactively to January 2009), as well as new criteria for the high risk pool. CMS approved the amended contracts in mid-December 2009, January 2010, and May 2011. As of 2011, the plans began reporting declines in utilization and more predictable costs, and the stop loss provision ended with the conclusion of CY2011, though reconciliation with the plans for the prior year continued.

The early high costs of care seen in HIP caused the State to identify ways to broaden access to the ESP, the high risk plan for HIP member with particularly costly conditions. The State expanded the list of qualifying conditions and modified the application process. When HIP applicants check one of the qualifying conditions on the application, they are now automatically enrolled in the ESP and remain 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 have six months to refer a member to the ESP. Those members found to have an ESP qualifying condition and scored at or above 150 points, using underwriting guidelines and a scoring methodology provided by the program's actuary (Milliman) are transferred to the ESP. This process continued through 2012. While the health plans reported that the ESP process ran

[7] The current MCEs were selected through a competitive procurement conducted in 2010. The contracts are for a four year base term with options to extend for an additional two years.

smoothly in most cases, they noted that challenges sometimes emerge when a member does not wish to transfer plans and when lags occur in the State's reconciliation of plan payments.

Calendar year 2012 marked the second year for the HIP and Hoosier Healthwise (HHW) integrated contracts. In 2012, all three of the health plans reported that the combined HIP and HHW contracts allowed for increased administrative ease and for improved care coordination, particularly for families with members enrolled in the two different programs. The plans noted that joint HIP/HHW call centers in particular have improved their ability to serve entire families more effectively. For example, while a call center worker is discussing an issue with a HIP member, the worker now has the ability to view the entire family's record, and can remind the adult if an HHW-enrolled child in the family needs a certain visit or service. In addition, the existence of a single call center enables workers to help families find ways to streamline care. For example, during a call, a member can select a PMP that serves both HHW and HIP members, so that the member and the child can see the same medical provider. Improved outreach was also cited by the plans as a benefit. If a HIP member places a call to the call center, staff will inquire whether the member has a child in the household in need of coverage.

The State has also realized important efficiencies from the integrated contracts, as it has been able to streamline HIP and HHW oversight and monitoring processes. The State has increased its quality review team to four full-time equivalent (FTEs) staff members, and is focused on aligning healthcare quality more closely with contract compliance. The integrated contracts allow both the State and MCEs to increase their focus on quality issues and member behaviors, such as smoking and weight management. Further, the integrated contracts have allowed discussions between the State and MCEs to focus on populations (children and families versus adults), whereas earlier discussions were focused on the differences between the HHW program and the HIP project. From the State's perspective, communication between the State and MCEs has improved as a result.

Calendar year 2012 also marked the second year of the HIP debit swipe cards. The health plans report that throughout 2012, the debit cards functioned primarily as member ID cards. The cards were intended 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 was also meant to be linked to members' POWER accounts. Anthem and MDwise issue a single-swipe card that functions as the ID and debit card, while MHS issues separate ID and debit cards.

B. MONITORING

Monthly on-site meetings are scheduled between the State and each MCE. These visits follow a uniform protocol so the MCEs know what to expect. In 2012, all three health plans noted their satisfaction with their regular meetings and communications with the State to discuss quality, collaboration, and technical issues. In addition, special working groups were established in 2012 to address specific issues requiring in-depth attention. Working group topics included prior authorization, standardization of forms, timely notice of pregnancy status, and presumptive

eligibility. From this work, the HIP MCE Reporting Manual was revised several times during 2012.

Some issues related to the timeliness with which encounter data were reported by the fiscal agent caused issues for the MCEs as they sought to account for the use of POWER account funds to pay for claims. However, most major issues were resolved by the end of 2012.

In its 2010 External Quality Report (EQR), Burns & Associates noted discrepancies related to how each MCE defines "timeliness" of processing prior authorizations (QR-PA1 reports). A timely review and processing of submitted prior authorizations for services are necessary to ensure that HIP members receive needed services. B & A established that an authorization is considered to have been processed in a timely manner if it processed within seven days for non-urgent pre-service requests, three business days for urgent pre-services requests, one business day after receiving all necessary information on concurrent requests, and 30 days for retrospective requests. The EQR notes that, according to this definition, MDwise processed 99.4 percent of prior authorization requests in a timely manner, approved 97.1 percent of requests, and fully denied 2.6 percent. Anthem processed 99.1 percent of requests in a timely manner, approved 79.1 percent, and fully denied 7.0 percent[8].

The EQR made several recommendations to improve the QR-PA1 reports. First, it recommended that all MCEs utilize the same definition of "number of days to process." Specifically, it noted that MDwise needed to update its methodology to count authorizations resolved on the same day as having taken zero days to process, to align with the other MCE. The EQR also recommended that the State update the service categories to "in-network" and "out-of-network," to reduce reporting problems in this area. To ensure that 100 percent of prior authorizations are reported, the EQR recommended adding a category of "open," "pending," or "modified" authorizations. Other recommendations included encouraging the State to request more information if an MCE reports a denial rate outside the norm, changing the turn-around times by eliminating the "longest number of days to process" statistic, and separately reporting turnaround times for different types of authorizations that are subject to different time restrictions.

In the spring of 2012, the new QR-PA1 reporting process was reviewed in an EQR work group session facilitated by Burns & Associates and the State. Modifications were made to the reporting instructions to clarify guidelines related to the timeliness of prior authorization processing and the in-network and out-of-network delineation. The State believes that these adjustments will improve the alignment of reporting between MCEs.

C. NON-CARETAKER ENROLLMENT

[8] Data is from 2010, when MHS was not involved in HHW/HIP.

To ensure that federal spending does not exceed what would have been spent on Medicaid had HIP not been implemented (budget neutrality), the CMS waiver Special Terms and Conditions (STC) caps the number of childless adults who can enroll in HIP. The initial cap of 34,000 non-caretakers was designated to ensure HIP remains budget neutral for the Federal government. On March 12, 2009, HIP closed enrollment to non-caretakers. At that time, the number of non-caretaker members had reached 32,000, just below the 34,000 cap established in the STCs. Enrollment for non-caretakers was closed before the cap was reached to ensure that applicants in the eligibility determination process or appealing denied applications could be enrolled 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.

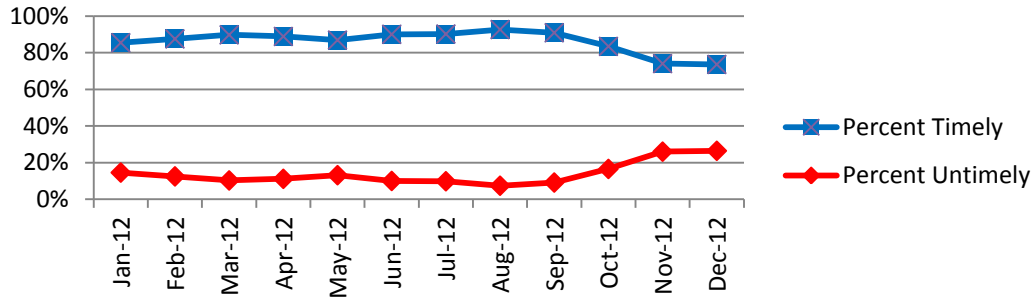
Since closing enrollment to non-caretakers in March 2009, enrollment has been opened three times to this group, once in November 2009 when CMS agreed to raise the cap by 2,500 individuals for an overall limit of 36,500 non-caretakers and again in August 2011. The first open enrollment period resulted in 1,087 new non-caretakers entering the HIP program between January and March 2010. The second open enrollment period resulted in 2,157 new non-caretakers by the end of 2011.

During the first quarter of the 2012 calendar year, 18,800 letters were sent to non-caretakers on the waitlist, inviting them to reapply for the program. In response to these letters, 1,587 individuals responded and were able to enroll (generating an 8.4 percent response rate), and 7,113 additional individuals were added to the waitlist. The rest of the letters generated no response, indicating that potential applicants' financial or living situations had changed, or they were no longer living at the address on record. The waitlist was closed as of April 2012 (no additional individuals were added between April and December) as the State waited for guidance from CMS on whether HIP could be used for the Medicaid expansion under the Affordable Care Act of 2010.

D. APPLICATION PROCESSING

Throughout the first nine months of 2012, application processing timeliness rates hovered between 85 and 90 percent, reaching 92.6 percent in August (Figure 5.1). In September, the timeliness rate started to decline, and during November and December approximately 25 percent of applications were not processed in a timely manner. Averaging across all months, 86.4% of applications were processed in a timely manner in 2012. The HIP application processing timeliness standard is 45 days.

Figure 5.1 Percentage of Pending Applications Processed in a Timely Manner, January-December 2012



Source: ICES Eligibility System, January 2012-December 2012

E. HIP AMENDMENTS APPROVED BY CMS

The State did not submit any amendments for the HIP program in 2012. In September 2012, CMS granted a one-year extension of HIP, in response to a waiver extension submitted in December 2011. In February 2013 the State submitted a request to extend the program beyond 2013 for the maximum waiver renewal period of 3 years. In response, CMS granted another one year extension which permits the program to operate through December 31, 2014.

5.3 FINANCIAL AND BUDGET NEUTRALITY

The State maintained waiver margins well below the CMS-approved limit from DY1 through DY4 by negotiating actuarially sound rate increases. This allowed the state to request the restoration of the Disproportionate Share Hospital funding. The cumulative cost of the HIP program from 2008-2012 was just over $1 billion, with an additional $12-$15 million in administrative costs annually[9]. In DY5 the waiver margin was negative due to increased hospital reimbursement rates authorized by Public Law 229-2011, Section 281 (described in more detail in Section 6.7). These increased rates led to higher Per Member Per Month (PMPM) expenditures for HHW caretakers, children, and pregnant women in 2012. PMPM expenditures for HIP caretakers and non-caretakers in DY5 aligned closely with DY4 expenditures for these groups. However, as the waiver margin is cumulative, HIP remained budget-neutral over the first five years of the demonstration.

5.4 CONSUMER ISSUES

[9] Source: Milliman Budget Neutrality Waiver Renewal Report to the Family and Social Services Administration, July 2013.

The State maintains a consumer issue management system known as the "Internet Quorum" or "IQ," which permits the State to monitor and manage formal and informal inquiries. Overall, the number of consumer inquires posed through the IQ has declined over the five years of the program, which could be correlated with the decrease in enrollment. Most questions posed in 2012 were classified as requesting "general information" on the program; other questions most commonly asked were regarding the HIP buy-in option.

Table 5.2 Internet Quorum Inquiries, 2008 - 2012

Quarter	Total Number of Inquiries					Change
	2008	2009	2010	2011	2012	
Year Total	1,695	1,205	693	575	364	-79%
First	628	425	270	152	133	-79%
Second	486	289	206	123	100	-79%
Third	278	261	128	164	95	-66%
Fourth	303	230	89	136	36	-88%

Source: HIP Quarterly Report to CMS, 2008 - 2012

Table 5.3 Types of Inquiries, 2012

Issue	Percentage of Inquiries on that Issue
General Questions	63%
Buy-in	18%
Waiting List	6%
Anthem	6%
ESP	1%
MDwise	4%
MHS	2%

Source: HIP Quarterly Reports to CMS, 2012

The State also tracks the number of eligibility appeal hearings each year. These appeals involve issues such as benefit terminations. Member appeals may also involve the required amount of POWER account contributions. The annual number of member appeals peaked in 2010, when total HIP enrollment also peaked.

Table 5.4 Formal Appeal Hearings, 2008 – 2012

Quarter	Total Number of Formal Appeal Hearings				
	2008	2009	2010	2011	2012
Year Total	1,003	2,223	6,118	5,391	5,783
First	181	263	1,422	1,182	1,503
Second	336	1,249	1,584	1,083	1,529
Third	286	586	1,721	1,690	1,394
Fourth	200	125	1,391	1,436	1,357

Source: HIP Quarterly Reports to CMS, 2008 – 2012

Table 5.5 Adjudication of Appeals and Hearings, 2009 – 2012

Findings	Percentage of Hearings and Appeals			
	2009	2010	2011	2012
Other Insurance	60%	44%	46%	30.47%
Did Not Complete Verifications Request from State	21%	26%	43%	59.7%
Other	10%	25%	0.2%	0.2%
Financial Eligibility	8%	5%	10%	9.4%

Source: HIP Quarterly Reports to CMS, 2009- 2012

5.5 ELIGIBILITY AND ENROLLMENT INFORMATION

A. DY5 HIP ENROLLMENT DEMOGRAPHICS

The State's analysis of HIP enrollment records indicates that HIP served a total of 56,245 unique individuals during 2012. The majority of 2012 members were female, and those in the 30 to 39 age group made up the greatest proportion of HIP members. Very few members were under 20 or above 60. Due to the program's cap and waitlist for non-caretakers, more than two-thirds of members in 2012 were caretakers. Over 80 percent of members were white, and African-Americans comprised approximately 10 percent of the HIP membership. These figures align closely with state demographic data—86.6 percent of Indiana's population in 2012 was white, and 9.4 percent was African-American. The majority of 2012 HIP members (70 percent) had incomes at or below the federal poverty level (FPL).

The DY 5 membership demographics are consistent with the cumulative demographic data for all members over the course of the HIP program (2008-2010). Between 2008 and 2012, women made up the majority of the membership (67.6 percent), and those in the 30-39 age range comprised the greatest share of beneficiaries. The 2008-2012 cumulative racial and ethnic breakdown is similar to that of 2012—African-Americans comprised approximately 12 percent of the total membership during this timeframe, and over 80 percent of members were white. Between 2008 and 2012, 70 percent of members had incomes at or below 100 percent of the FPL.

Table 5.6. Enrollment Demographics, DY5 (2012)

Characteristic	Number of Members in 2012	Percentage of Total
Total number	56,245	100.0
Gender		
Female	38,030	67.6%
Male	18,215	32.4%
Age		
<20	21	< 0.1%
20-29	7,680	13.7%

Characteristic	Number of Members in 2012	Percentage of Total
30-39	17,251	30.7%
40-49	16,407	29.2%
50-59	11,130	19.8%
60+	3,756	6.7%
Caretaker Status		
Caretaker	38,740	68.9%
Non-caretaker	17,505	31.1%
Race/Ethnicity		
Asian	1,159	2.1%
Black	5,895	10.5%
Hispanic	1,927	3.3%
American Indian	45	0.1%
Other	1,083	1.9%
White	46,136	82.0%
Income as a Percentage of FPL		
<22%	15,570	27.7%
23%-50%	6,780	12.1%
51%-100%	17,145	30.4%
100%-150%	11,123	19.8%
>150%	5,627	10%

Source: OMPP Data Management & Analysis

B. IMPACT ON THE STATE'S UNINSURANCE RATE

HIP was designed to serve a limited number of Hoosiers, and the Indiana General Assembly cigarette tax increase does not generate sufficient revenue to cover all adult Hoosiers under 200 percent of FPL. Crowd-out provisions, such as the requirements to be uninsured for six months and having no access to employer-sponsored health insurance, also limit the number of individuals who are eligible. According to Current Population Survey (CPS) estimates, individuals with income under 100 percent of the FPL had the highest uninsurance rate in the years before HIP was implemented, ranging from 47 percent among the most low-income group to 41 percent for those with incomes just below the poverty level (Table 5.7).[10]

Using data from the American Community Survey (ACS) from 2008-2011, Milliman estimates that the number of uninsured adult Hoosiers with incomes below 200 percent of FPL (Table 5.7) grew from the pre-HIP period and continued to increase over the four-year period, likely due in part to the national recession occurring during this time period. However, these trends mask the variation that occurs at different income levels. The uninsured rate for Hoosiers with incomes under 50 percent of FPL has *decreased* from about 47 percent in 2005-2007 and held steady at

[10] The data for individuals with incomes less than 51 percent of poverty were aggregated because the CPS does not separate estimates for incomes less than 22 percent of poverty or between 23 and 50 percent of poverty.

approximately 43 percent between 2008 and 2012. Uninsured rates for other income groups have increased since before HIP was implemented. The increase in the uninsurance rate among income groups above 50 percent of the FPL is likely due to external factors such as the national economic recession and high unemployment rates during the HIP implementation period.

Table 5.7. Uninsured Rates, by FPL before and after HIP

	Uninsured Adults Ages 19-64 before HIP (CPS 2005-2007)		Uninsured Adults Ages 19-64 (ACS 2008)		Uninsured Adults Ages 19-64 (ACS 2009)		Uninsured Adults Ages 19-64 (ACS 2010)		Uninsured Adults Ages 19-64 (ACS 2011)		HIP Members Ever Enrolled in 2012
FPL Level	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number
Under 50% FPL	85,977	47.2%	88,974	43.3%	95,878	40.1%	115,308	43.1%	121,959	43.1%	20,862
51% - 100% FPL	80,063	40.8%	103,102	42.3%	111,258	40.7%	124,712	44.2%	121,812	43.5%	11,329
101% - 150% FPL	89,426	34.8%	113,782	41.7%	115,394	39.1%	127,031	37.8%	133,837	41.0%	17,818
151% - 200% FPL	79,497	26.5%	86,535	28.4%	108,586	33.2%	115,320	32.9%	108,075	31.9%	6,236
Total	***334,963***	***35.8%***	***392,393***	***38.22%***	***431,116***	***37.97%***	***482,371***	***39.03%***	***485,683***	***39.28%***	***56,245***

Source: Milliman, Inc. "Uninsured rates by FPL and year." November 16, 2012. Baseline uninsured numbers and percents are from the U.S. Census Bureau, CPS, Annual Social and Economic Supplement, 2006-2008, CPS three-year average data collected 2006-2008 reporting on the prior year (2005-2007). http://www.census.gov/hhes/www/cpstc/_cps_table_creator.htm. Accessed March 10 2011. HIP enrollment numbers supplied by the State of Indiana.

Note: 2012 ACS data were unavailable at the time this report was written.

There is also some variation in the uninsurance trends with respect to gender and age. During the time of HIP implementation, uninsured rates among men increased more than those among women. At the same time, the Medicaid coverage rate among women increased 3 percent from 2008 to 2011, as compared to 2.3 percent for men. Uninsured rates also varied by age. While those in the 19-29 age group saw a drop in uninsured rates, older groups saw an increase. The 50-64 age group experienced a 5.1 percentage point increase in the uninsurance rate from 2008 to 2011. The uninsurance rate among caretakers dropped 1 percentage point during this time period, while the Medicaid coverage rate among the same group rose 6.3 percentage points. Nevertheless, the uninsurance rate among non-caretakers is most likely to be affected by the HIP program, because these individuals can only access Medicaid if they are disabled. Statewide non-caretaker uninsured rates rose by 1.8 percentage points, while Medicaid coverage among non-caretakers increased by 1.7 percentduring this time. Presumably, the uninsured rates for these groups would have been higher had Medicaid, and possibly HIP, not been available. The ACS data do not allow a more detailed analysis of whether these non-caretakers were obtaining coverage through HIP or Medicaid's provision for people with disabilities, but some proportion would have been uninsured during this period had the HIP program not been available to them.

See Table 5.8.

Table 5.8: Proportion of Indiana's Low-Income Working-Age Adults (19 through 64) Who Are Uninsured, 2008-2011

Subgroup	Statewide Uninsured Rates					Statewide Medicaid Coverage Rates				
	2008	2009	2010	2011	Percentage Point Change	2008	2009	2010	2011	Percentage Point Change
Total	38.2%	38.2%	39.2%	39.5%	1.3	18.0%	20.7%	19.6%	20.6%	2.6
Males	41.3%	42.9%	43.8%	43.5%	2.2	13.8%	15.6%	15.4%	16.1%	2.3
Females	35.6%	34.3%	35.3%	36.0%	0.4	21.6%	25.2%	23.3%	24.6%	3.0
Ages 19-29	42.5%	41.9%	43.4%	40.6%	-2.0	15.6%	18.6%	16.7%	17.1%	1.5
Ages 30-49	40.0%	39.3%	39.9%	42.2%	2.2	17.5%	20.6%	19.9%	21.2%	3.7
Ages 50-64	28.4%	30.3%	31.8%	33.5%	5.1	22.5%	24.5%	23.2%	24.6%	2.1
Caretakers	34.3%	30.3%	33.1%	33.3%	-1.0	22.1%	29.2%	25.7%	28.4%	6.3
Non-Caretakers	39.5%	40.9%	41.1%	41.3%	1.8	16.7%	17.9%	17.7%	18.4%	1.7

Source: Mathematica analysis of 2008-2011 ACS data.

C. AUTO-ASSIGNMENTS AND REASSIGNMENTS

Three-fourths of individuals enrolling in HIP for the first time in 2012 selected their plan of choice at the time of application, while 22 percent were auto-assigned to a plan. Twenty percent were auto-assigned to one of the health plans—Anthem, MDWise, or MHS, and two percent to the ESP program. Approximately three percent received assistance from an enrollment broker (Table 5.9). A majority of new members for Anthem and MDwise selected their plans at enrollment, while most of MHS' new members were auto-assigned to their plan.

The total number of new members in 2012 was comparable to 2011 totals (with 13,284 new members in 2012 and 12,980 in 2011), and all plans saw an increase in new members. Anthem gained 66 percent of the new members, MDwise, 10 percent of the new members, and MHS 22 percent of the new members. However, the distribution of new members across plans changed in DY5. MDwise gained 61 percent fewer new members in 2011 than in 2012. These new members either selected, or were auto-assigned, to Anthem and MHS. (Because MHS was new in 2011, enrollees in the service area were auto-enrolled if they did not select a plan on their own).

The number of individuals assisted by an enrollment broker dropped between 2011 and 2012. While 734 new members selected a plan with the assistance of a broker in 2011, only 428 received this type of assistance in 2012, a 42 percent decrease.

Table 5.9. Health Plan Assignment Methods, Initial Assignments for Those Enrolling in HIP for the First Time in 2012

Form of Plan Selection	Anthem	ESP	MDwise	MHS	Total Number
	%	%	%	%	%
Total	8,808	209	1,299	2,968	13,284
	66.3%	1.6%	9.8%	22.3%	100.0%
Assigned to ESP	1	208	0	0	209
	0.0%	99.5%	0.0%	0.0%	1.6%
Auto-Assigned	559	1	195	1,982	2,737
	6.4%	0.5%	15.0%	66.8%	20.6%
Enrollment Broker Assisted	309	0	72	47	428
	3.5%	0.0%	5.5%	1.6%	3.2%
Member Selection on Application	7,939	0	1,032	939	9,910
	90.1%	0.0%	79.5%	31.6%	74.6%

Source: OMPP Data Management & Analysis

D. HEALTH PLAN CHANGES

Upon enrollment in the HIP, members select or are assigned to one of the three health plans, unless answers to the Health Screening Questionnaire portion of the HIP application indicate that assignment to the ESP is appropriate. Once enrolled, members may change their plan selection before making their first POWER account contribution (or afterwards, for cause, as discussed below). After receiving notice of a new member's conditional eligibility, the health plan sends a "welcome letter" notifying the member that the first POWER account contribution will be due within 60 days of the conditional eligibility date. Members *not* in the ESP may change health plans without cause within this 60-day window, before they make their first POWER account contribution. After the first POWER account contribution is made, members cannot change plans without filing a grievance with the MCE or unless they move out of the MCE's service area.[11] Members may also change plans when their eligibility for the program is redetermined (at annual renewal).

During the first three years of program operations, a total of 2,475 plan changes occurred, out of almost 60,000 enrolled members. In 2008, 520 changes occurred, 837 changes occurred in 2009, and 1,118 changes happened in 2010. The number of plan changes increased in 2011 and 2012, as an additional MCE was added and enrollment grew (Table 5.10).

Table 5.10 Health Plan Changes in the HIP by Year, 2008-2012

[11] A member may request to change health plans for cause at any time after exhausting the plan's internal grievance and appeals process.

Type of Change	2008		2009		2010		2011		2012	
	Number of Plan Changes	%	Number of Plan Changes	%	Number of Plan Changes	%	Number of Plan Changes	%	Number of Plan Changes	%
Total Number of Plan Changes	520	100%	837	100%	1,118	100%	2,988	100%	1,941	100%
Anthem →MDwise	9	2%	225	27%	137	12%	274	9.2%	231	11.9%
Anthem → MHS	-	-	-	-	-	-	97	3.2%	83	4.3%
Anthem → ESP	40	8%	67	8%	268	24%	552	18.5%	482	24.8%
MDwise →Anthem	12	2%	236	28%	128	11%	913	30.6%	254	13.1%
MDwise → MHS	-	-	-	-	-	-	459	15.4%	53	2.7%
MDwise →ESP	18	3%	73	9%	478	43%	275	9.2%	249	12.8%
MHS → Anthem	-	-	-	-	-	-	211	7.1%	293	15.1%
MHS → MDWise	-	-	-	-	-	-	80	2.7%	108	5.6%
MHS → ESP	-	-	-	-	-	-	4	0.1%	19	1%
ESP → Anthem	301	58%	125	15%	70	6%	54	1.8%	82	4.2%
ESP → MDwise	140	27%	111	13%	37	3%	67	2.2%	66	3.4%
ESP → MHS	-	-	-	-	-	-	2	0.1%	21	1.1%

Source: OMPP Data Management & Analysis, via HP and Maximus

Table 5.11 Month of Enrollment when Health Plan Change occurred, for those who changed health plans, by year, 2011 and 2012

	2011	2012
Percent who switch in month 1	8.5%	11.2%
Percent who switch in month 2	3.3%	4.4%
Percent who switch in months 3	3.1%	3.8%
Percent who switch in month 4-12	27.2%	41.2%
Percent who switch in month 13 +	57.9%	39.4%

Source: OMPP Data Management & Analysis, via HP

5.6 POWER ACCOUNTS

A. POWER ACCOUNT CONTRIBUTIONS

The POWER account is a key feature of the Healthy Indiana Plan. 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 ($1,100 annually). Contributions are based on a sliding scale tied to income 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 his or her income to the POWER account, consistent with CMS rules. The State then subsidizes the POWER account to ensure that it is fully funded, up to the amount of the deductible. Employers are also currently allowed to make up to 50% of the member's required contribution.

Participants have control over how POWER account dollars are spent and receive monthly statements on POWER account expenditures and account balances. Unlike traditional premiums or copayments, HIP members own their contributions and are entitled to any unused contributions if they leave the program. Additionally, HIP members who receive required preventive services are rewarded by the program allowing any remaining POWER account balance after 18 months of enrollment— including the portion that is the State's contribution—to roll over and 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. The incentive is designed to increase the use of preventive care. Because the health plans wait six months after the member's benefit period ends for claims to run out, they do not calculate rollovers until members have been enrolled for 18 months to assure that all services have been reimbursed.

While every HIP member has a POWER account, members make different monthly contributions based on a sliding scale tied to income. Contributions vary from 2 to 5 percent of household income. In 2012, 77 percent of HIP members were required to make some contribution to their POWER accounts. Those in the lowest income bracket – 22 percent of the FPL or below – make the lowest average monthly contribution, $7.94 each month (Table 5.12). The amount of the required payments rise as income increases, with individuals with incomes between 150 and 200 percent of the FPL ($15,756-$23,340) required to make average monthly payments of $61.01, but not more than $93.08.

Table 5.12 Average POWER Account Monthly Payment in 2012, by FPL

FPL	Estimated Income for an Individual	Average Monthly Contribution for HIP Members
<22%	$0 - $11,170	$7.94
23%-50%	$11,171 - $13,963	$10.32
51%-100%	$13,964 - $15,083	$17.77

FPL	Estimated Income for an Individual	Average Monthly Contribution for HIP Members
100%-150%	$15,084 - $16,755	$39.69
>150%	$16,756 - $23,340	$61.01

Source: OMPP Data Management & Analysis

Approximately twenty-three percent of HIP members were *not* required to make monthly contributions to their POWER accounts in 2012 (Table 5.13). These individuals do not make contributions either because they have no income, or because the family is already spending five percent of its income on premiums and cost-sharing requirements for family members covered by Medicaid or the State Children's Health Insurance Program. Those in the non-contributor group tend to report much lower incomes than the HIP population as a whole. See Table 5.13.

Table 5.13. Demographic Characteristics of HIP Members Not Required to Make Monthly POWER Account Contributions, 2012

Characteristics	All HIP Members in 2012		HIP Members with No Monthly Contributions	
	Number	Percentage of Total	Number	Percentage of Total
Total number	56,245	100.0%	12,688	22.6%
Gender				
Female	38,030	67.6%	7,586	59.8%
Male	18,215	32.4%	5,102	40.2%
Caretaker Status				
Caretaker	38,740	68.9%	6,042	47.6%
Non-caretaker	17,505	31.1%	6,646	52.4%
FPL				
<22%	15,570	27.7%	10,470	82.5%
23%-50%	6,780	12.1%	417	3.3%
51%-100%	17,145	30.4%	447	3.5%
100%-150%	11,123	19.8%	1,136	9.0 %
>150%	5,627	10%	218	1.7%

Source: OMPP Data Management & Analysis

Each year, the majority of HIP members who were involved in the POWER account rollover process did not have an account balance left after 18 months of enrollment. This is a reflection of the high prevalence of chronic disease among the HIP population, as discussed further in Section 6.5. A Milliman analysis of 2012 claims showed that among those enrolled in HIP for at least six months during 2012, 32 percent of members had cardiovascular disease, 24 percent had a psychiatric diagnosis, 20 percent had a skeletal and connective tissue disease, 19 percent had a gastrointestinal ailment, and 13 percent had diabetes. Multiple diagnoses were common as

well—approximately 30 percent of HIP members had been diagnosed with three or more chronic conditions in 2012. These members incur higher healthcare costs to manage and treat their chronic disease(s), and therefore tend to quickly meet the deductible and exhaust the POWER account. By the end of 2012, just over one-third of POWER accounts eligible for a rollover over the course of the demonstration contained any funds to carry forward. Similar data has been previously reported at the end of 2009 and 2010; however, the rates discussed here reflect updated data sets from the MCE's in which all member account reconciliations have been included. This data is cumulative, reported on a rolling basis as of the end of each calendar year.

Table 5.14 POWER Account Rollover Reconciliation

Status	2009	2010	2011	2012
Percent of accounts with a balance after 18 months of member enrollment	36.1%	35.2%	34.7%	34.6%
Of those accounts, percent that received a partial rollover (did not receive recommended care)	44.7%	58.9%	64.9%	65.2%
Of those accounts, percent that received a full rollover (received recommended preventive care)	55.3%	41.1%	35.1%	34.8%

Source: MCE POWER Account Reconciliation Files

Of those accounts that did have a balance, the majority received a partial rollover, meaning just member contributions were rolled over. Members who do not spend down their POWER accounts and retain a balance at the end of 18 months are likely to be healthier, have a lower rate of chronic disease, and use fewer healthcare services (totaling less than $1,100 annually) than those who do exhaust their funds. Since overall preventive care utilization rates are much higher in the general HIP population, the observed lower rate among those with funds remaining in the POWER account might be due to a perception of lower need for routine physicals and screenings and lower health service utilization in general. The MCEs continue to work to promote the preventive care incentive and develop member awareness and understanding of how the POWER account works.

B. COST-SHARING LIMIT MONITORING

Per CMS rules for HIP caretakers, the total aggregate amount of (1) POWER account contributions, (2) HIP Emergency Room copayments, (3) Medicaid cost sharing requirements, and (4) CHIP cost sharing requirements may not exceed five percent of family income. The health plan verifies the member's cost-sharing documentation, and then notifies the HIP program manager that the member has reached the five percent maximum contribution amount and the date it occurred. Then 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.

C. COST-SHARING-POWER ACCOUNT CONTRIBUTION RATES

After completing an application and meeting the financial and other eligibility criteria, members are "conditionally eligible" for the HIP program. They do not become fully eligible until they make their first POWER account contribution. Individuals with no required POWER account contribution, however, become eligible immediately after they meet the financial and other criteria. (Individuals with no required contributions either have no income, or are exempt due to CMS cost-sharing rules). Once fully enrolled, members must continue to make monthly contributions to maintain their HIP eligibility. If they fail to do so within the grace period, they are disenrolled, and must wait 12 months to re-apply. The State has collected annual data on the rates at which HIP members make required contributions to the POWER account. The rate of members who make their initial contributions to complete the enrollment process has increased consistently each year of the demonstration. The rate of members who continue to make subsequent required monthly contributions has decreased slightly, but continues to stay well under 10 percent.

Over the demonstration period, the State has refined both the quality of the data as well as the methods of accessing the records used to assess rates of member contribution over the course of the demonstration. In the past, if members were missing data in any fields of their eligibility file, they were excluded from analysis. The State has developed mechanisms to correct this, leading to inclusion of more members in the analysis and more robust reporting. The new methodology has been applied retroactively and the data below represents an updated annual review of contribution rates.

The HIP program has historically had low non-contribution rates, suggesting that the disenrollment penalty could be a strong motivating factor to make regular payments. Data from the 2013 Mathematica survey also supports that the required financial contributions are affordable and HIP participants prefer making upfront contributions rather than making copays. According to the survey, 85 percent of HIP enrollees believed that their required contributions were either the right amount or below the right amount. In 2012, 94.2 percent (52,996) of HIP members made the initial POWER account contribution if required and only 5.8 percent (3,249 individuals) did not. Although there is some variation between income brackets, the majority of individuals at all levels made the first required POWER account contribution.

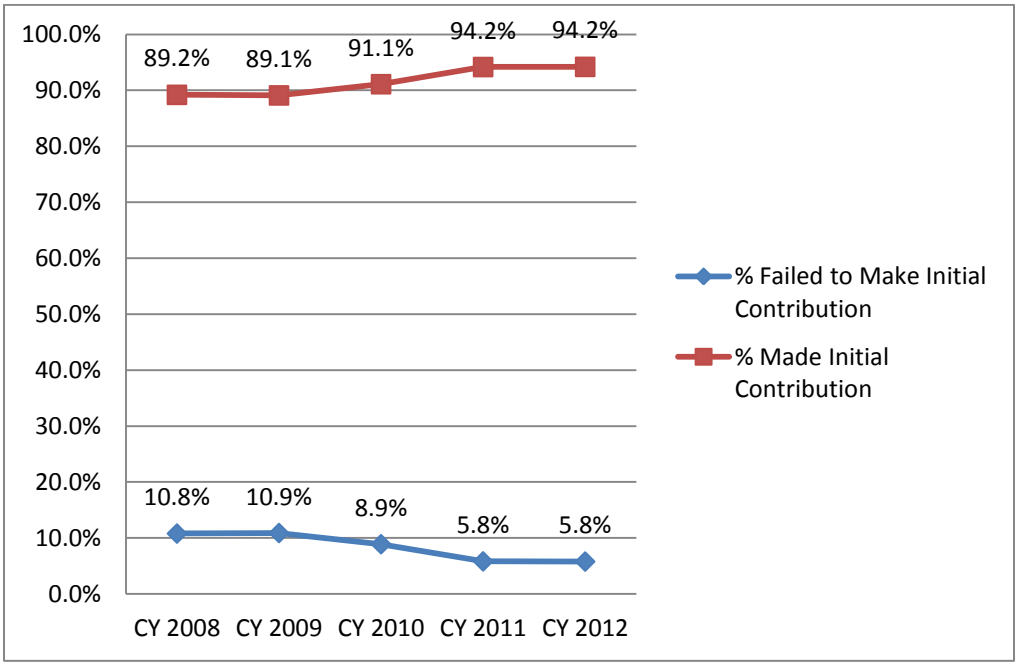
Table 5.15. Calendar Year 2012 Initial Non-Contribution Rates (Did Not Make First POWER Account Contribution)

FPL Level	Number Who Never Made First Contribution	Total Members	Initial Non-Contribution Rate
<22%	522	15,570	3.4%
23%-50%	401	6,780	5.9%
51%-100%	1,445	17,145	8.5%
101%-150%	641	11,123	6.1%
>150%	240	5,627	4.3%
Total	**3,249**	**56,245**	**5.8%**

Source: OMPP Data Management & Analysis
Note: Almost one quarter (13,293) of total 2012 enrollees (56,245) were exempt from making POWER account contributions.

Initial contribution rates have increased consistently over the course of the HIP demonstration. In DY 1 (CY 2008), the initial non-contribution rate among HIP enrollees was about 10.8 percent. This rate dropped over five years; reaching 5.8 percent in in 2011 and staying steady in 2012 (see Figure 5.2). These figures include members not required to make contributions in the calculations.

Figure 5.2. Initial POWER Account Contribution and Non-Contribution Rates, CY 2008-2012



Source: MedInsight, HP

In 2012, 93 percent of HIP members continued to make their required monthly contributions to remain enrolled in the program. Another 3,924 HIP members (about 7 percent) failed to make a required monthly contribution and were disenrolled (Table 5.16). Subsequent non-contribution rates were similar across all income brackets—highest at the 51-100 percent FPL bracket, and lowest at the <22 percent FPL income bracket. These figures include members not required to make contributions in the calculations.

Table 5.16. Calendar Year 2012 Subsequent Non-Contribution Rates

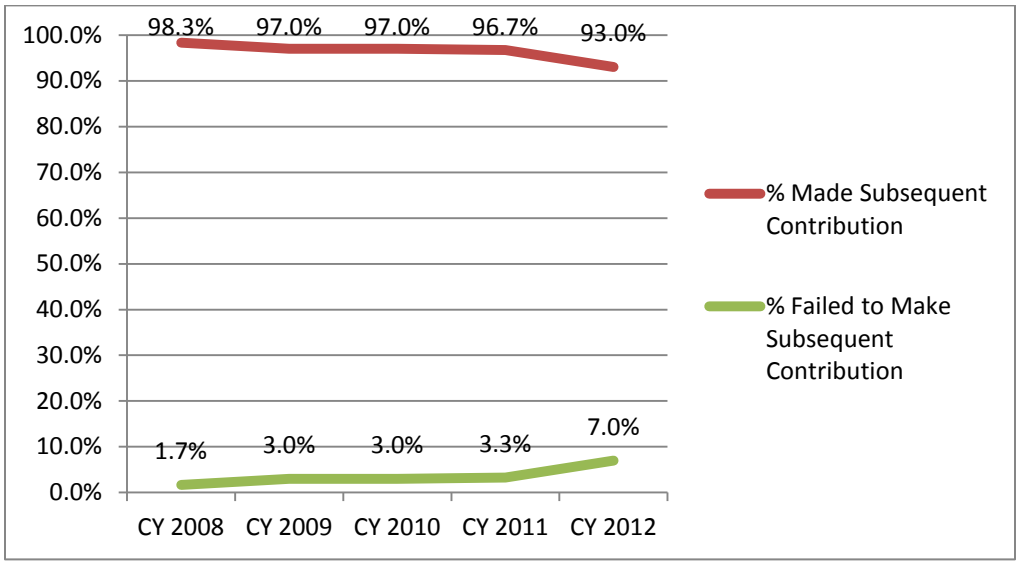
FPL Level	Number Who Missed a Subsequent Monthly Contribution	Total Members	Subsequent Non-Contribution Rate
<22%	333	15,570	2.1%
23%-50%	606	6,780	8.9%
51%-100%	1,616	17,145	9.4%
100%-150%	961	11,123	8.6%
>150%	408	5,627	7.3%
TOTAL	**3,924**	**56,245**	**7.0%**

Source: OMPP Data Management & Analysis

Note: Almost one quarter (13,293) of total 2012 enrollees (56,245) were exempt from making POWER account contributions.

Annual subsequent non-contribution rates rose slightly during the demonstration. In DY 1 (CY 2008), the subsequent non-contribution rate was very low, 1.7 percent (see Figure 5.3). It rose slightly to 3 percent in 2009 and hovered around the same rate for three years. In CY 2012, the subsequent non-contribution rate rose again, perhaps due to reasons unrelated to cost such as uncertainty surrounding the future of the program or gaining other insurance. For the first four years of the program, subsequent non-contribution rates were lower than initial non-contribution rates, suggesting that once members are fully enrolled, they tend to remain in the program and that contribution amounts are affordable.

Figure 5.3. Subsequent POWER Account Contribution and Non-Contribution Rates, CY 2008-2012



Source: MedInsight, HP

Failure to make an initial POWER account payment was also not one of the top five reasons for HIP enrollment denials in 2012 (Table 5.17), which is consistent with earlier years (Table 5.18).

Table 5.17. Top Five Types of HIP Denials in Calendar Year 2012

Member Count	Denial Reason
43,105	Non-Caretaker cap reached
18,172	Did not verify income
11,100	Failure to provide insurance information
8,603	No proof of citizenship
4,420	Employer offers health insurance

Source: OMPP Data Management & Analysis

Table 5.18. Top Five Types of HIP Denials in Calendar Years 2008-2012

Member Count	Denial Reason
191,053	Non-Caretaker cap reached
73,179	Did not verify income
38,170	Failure to provide insurance information
37,268	No proof of citizenship
26,466	Employer offers health insurance

Source: OMPP Data Management & Analysis

Failure to make a subsequent POWER account payment was the second most common reason for dis-enrollment in 2012 (Table 5.19). Other top reasons included a failure to return the HIP renewal packet, the presence of other health insurance, a failure to verify income, or closure due to an appeals ruling. This is consistent with earlier years.

Table 5.19. Top Five Types of HIP Member Accounts Closed in Calendar Year 2012

Member Count[12]	Denial Reason
4,415	HIP packet not returned
3,924	Failure to make POWER account payment
2,658	Closed due to appeals ruling
1,805	Other current health insurance
1,085	Did not verify income

Source: OMPP Data Management & Analysis

Table 5.20. Top Five Types of HIP Member Accounts Closed in Calendar Years 2008-2012

Member Count[13]	Denial Reason
22,643	HIP packet not returned
12,490	Failure to make POWER account payment
7,724	Other current health insurance
5,293	Closed due to appeals ruling
5,165	Medicare Part A or B currently.

Source: OMPP Data Management & Analysis

Coverage and Benefit Limits

HIP benefits are limited to $300,000 annually and $1 million lifetime. The health plans and the State identify members when they reach $200,000 in annual benefits. The health plans and the State closely monitor these members, and work to refer them appropriately to other programs, including Medicaid and M.E.D. Works (Indiana's Medicaid Buy-In program for those with disabilities). For the calendar year 2012, no HIP member had reached the lifetime benefit maximum.

[12] Total unique enrollment in 2012: 56,245 members. Therefore, 25 percent of members disenrolled for some reason in 2012.

[13] Total unique enrollment across all five years: 105,197. Therefore, over 5 years, 50.7% of those who have enrolled have disenrolled for some reason.

Table 5.21. Number of HIP Members Who Reached $200,000 in Annual Benefits During 2012

	Anthem	MDwise	MHS	Total
Total Number	0	2	0	2

Source: HIP Quarterly Reports to CMS, 2012

Table 5.22. Number of HIP Members Who Reached $300,000/Annual or $1,000,000/Lifetime in Benefits During 2012

	Anthem	MDwise	MHS	Total
Total Number	0	0	0	0

Source: HIP Quarterly Reports to CMS, 2012

SECTION 6: EVALUATION FINDINGS TO DATE

In March 2009, Mathematica Policy Research was selected as the evaluation contractor for HIP. This section represents the analyses Mathematica has completed for the fifth year of the demonstration program (calendar year 2012). Results of the second telephone survey of HIP members undertaken since the HIP demonstration began are also presented. This survey, completed in the spring of 2013, included a sample of 847 current HIP enrollees, along with 620 individuals who had been previously enrolled in HIP within 12 months of the survey.

6.1 GOAL I – REDUCE THE NUMBER OF UNINSURED LOW-INCOME HOOSIERS

HIP seeks to reduce the number of uninsured low-income Hoosiers by providing an insurance option for those who do not have access to employer-based coverage and do not currently qualify for other public insurance. While 2012 ACS data on uninsurance rates are unavailable at the time of writing, uninsured rates for individuals aged 19 to 64 and below 200 percent of the FPL remained relatively constant through the first four years of the demonstration. Two factors may have impeded the program's ability to reduce the number of uninsured low-income Hoosiers. First, the program was implemented during a significant economic downturn when the uninsured rate was increasing. Second, the program limits enrollment of non-caretaker adults by design to meet its budget neutrality requirements.

After five years, HIP has served 105,197 Hoosiers. Major findings on HIP enrollment include:

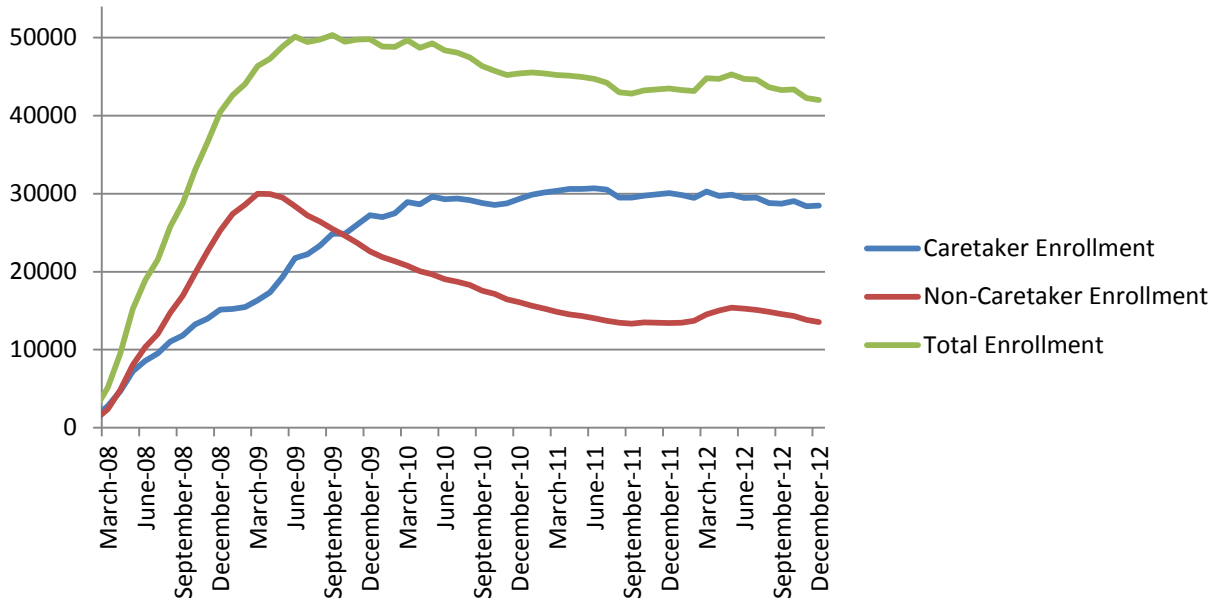
- As reported in previous demonstration years, monthly enrollment grew steadily from the program's inception until April 2009, when it began to level off with about 46,000 to 47,000 enrollees per month. Enrollment figures approached the non-caretaker adult cap in early 2009 and the State closed enrollment to non-caretakers at that time. Monthly enrollment remained relatively stable until September 2010, when it fell into the 43,000-44,000 range. The State opened the non-caretaker waiting list in 2010 and again in 2011. By December 2011, enrollment numbers had dropped. As of December 31, 2012, 39,005 individuals were enrolled in the program. At this time, an additional 3,005 Hoosiers were conditionally enrolled (had been determined eligible, but had not yet made the required initial POWER account contribution), for a total of 42,010 individuals.
- The program continues to enroll more women than men (38,030 women vs. 18,215 men enrolled during 2012), and more caretakers than non-caretakers (38,740 caretakers vs. 17,505 non-caretakers during 2012). However, non-caretakers comprised a greater proportion of the total HIP population until about September 2009, about six months after the non-caretaker cap was reached and the waitlist was implemented.

A. ENROLLMENT TRENDS IN HIP

Overall monthly enrollment in HIP increased steadily from the program's inception in January 2008 through mid-2009 (Figure 6.1). Non-caretakers enrolled at a much higher rate than caretakers through April of 2009, when non-caretaker adults found to be eligible were placed on

a waiting list. Enrollment of this group steadily decreased through October 2011. In February of 2012, the number of non-caretaker enrollees began to increase and continued to rise until June, when numbers began to decrease again. By December 2012, the total number of enrolled non-caretakers had returned to levels seen at the beginning of 2012. Caretaker enrollment increased steadily from the beginning of the program through July of 2010, when it began to level off. Caretaker enrollment remained relatively steady through 2012, dropping slightly toward the end of the year.

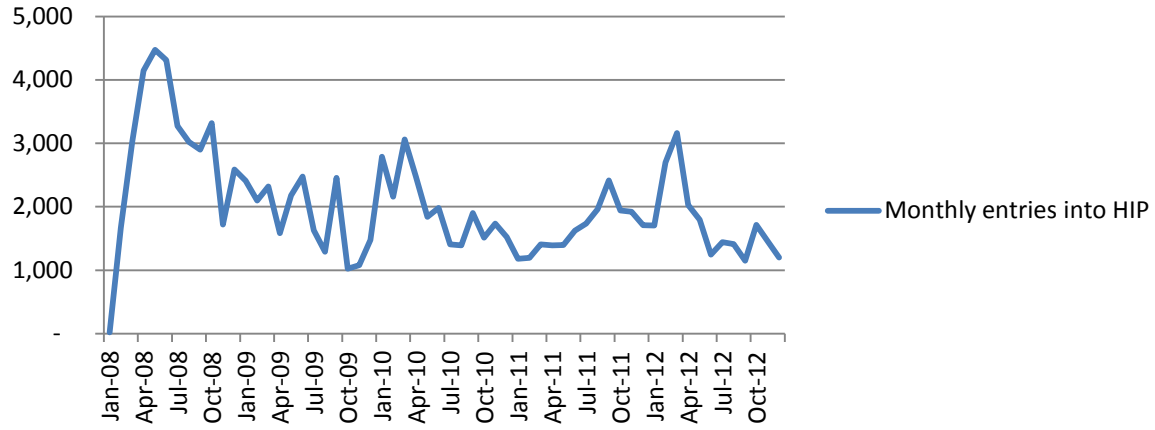
Figure 6.1: Monthly HIP Enrollment, Overall and by Caretaker Status, January 2008-December 2012.



Source: ICES data, September 2013

Monthly enrollment figures are affected by the number of people entering and leaving the program each month. Figure 6.2 shows the number of people that entered the program each month from January 2008-December 2012.

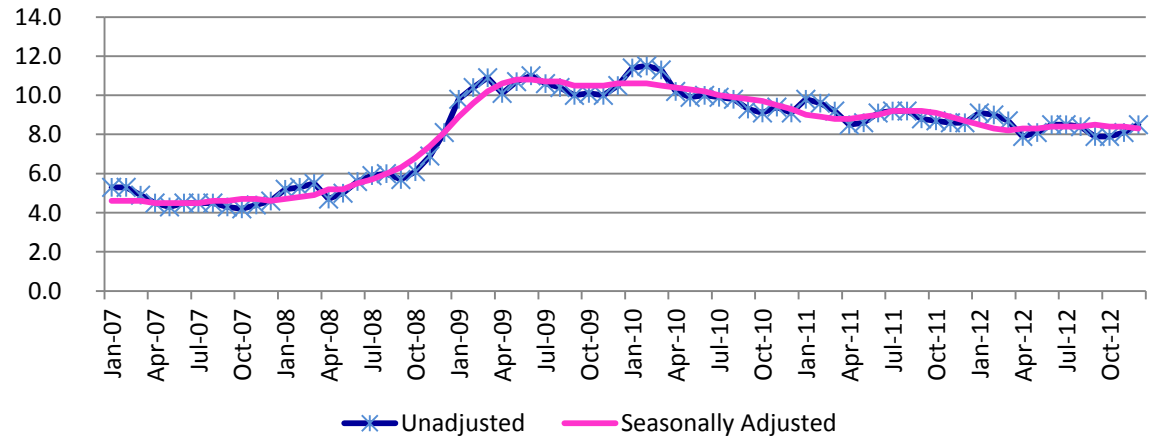
Figure 6.2 Monthly Entries into HIP, January 2008 – December 2012



Source: ICES data, September 2013

Because Hoosiers must be uninsured for at least six months before becoming eligible for HIP, trends in unemployment rates are of interest. Hoosiers that otherwise fit the eligibility criteria for HIP who previously had employer-sponsored insurance may lose it due to becoming unemployed, or allow any privately-purchased covered to lapse due to a loss of income. For months with high program entry numbers, there may be a spike in unemployment rates six months earlier Monthly enrollment spiked in April of 2010 and April of 2012 (after the non-caretaker waiting list was re-opened (early spikes were likely related to the program's inception). No significant unemployment figure six-month lag/enrollment spike correlation is observed, likely because there are too many other factors at play, including the non-caretaker cap and subsequent re-opening of the waitlist.

Figure 6.3: Monthly Unemployment Rates in Indiana: January 2007-December 2012

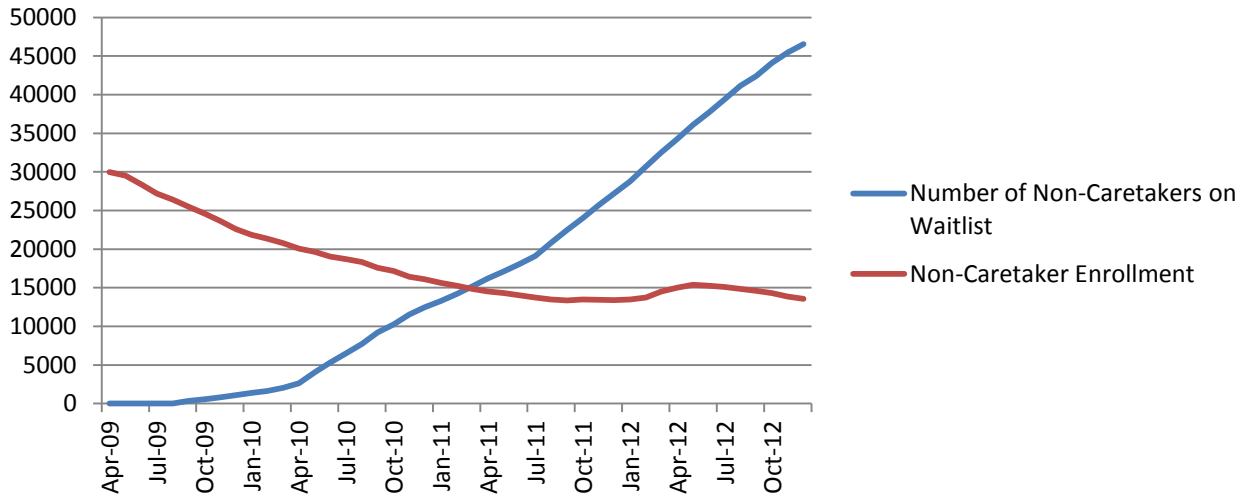


Source: U.S. Bureau of Labor Statistics, Local Area Unemployment Statistics. Available at: http://www.bls.gov/data/#unemployment

After non-caretaker enrollment was capped in March 2009, the waitlist continued to grow and non-caretaker enrollment declined through January of 2012 (see Figure 6.4). In November 2009, 5,000 letters were sent to individuals on the waiting list inviting them to re-apply for HIP. In August 2011, the waitlist was opened to 8,000 additional members. By the end of December 2011, 19,500 letters had been sent and 2,157 individuals on the waiting list had enrolled in the program (11 percent response rate). Due to the length of time many applicants had spent on the waiting list, some individuals who received letters may have experienced a life change, such as moving out of state or no longer meeting eligibility criteria for the program.

During the first quarter of the 2012 calendar year, 18,800 letters were sent to non-caretakers caretakers on the waitlist, inviting them to reapply for the program. In response to these letters, 1,587 individuals were able to enroll, an 8.4 percent response rate (see Figure 6.4). During this time, 7,113 additional individuals were added to the waitlist. The waitlist was closed to new non-caretaker applicants in April 2012 as the State waited for guidance from CMS on whether HIP could be used as a framework for a potential Medicaid expansion under the Affordable Care Act of 2010.

Figure 6.4 Non-Caretaker Waitlist and Non-Caretaker Enrollment, April 2009-December 2012



B. DEMOGRAPHIC CHARACTERISTICS OF THOSE EVER ENROLLED IN HIP

The State's analyses of HIP enrollment records indicate that HIP served 56,245 unique individuals during 2012 and 105,197 individuals over the five demonstration years. The demographics of HIP enrollees in 2012 compared to the enrollment composition over the life of the demonstration are somewhat similar (Table 6.1). The proportion of females in HIP was slightly higher in 2012, though women have made up a majority of the HIP population over the course of the program. HIP enrollees in 2012 were slightly older when compared to composite

enrollment statistics from 2008-2012. In 2012, 14 percent of enrollees were ages 20-29, as compared to 18 percent over the five-year demonstration, while percentages of those in the 30-39, 40-49, and 50-59 age groups were slightly higher in 2012. Enrollment of African-Americans was slightly lower in 2012 (10 percent) than over the life of the program (12 percent). Member income distribution is fairly similar when comparing 2012 enrollment with cumulative enrollment.

Table 6.1. Demographic Characteristics of Those Ever Enrolled in HIP in 2008-2012 vs. 2012

	2008-2012 Enrollment	2008-2012 % of Total	2012 Enrollment	2012 % of Total	Low-Income Uninsured Working-Age Indiana Adults, 2011	Low-Income Uninsured Working-Age Indiana Adults, 2011 % of Total
Gender						
Female	68,378	65%	38,030	68%	233,201	48.9%
Male	36,819	35%	18,215	32%	243,356	51.1%
Age Group						
<20	79	0%	21	<1%	11,511	2.4%
20-29	19,394	18%	7,680	14%	151,246	31.7%
30-39	30,400	29%	17,251	31%	116,116	24.4%
40-49	28,391	27%	16,407	29%	98,753	20.7%
50-59	19,446	18%	11,130	20%	74,771	15.7%
60+	7,486	7%	3,756	7%	24,160	5.1%
Race/Ethnicity						
Asian	1,581	2%	1,159	2%	7,871	1.7%
Black	12,948	12%	5,895	10%	67,459	14.2%
Hispanic	3,591	3%	1,927	3%	69,404	14.6%
American Indian	74	0%	45	<1%	6,171	1.3%
Other	1,695	2%	1,083	2%	35,922	7.5%
White	85,308	81%	46,136	82%	369,571	77.6%
Income as % of FPL						
<22%	30,265	28.7%	15,570	27.7%	65,297	13.7%
23%-50%	11,321	10.8%	6,780	12.1%	47,536	10.0%
51%-100%	31,330	29.9%	17,145	30.4%	121,812	25.6%
100%-150%	21,083	20%	11,123	19.8%	133,837	28.1%
>150%	11,197	10.6%	5,627	10%	108,075	22.7%

Source: ACS data, 2011.

6.2 GOAL II – REDUCE BARRIERS AND IMPROVE STATEWIDE ACCESS TO HEALTH CARE SERVICES FOR LOW-INCOME HOOSIERS

A key goal of HIP is to improve access to health care among low-income Hoosiers. To accomplish this goal, it is important not only to provide health insurance, but also to ensure that HIP members have access to both a primary medical provider (PMP) and needed specialists. Over the past five years, HIP has consistently achieved this goal by providing full access to PMPs and access to most specialists.

A. PROVIDER NETWORKS

1. Primary Care Providers

In 2012, all HIP members were required to select a PMP, or were auto-assigned to a provider. All three plans use Geo-Access software on a quarterly basis to evaluate whether their network meets the standard of access: a PMP within 30 miles of all members' homes. In 2012, all plans continued to meet geo-access standards for PMPs. The health plans reported that HIP's higher payment rate has not been a significant factor in their ability to recruit providers. Most HIP providers already serve both HHW and HIP patients, and have therefore already accepted Medicaid reimbursement rates. HIP reimburses most services at Medicare rates. The plans have noted that some providers have faced billing challenges during the demonstration, as not every service provided to Medicaid patients has a corresponding Medicare billing code.

In addition to seeking primary care with PMPs, HIP members may also go to any Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC). All health plans reported contracting with most FQHCs, community mental health centers (CMHCs), and RHCs in the State.

2. Specialty Care

In the first year of HIP operations, development of specialist networks was a challenge for Anthem and MDwise, the initial HIP health plans. However, these plans made significant strides in expanding their networks since then, and by the end of 2012 both reported that members had access to most categories of specialists within 60 miles of their homes. During its initial year, MHS met geo-access standards for approximately half of its specialist categories, and made significant improvements during 2012.

All plans reported meeting geographic access standards in most categories during 2012, and provided transportation services to members when necessary. The plans noted a few types of specialists that are difficult to locate within certain geographic areas, including nephrologists and those providers offering prosthetics, making it difficult to meet standards in these categories. However, all three plans reported that they had made efforts during 2012 to maintain their specialist networks.

In 2012, Anthem met the requirements for specialist access standards in all areas except for endocrinology, hematology, occupational therapy, and speech pathology, the same areas which

lacked sufficient access in 2011. No access information was available for the specialty areas of clinical psychology and diagnostic radiology. Between 2011 and 2012, Anthem expanded the number of specialists in its network in all categories except for neurosurgery and radiation oncology, though even these categories have been expanded since 2008. No information was available on the number of diagnostic radiology specialists available in 2011 or 2012. No 2011 information on the number of clinical psychologists in the network was available, though Anthem expanded the number of specialists in this category from 3,321 in 2010 to 5,432 in 2012.

Table 6.2. Anthem Specialist Network, 2008-2012

Specialty Type	Providers in 2008	Providers in 2009	Providers in 2010	Providers in 2011	Providers in 2012	% Change 2008-2012	Total Number of Provider Locations 2012	Complete Coverage of Indiana, with 60-Mile Radius from Providers
Anesthesiology	88	170	199	219	219	148.9%	179	✓
Cardiovascular	1,276	2,713	3,261	2,866	3,124	144.8%	375	✓
Clinical Psychology	1,726	2,720	3,321	*	5,432	214.7%	948	*
Dermatology	32	87	127	181	213	565.6%	71	✓
Diagnostic Radiology	159	201	247	*	*		*	*
Endocrinology	48	129	159	159	168	250.0%	76	
Gastroenterology	210	332	351	376	556	164.8%	142	✓
General Surgery	335	658	739	813	951	183.9%	268	✓
Hematology	129	221	216	225	228	76.7%	105	
Infectious Disease	32	184	198	199	210	556.3%	67	✓
Medical Oncology	696	829	863	817	913	31.2%	171	✓
Nephrology	208	462	683	1,032	1,194	474.0%	207	✓
Neuro Surgery	103	135	240	261	252	144.7%	73	✓
Neurology	257	1,339	1,460	1,589	1,617	529.2%	214	✓
Occupational Therapy	49	64	84	95	121	146.9%	101	
Ophthalmology	388	565	594	740	779	100.8%	264	✓
Optometry	346	459	494	573	688	98.8%	266	✓

Specialty Type	Providers in 2008	Providers in 2009	Providers in 2010	Providers in 2011	Providers in 2012	% Change 2008-2012	Total Number of Provider Locations 2012	Complete Coverage of Indiana, with 60-Mile Radius from Providers
Orthopedic Surgery	330	462	603	685	849	157.3%	245	✓
Otolaryngology	444	567	751	910	1,012	127.9%	273	✓
Pathology	32	35	45	40	45	40.6%	39	✓
Physical Therapy	99	133	177	180	211	113.1%	183	✓
Pulmonary Disease	214	472	522	558	594	177.6%	211	✓
Radiation Oncology	439	635	605	567	629	43.3%	123	✓
Rheumatology	35	138	156	135	148	322.9%	76	✓
Speech Pathology	11	18	20	21	22	100.0%	22	
Urology	500	546	637	790	798	59.6%	182	✓
TOTAL	**8,186**	**14,274**	**16,752**	**At least 14,031**	**At least 21,121**	**At least 73.2%**	**At least 4,881**	**At least 20 of 26**

Source: Anthem Specialists 2012 Summary

Note: * indicates information not available.

In 2012, MHS met geo-access standards in all categories except for anesthesiology, dermatology, endocrinology, neurosurgery, pathology, physical therapy, and speech pathology. The plan notes that it meets the 90-mile access standards for all of these specialties except speech pathology. Between 2011 and 2013 (the date for which MHS provided information), MHS expanded or maintained its specialist networks in most categories, except for hematology, infectious disease, neurology, and physical therapy. No information was available to determine whether MHS had enough diagnostic radiologists in its network to meet standards.

Table 6.3. MHS Specialist Network, 2011-2013

Specialty Type	Number of Providers 2011	Number of Providers 2013	% Change 2011-2013	Total Number of Provider Locations 2013	Complete Coverage of Indiana, with 60-Mile Radius to Providers
Anesthesiology	211	211	0.0%	49	

Specialty Type	Number of Providers 2011	Number of Providers 2013	% Change 2011-2013	Total Number of Provider Locations 2013	Complete Coverage of Indiana, with 60-Mile Radius to Providers
Cardiovascular	275	347	26.2%	156	✓
Clinical Psychology	264	394	49.2%	244	✓
Dermatology	53	535	909.4%	27	
Diagnostic Radiology	244	244	0.0%	*	*
Endocrinology	41	41	0.0%	34	
Gastroenterology	168	176	4.8%	64	✓
General Surgery	316	352	11.4%	157	✓
Hematology	137	86	-37.2%	60	✓
Infectious Disease	37	30	-18.9%	23	✓
Medical Oncology	**	86		60	✓
Nephrology	87	100	14.9%	46	✓
Neurosurgery	41	72	75.6%	28	
Neurology	182	100	-45.1%	46	✓
Occupational Therapy	23	33	43.5%	24	✓
Ophthalmology	94	112	19.1%	53	✓
Optometry	72	113	56.9%	57	✓
Orthopedic Surgery	223	275	23.3%	131	✓
Otolaryngology	131	139	6.1%	58	✓
Pathology	91	117	28.6%	25	
Physical Therapy	85	77	-9.4%	38	
Pulmonary Disease	101	113	11.9%	68	✓
Radiation Oncology	57	58	1.8%	37	✓
Rheumatology	7	32	357.1%	27	✓
Speech Pathology	14	17	21.4%	9	
Urology	137	153	11.7%	61	✓
TOTAL	**At least 3,091**	**At least 4,013**	**At least 29.8%**	**At least 1,582**	**At least**

Specialty Type	Number of Providers 2011	Number of Providers 2013	% Change 2011-2013	Total Number of Provider Locations 2013	Complete Coverage of Indiana, with 60-Mile Radius to Providers
					18 of 26

Source: MHS Specialists Summary, 2013

Note: * indicates information not available. MHS provided information for 2013 and not for 2012.

In 2012, MDwise met geo-access standards for all specialist areas except for dermatology and nephrology. Between 2008 and 2012, it expanded its access in all specialty areas except for dermatology.

Table 6.4. MDWise Specialist Network, 2008-2012

Specialty Type	Number of Locations 2008	Number of Locations 2009	Number of Locations 2010	Number of Locations 2011	Number of Locations 2012	% Change 2008–2012	Complete Coverage of Indiana, with 60-Mile Radius from Providers
Anesthesiology	91	134	609	197	237	160%	✓
Cardiovascular	149	245	340	335	403	170%	✓
Clinical Psychology	9	9	383	333	405	4,400%	✓
Dermatology	369	387	37	45	50	-86%	
DME and Prosthetic Suppliers	33	42	81	252	247	648%	✓
Gastroenterology	37	51	117	137	164	343%	✓
General Surgery	82	113	234	270	346	321%	✓
Gynecology	99	124	280	370	515	420%	✓
Home Health	13	16	29	55	103	692%	✓
Nephrology	28	46	101	124	150	435%	
Neuro Surgery	13	13	60	44	74	469%	✓
Neurology	37	44	155	167	190	413%	✓
Oncology	24	40	99	190	237	887%	✓
Ophthalmology	23	32	92	156	194	743%	✓
Optometry	11	14	71	149	158	1,336%	✓
Orthopedic Surgery	56	69	139	193	247	341%	✓
Otolaryngology	46	44	95	124	145	215%	✓

Pathology	20	29	129	189	213	965%	✓
Physical Therapy	15	30	176	222	272	1,713%	✓
Psychiatry	7	346	314	231	265	3,685%	✓
Pulmonary Disease	39	48	90	151	196	402%	✓
Radiology	131	253	380	183	219	67%	✓
Urology	22	65	107	138	158	618%	✓
TOTAL	**1,354**	**2,194**	**4,118**	**4,255**	**5,188**	**283%**	**21 of 23**

Source: MDwise specialists summary, 2013.

B. MEMBER PERCEPTIONS OF COST SHARING REQUIREMENTS

To examine access to care among members and to evaluate whether HIP's cost sharing requirements serve as a barrier to coverage for low-income Hoosiers, Mathematica conducted a telephone survey of 847 current HIP members who had been enrolled at least two years at the time of the survey. Another survey of 613 "leavers," individuals who had been enrolled in HIP within the last 12 months but were not enrolled at the time of the survey, was also conducted. When the survey weights are applied, the respondents to the survey of current HIP members represent 16,830 current members who have been enrolled at least two years and the respondents to the survey of HIP leavers represent 4,049 former members. Survey respondents shared their perceptions of cost-sharing requirements (including POWER account contributions and ER co-payments).

1. Monthly POWER Account Contributions

General Perception of the Method of Contributing to the Cost of Healthcare: The 2013 survey assessed currently enrolled HIP members' preferences for the method of contributing to their healthcare costs (up-front contributions versus making copayments at the time of service). A significant majority of HIP members (83.1 percent) reported that when given the choice between paying a fixed monthly amount up front with the opportunity to receive funds back and making a payment each time they visited a health professional, pharmacy, or hospital, they preferred to pay up front (make a POWER account contribution). Members with incomes above 100 percent of the FPL were slightly more likely to report a preference for paying up front than those at or below 100 percent of the FPL (86.2 percent versus 81.6 percent, respectively).

Table 6.5. Preferred Method of Contributing to Healthcare Costs

	All Respondents	≤ 100% FPL	> 100% FPL
Number of Members	16,830	11,477	5,353
Prefer paying up front (POWER account)	83.1%	81.6%	86.2%
Prefer paying each doctor visit	13%	15%	8.9%

	All Respondents	≤ 100% FPL	> 100% FPL
(copayments)			
Refused/Don't Know	3.9%	3.4%	4.9%

General Perception of the Size of the Monthly Contribution. In the survey samples, 84 percent of current HIP members and 82 percent of former HIP members contributed to their POWER accounts. Among those who made a monthly contribution to their HIP POWER accounts, approximately three quarters of current HIP members felt that their monthly contributions were "the right amount," and nearly 85 percent believed the amount was either right or below the right amount. Former HIP members had the same perception of the contributions they made while enrolled; 74 percent believed they were the right amount and 82 percent believed they were either the right amount or below the right amount. Compared to HIP members, former members were slightly more likely to report that their contributions had been too much, 17 percent compared to 14 percent. Members' perception of their contributions varied by income, but the variation was not consistent between current and former members. Current HIP members with incomes at or below 100 percent of FPL were the group most likely to report the monthly contribution was the right amount or too low (87 percent), whereas former HIP members with income at or below 100 percent of FPL were the least likely to report the amount was right or too low (79 percent). Those with income above 100 percent of FPL fell in between, with former HIP members in this income range more likely to report the monthly contribution was right or too low (84 percent) compared to current HIP members in the same income group (82 percent).

Table 6.6. Perception of Monthly Contributions (Weighted Data)

Perception of Monthly Contribution	All Respondents Who Made Monthly Contributions		≤100% FPL		> 100% FPL	
	Current Members	Former Members	Current Members	Former Members	Current Members	Former Members
Number of Members	14,126	3,295	9,059	1,468	5,067	1,361
Too much	14.3%	16.8%	11.9%	19.9%	18.6%	15.4%
The right amount	76.3%	73.5%	78.6%	71.9%	72.1%	74.4%
Below the right amount	8.6%	8.8%	8.2%	7.4%[b]	9.4%[b]	9.4%[b]
Don't know	0.4%[b]	0.7%[b]	0.7%[b]	0.5%[b]	0.0%[b]	0.9%[b]

Source: Mathematica analysis of 2013 survey of current and former HIP members.

Notes: Approximately 14.2 percent of respondents to the survey of former HIP members did not provide income information. These respondents are included in the "all respondents" column, but not in those containing income breakdowns. The source information for income varied by survey sample. For current HIP members, income information came from HIP administrative records and was therefore the income at the time of the member's last annual redetermination. Respondents to the survey of former HIP members were asked to report their income at the time of the survey, which was necessarily after they had disenrolled in HIP.

[b] These estimates may be unreliable because they are based on fewer than 30 respondents.

Worries About Ability to Pay the Monthly Contribution. Current and former HIP members reported similar rates of worrying about having enough money to pay their monthly contributions (Table 6.7). Approximately 81 percent reported that they sometimes, rarely or never were worried about having enough money to pay their monthly contribution. Conversely, 17 percent of current HIP members and 19 percent of former members reported that they "always" or "usually" worried about having enough money to pay their monthly contributions. Income appears to have an important association with this type of worry among former HIP members. The percentage of former HIP members who reported they sometimes, rarely, or never worried about their monthly contributions ranged from 75 percent among those with income at or below 100 percent of FPL to 85 percent among those with income above 100 percent of FPL. Current HIP members did not show the same level of variation in responses and income did not appear to have an important association.

Table 6.7. Worries About Paying Monthly Contributions Among Members Who Made Monthly Contributions (Weighted Data)

Frequency of Worrying About Paying Their Monthly Contribution	All Respondents Who Made Monthly Contributions		≤100% FPL		> 100% FPL	
	Current Members	Former Members	Current Members	Former Members	Current Members	Former Members
Number of Members	14,126	3,295	9,059	1,468	5,067	1,361
Always/Usually	17.3%	19.0%	16.8%	24.8%	18.2%	14.7%[b]
Sometimes	32.9%	32.0%	31.1%	34.1%	36.1%	29.6%
Rarely	18.9%	22.0%	19.0%	18.3%	18.9%	25.8%
Never	29.5%	27.0%	32.3%	22.8%	26.3%	29.9%
Don't know	0.7%[b]	0.0%[b]	0.9%[b]	0.0%[b]	0.4%[b]	0.0%[b]

Source: Mathematica analysis of 2013 survey of current and former HIP members.

Notes: Approximately 14.2 percent of respondents to the survey of former HIP members did not provide income information. These respondents are included in the "all respondents" column, but not in those containing income breakdowns. The source information for income varied by survey sample. For current HIP members, income information came from HIP administrative records and was therefore the income at the time of the member's last annual redetermination. Respondents to the survey of former HIP members were asked to report their income at the time of the survey, which was necessarily after they had disenrolled in HIP. The questions posed to current HIP members and former members varied slightly. Members were asked how often they were worried about having enough money to pay their monthly contributions over the last 12 months. Former members were asked how often they were worried about having enough money to pay their monthly contribution while they were enrolled in HIP.

[b] These estimates may be unreliable because they are based on fewer than 30 respondents.

Former members were also asked to report how often they had worried about their medical expenses at the time of the survey. Overall, 54 percent of former members reported "always" or "usually" worrying about their medical expenses, which was much higher than the 19 percent who reported that they had "always" or "usually" worried about their monthly payments (Table 6.8). While former members with incomes above 100 percent of FPL were more likely than those at or below the FPL to report "rarely" or "never" worrying about either monthly payments

or medical expenses, both groups reported worrying about current medical expenses more frequently than they had worried about their monthly payments.

Table 6.8. Former Members' Frequency of Worrying about Monthly Contribution and Medical Expenses (Weighted Data)

Frequency of Worrying About Payment/Expenses	All Respondents Who Made Monthly Contributions		≤ 100% FPL		> 100% FPL	
Number of Former Members	3,295		1,468		1,361	
	Monthly Payment	Medical Expenses	Monthly Payment	Medical Expenses	Monthly Payment	Medical Expenses
Always/usually	19%	51.1%	24.8%	54.6%	14.7%[b]	49.2%
Sometimes	32.0%	23.7%	34.1%	23.1%	29.6%	24.7%
Rarely/never	49.0%	22.6%	41.1%	19.1%	55.7%	24.7%
Don't Know	0.0%[b]	0.4%[b]	0.0%[b]	0.5%[b]	0.0%[b]	0.0%[b]

Source: Mathematica analysis of 2013 survey of former HIP members.

Note: 14.2 percent of former members did not provide income information. They are included in the "all respondents" category but not in the categories providing income breakdowns. 2.9 percent of respondents who made monthly contributions did not provide information on their frequency of worrying about medical expenses.

[b] These estimates may be unreliable because they are based on fewer than 30 respondents.

At the time of the survey, over half of former members said that they were currently uninsured, while 22 percent had gained public insurance through Medicare or Medicaid and 20 percent had gained private insurance through an employer or by purchasing an individual policy (Table 6.8). Individuals reporting income at or below 100 percent FPL at the time of the survey were more likely to have public insurance than private (27 percent versus 12 percent). Of those reporting income greater than 100 percent FPL, 13 percent reported having public insurance coverage, while 31 percent had private coverage. Former HIP members who were uninsured at the time of the survey were more than twice as likely as those with public or private insurance to say that they "always" worried about medical expenses. Uninsured former members below the FPL were more likely than those above the FPL to say they were "always" or "usually" worried about their medical expenses (74 percent versus 67 percent). Though the uninsured worried about medical expenses at far higher rates than those with insurance, individuals with public insurance were more likely than those with private insurance to say that they "rarely" or "never" worried about their medical expenses. Though higher-income individuals appear to worry less often about medical expenses than those with income at or below 100 percent FPL, the number of individuals in each income group is too small to provide reliable data.

Table 6.9: Former Members' Frequency of Worrying about Medical Expenses by Insurance Status (Weighted Data)

Frequency of Worrying About Medical Expenses	All Respondents			≤ 100% FPL			> 100% FPL		
	Uninsured	Public	Private	Uninsured	Public	Private	Uninsured	Public	Private

Number of Members	2,230	870	809	1,054	491	220	836	211	496
Always/Usually	69.4%	32.5%	35.7%	74.0%	35.6%	34.8%[b]	67.1%	27.8%[b]	33.5%[b]
Sometimes	15.5%	30.3%	34.0%	12.7%[b]	29.6%[b]	45.8%[b]	18.0%[b]	34.2%[b]	30.8%[b]
Rarely/never	10.5%	37.2%	30.3%	8.8%[b]	34.9%	19.5%[b]	12.8%[b]	38.0%[b]	35.7%[b]
Don't know	0.7%[b]	0.0%[b]	0.0%[b]	0.8%[b]	0.0%[b]	0.0%[b]	0.0%[b]	0.0%[b]	0.0%[b]

Source: Mathematica analysis of 2013 survey of former HIP members.

Note: 14.2 percent of former members did not provide income information. They are included in the "all respondents" category but not in the categories providing income breakdowns.

[b] These estimates may be unreliable because they are based on fewer than 30 respondents.

Willingness to Pay a Higher Monthly Contribution. Current HIP members were overwhelmingly willing to pay more each month to remain enrolled in HIP (Table 6.10). Among those currently making monthly contributions, nearly 94 percent are willing to pay $5 more each month and 88 percent are willing to pay $10 more to remain enrolled in HIP. Among those members who were not making monthly contributions, 82 percent reported that they would be willing to pay $5 each month for HIP coverage, while 75 percent said they would be willing to pay $10 each month. Willingness to pay more was fairly consistent between income groups.

Table 6.10. Member Willingness to Contribute More (Weighted Data)

Willingness to Contribute More	All Respondents		≤100% FPL		> 100% FPL	
	Current Contributors	Current Non-Contributors	Current Contributors	Current Non-Contributors	Current Contributors	Current Non-Contributors
Number of Members	14,126	2,643	9,059	2,378	5,067	266
Would pay $5 more	93.5%	81.7%	93.0%	81.4%	94.5%	85.0%[b]
Would pay $10 more	88.1%	75.0%	87.7%	74.8%	88.6%	77.2%[b]

Source: Mathematica analysis of 2013 survey of current and former HIP members.
Notes: Former members were not asked whether they would have paid more to remain in the program.

[b] These estimates may be unreliable because they are based on less than 30 respondents.

Program Costs and Disenrollment. Among those surveyed members who disenrolled from HIP within the past year, program costs were only cited by 14 percent as the reasons for disenrolling (Table 6.11). More commonly, former members indicated they did not follow the requirements necessary to redetermine their eligibility (28 percent) or obtained other insurance (14 percent obtained other public insurance such as regular Medicaid or Medicare and 12 percent obtained private coverage). Twelve percent disenrolled specifically because they forgot to pay their monthly contribution (data not shown and subsumed in the group that did not follow the requirements necessary to redetermine eligibility).

Some variation by income was observed, with 19 percent of former members at or under 100 percent FPL reporting that they left due to cost, compared with 9 percent among those above 100 percent of FPL (Table 6.11). In addition, former members at or under 100 percent FPL were disproportionately more likely to have left because they gained other public insurance (Medicare or Medicaid), while those above 100 percent FPL were disproportionately more likely to have gained private insurance.

Table 6.11. Former Members' Reasons for Disenrolling from HIP (Weighted Data)

Reason for Leaving HIP	All Respondents	≤ 100% FPL	> 100% FPL
Number of Members	4,049	1,836	1,594
Cost too much	14.2%	19.0%	8.8%[b]
Didn't complete paperwork in time/Forgot to re-enroll/Forgot monthly payment	28.3%	30.7%	27.3%
Process issue	8.6%	9.3%[b]	6.6%[b]
Gained other public insurance	13.5%	16.5%	8.7%[b]
Gained private insurance	12.3%	7.8%[b]	18.8%
Reported other unspecified insurance	7.3%	8.1%[b]	7.3%[b]
Increase in income	10.1%	5.7%[b]	16.1%
Other	10.9%	9.9%[b]	9.9%[b]

Source: Mathematica analysis of 2013 survey of former HIP members.

Note: Respondents had the option to select more than one reason for disenrolling in HIP. 14.2 percent of former members did not provide income information. They are included in the "all respondents" category but not in the categories providing income breakdowns. Former members were asked to report their income at the time of the survey, which was necessarily after they had disenrolled in HIP.

[b] These estimates may be unreliable because they are based on fewer than 30 respondents.

2. Costs as a Barrier to Care.

Members were also asked about the frequency with which they had needed medical care in the last six months, but had decided not to seek it. Only 12 percent of members reported at least one instance where they decided not to seek care despite needing it (data not shown). Respondents had varied reasons for not seeking care, but cost was not a major factor, with only 6 individuals reporting cost as the reason.

3. Emergency Room Copayments

Current HIP ER co-payments range from $3 to $25, depending on caretaker status and income. Overall, 72 percent of members never utilized the ER during the past six months (Table 6.12). Of the 28 percent of members who went to the ER at least once in this time frame, 60 percent

reported that they were never asked to pay a copayment, while 28 percent said that they were asked to pay each time. Of the members who were asked to pay a copayment, 79 percent reporting being able to pay it. While this ability appeared to vary by income (with more individuals at or below 100 percent FPL reporting an inability to pay the copay), the number of individuals asked to pay a copay was extremely small, and when this group was further broken down by income, the number of individuals in each category became too small to produce reliable estimates. Survey respondents were also asked whether the ER copayment policy ever caused them to decide not to go to the emergency room. Less than seven percent of members reported that they avoided the ER because of the copayment (data not shown).

Table 6.12. Emergency Room Copayments and Current Members' Use of the Emergency Room (Weighted Data)

ER Copayment and usage	Respondents
Total number	16,830
Percent of members who went to ER in past 6 months	27.8%
Of Members Who Decided Not to Go to ER Because of the Copayment	
Number	1,093
Got care someplace else	39.7%[b]
Did not get care	60.3%
Of members who went to ER in past 6 months:	
Number	4,670
Asked to pay a co-pay every time	27.9%
Sometimes asked to a pay a co-pay	5.0%[b]
Never asked to pay a co-pay	59.5%
Admitted to hospital each time	5.0%[b]
Don't know	2.6%[b]
Of members asked to a make a co-pay:	
Number	1,537
Able to pay it	78.8%
Not able to pay it	21.2%[b]
Don't know	0.0%[b]

Source: Mathematica analysis of 2013 survey of current HIP members.

[b] These estimates may be unreliable because they are based on fewer than 30 respondents.

When asked their thoughts on paying a $25 co-payment to go to the emergency room, the majority of non-caretaker, current members (68 percent) reported that it would be the right amount or below the right amount, while approximately a third (31 percent) said that it would be too much (Table 6.13). This perception varied by income, with 36 percent of members at or under 100 percent FPL saying this would be too much, compared to 22 percent of members above 100 percent FPL.

Table 6.13. Perception of $25 Copayment, By Income (Weighted Data)

Perception of a $25 ER Copayment	All Respondents	≤ 100% FPL	> 100% FPL

Number of Members	16,830	11,477	5,353
Too much	31.4%	35.7%	22.3%
The right amount	62.6%	58.3%	71.8%
Below the right amount	5.0%	4.9%	5.2%[b]
Don't know	0.9%[b]	1.0%[b]	0.7%[b]

Source: Mathematica analysis of 2013 survey of current HIP members.

[b] These estimates may be unreliable because they are based on fewer than 30 respondents.

6.3 GOAL III – PROMOTE VALUE-BASED DECISION-MAKING AND PERSONAL HEALTH RESPONSIBILITY

HIP employs a number of financial incentives in an effort 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 contributions to their POWER accounts.

To assess the goal of value-based decision-making, the 2013 survey asked current and former HIP members about their knowledge of HIP program policies and incentives. The survey sought to assess whether members were knowledgeable about (1) the POWER account feature; (2) the status of their own POWER account; (3) incentives built into the program to encourage preventive care, such as rollovers; and (4) incentives built into the program to discourage non-emergent use of the ER. Key findings include:

- Most HIP members had heard of the POWER account, and many check the balance in their account at least monthly.

- More education is likely necessary to ensure that HIP members fully understand the link from securing preventive care to receiving a rollover to benefiting from reduced monthly contributions.

- Most respondents were aware of the required ER copayment. However, of the respondents who utilized the ER, the majority were not asked to make a copayment.

A. POWER ACCOUNT CONTRIBUTIONS

In 2012, about 77 percent of those eligible for HIP were required to make contributions to their POWER account.[14] This rate has increased since 2008, when 65 percent of members were required to make a contribution.

[14] The percentage of HIP members required to make a monthly contribution is somewhat higher than the percentage that actually make the contribution. MHS reports that while the majority of its members are required to pay a monthly contribution, they waive the payment if the monthly contribution is less than a dollar each month due to the administrative costs associated with collecting and monitoring these payments.

Employers may pay for a portion of the employees' monthly contributions. Health plans provide information for members to give their employers about their ability to provide HIP subsidies for employers; however, few have taken up this option. As of December 2012, 34 employers had contributed $10,834.90 on behalf of 38 Anthem members, for an average employee contribution of $285.13. MDwise had seven employers contribute $4,822.20 to POWER accounts for nine HIP members for an average employer contribution of $535.80. MHS received $2,523.55 from five employers for six members, for an average employee contribution of $420.59.

Mathematica's 2013 survey of current members asked respondents about their experiences requesting employer assistance with the monthly contributions. Forty-one percent of currently employed members reported that they were aware that employers could help to pay their monthly contributions (Table 6.14). Among those aware of the employer option, 83 percent of members with incomes at or below the FPL and 67 percent with incomes above the FPL reported that they had not asked their employers for assistance. Across income groups, the most popular reason for not asking was that members were confident that their employers would say no. Of the members who asked their employers for assistance, 92 percent reported that their employers had said no. However, the number of individuals who chose to ask their employers is too small to provide reliable information.

Table 6.14. Member Experiences Requesting Employer Assistance With Monthly Contributions (Weighted Data)

Member Experiences with Employer Assistance	Currently Employed Respondents	≤100% FPL	>100% FPL
Number of members	5,500	3,222	2,279
Aware that employers could help pay monthly contribution			
Yes	41.0%	40.3%	42.0%
No	53.6%	53.6%	53.7%
Don't Know	1.5%	1.8%	0.9%
Of those aware:			
Number	2,254	1,297	957
Have asked employer to help pay monthly contribution			
Yes	23.1%[b]	17.4%[b]	30.9%[b]
No	76.0%	82.6%	66.9%
Don't Know	0.0%[b]	0.0%[b]	0.0%[b]
Of those who asked:			
Number	521	226	296
Employer response:			
Agreed to pay all of contribution	8.0%[b]	9.3%[b]	7.1%[b]
Agreed to pay part of contribution	0.0%[b]	0.0%[b]	0.0%[b]
Did not agree to contribute	92.0%[b]	90.8%[b]	92.9%[b]
Still deciding	0.0%[b]	0.0%[b]	0.0%[b]
Other	0.0%[b]	0.0%[b]	0.0%[b]
Don't Know	0.0%[b]	0.0%[b]	0.0%[b]

Member Experiences with Employer Assistance	Currently Employed Respondents	≤100% FPL	>100% FPL
Of those who did not ask:			
Number	1,712	1,071	641
Reason for not asking[a]:			
Didn't know who to ask	2.4%[b]	3.9%[b]	0.0%[b]
Afraid of losing my job/Asking may jeopardize my job	9.2%[b]	9.2%[b]	9.2%[b]
Confident my employer would say no	40.0%	33.4%[b]	50.9%[b]
Didn't want employer to know I'm on HIP	3.4%[b]	3.7%[b]	3.0%[b]
Felt like I was asking for a favor	4.7%[b]	5.7%[b]	3.0%[b]
Other	2.3%[b]	1.8%[b]	3.3%[b]
Don't know	7.2%[b]	7.2%[b]	0.0%[b]

Source: Mathematica 2013 survey of current HIP members.

[a] Members were allowed to select more than one reason for not asking their employer.

[b] These estimates may be unreliable because they are based on fewer than 30 respondents.

B. HIP DISENROLLMENTS

HIP uses the POWER account to promote value-based decision making and personal health responsibility among its members. Of the 126,607 Hoosiers found eligible for HIP over the five-year demonstration, 105,197 individuals (83 percent) made their first POWER account payment and fully enrolled in the program (Table 6.15), while 21,472 individuals (17 percent of those otherwise found eligible) did not. Those with incomes at or below 100 percent of the FPL were most likely not to make an initial contribution—69 percent of the initial non-contributors were at or below the poverty level.

Over the five year- period, 12,490 HIP members (12 percent of those ever fully enrolled) left the program for failure to make a subsequent POWER account contribution. The majority of those who disenrolled due to a failure to make a subsequent contribution were also at or below 100 percent of poverty (57.5 percent).

Table 6.15. Summary of Denials and Disenrollments Associated with Monthly Contributions

Types of Denials or Disenrollments	2008-2012
Number determined eligible for HIP	126,669
Number ever enrolled in HIP	105,197
Percent of those found eligible who enrolled	83%
Number who left HIP for failure to make a subsequent POWER account contribution	12,490
Percentage of those ever enrolled who left HIP for failure to make a subsequent POWER account contribution	10%
Percentage of those who disenrolled who left HIP for failure to make a subsequent POWER account contribution	10%

Source: OMPP analysis of HIP eligibility records extracted from MedInsight; OMPP data request number 7527, June 3, 2010; OMPP data request number 7939, April 3, 2011; OMPP data request 8790, October 18, 2012, OMPP data request number 9515, April 25, 2013.

In 2012, most HIP disenrollments (31.8 percent) occurred after a member did not return his or her HIP re-determination packet. The failure to make a POWER account payment accounted for the second largest number of HIP individual accounts closed during 2012, with 3,924 members (28.3 percent of total disenrollment) failing to make a subsequent POWER account payment.

Table 6.16. Top Five Types of HIP Member Counts Closed in CY 2012

Member Count	Closed Reason
13,887	Total
4,415	HIP redetermination packet not returned
3,924	Failure to make POWER Account payment
2,658	Closed due to Appeals ruling
1,805	Other current health insurance
1,085	Did not verify income

Source: OMPP data request number 9515 April 23, 2013

C. POWER ACCOUNT ROLLOVERS

The majority of HIP members who were involved in the POWER account rollover process during calendar year 2012 did not have an account balance left after 12 months (they exhausted their POWER accounts over the course of the year), which is a reflection of high level of chronic disease burden in the HIP population. Of those who did have a balance, the majority received a partial rollover (their own contributions were rolled over, but not the State's). A full rollover (member contributions plus those of the state) is received if the members meet the preventive care receipt requirement. The members who do not spend down their POWER accounts (have a balance left at the end of 12 months) may be healthier than those who do, so the observed lower rate of preventive care receipt might be due to a perception of lack of need. The MCEs continue to work to promote the preventive care incentive and develop member awareness and understanding of how the POWER account works. By the end of 2012, just over one-third of POWER accounts eligible for a rollover over the course of the demonstration contained any funds to carry forward after 18 months of enrollment. Of the accounts with a remaining balance, about 65 percent received partial rollovers and about 35 percent received full rollovers.

D. MEMBER KNOWLEDGE OF POWER ACCOUNTS

The POWER account is structured to incentivize the use of preventive services among HIP members because they can reduce their future monthly contributions if they obtain appropriate preventive services, available at no cost. Members who do not use their entire POWER accounts during the course of a year will have the remainder of the account "rolled over" to the next year.

State subsidies are also rolled over, as long as members have met their preventive services requirements. The amount rolled over is then used to reduce the member's future monthly contributions.

For the incentive structure to work as intended, members must understand the POWER account and the program's mechanisms for reducing their monthly contribution. Maximus, the state's enrollment broker, strives to explain the HIP program and POWER account to enrollees. However, the health plans noted that new members continue to have many questions after enrolling in HIP.

Mathematica's 2013 survey evaluated the extent to which current and former HIP members understood the POWER accounts and the HIP program incentives. Key findings include:

- More than three-quarters of current members had heard of the POWER account.
- Among current members, nearly 60 percent reported checking their POWER account at least monthly.
- More education is needed for members to fully understand program incentives. Most members believed that the cost of preventive screenings would be deducted from their POWER accounts, and many appeared unaware of the connection between the receipt of preventive services and POWER account rollovers.

Familiarity with the POWER Account. Familiarity with the POWER account was high among survey respondents. Three-quarters (77 percent) of current HIP members reported that they had heard about the POWER account (Table 6.17). This rate was slightly lower among former members (67 percent). When asked how they had learned about the POWER account, current and former members offered similar answers. The most common methods for learning about the account included the member handbook and "the health plan," though smaller percentages said they had learned about it through the HIP Web site or because "someone from the plan had called them to explain."

Table 6.17. Knowledge of POWER Account (Weighted Data)

POWER Account knowledge	Current HIP Members	Former HIP Members
Number of Members	16,830	4,048
Had ever heard or learned about the POWER Account		
Yes	76.5%	67.0%
No	22.1%	27.2%
Don't Know	1.4%	5.8%
Of those who had heard of the POWER account:		
Number	12,875	2,714
Methods of learning about the POWER account[a]		
Member handbook	44.2%	44.0%
Someone from the plan called to explain	14.4%	16.5%
HIP Web site	12.4%	9.6%
Health plan	40.5%	40.2%

POWER Account knowledge	Current HIP Members	Former HIP Members
Medical provider	4.7%	4.8%[b]
Family/Friends	6.6%	3.6%[b]
None of these	7.0%	6.4%[b]
Don't know	1.3%[b]	1.6%[b]

Source: Mathematica analysis of 2013 survey of current and former HIP members.

[a]Respondents were allowed to select more than one method they used to learn about the POWER Account.

[b] These estimates may be unreliable because they are based on fewer than 30 respondents.

Knowledge of POWER Account Balance. Three quarters of current HIP members had heard of the POWER account, while nearly 60 percent of these respondents checked their account balance at least monthly (Table 6.18). Forty-seven percent reported an account balance at or below $1,100, while the remainder said they either did not know their balance, or reported an amount above $1,100 (the maximum amount for a POWER account).

Table 6.18. Knowledge of POWER Account Balance Among Current Members (Weighted Data)

Knowledge of POWER Account Balance	All Respondents Who Had Heard of POWER Account	≤100% FPL	> 100% FPL
Number of Members	12,875	8,837	4,038
Frequency with which member checks POWER account balance			
Weekly	0.6%[b]	0.9%[b]	0.0%[b]
A few times a month	2.8%[b]	2.9%[b]	2.4%[b]
Monthly	54.9%	53.5%	57.9%
A few times a year, not every month	13.3%	12.3%	15.4%
Once a year	5.3%	5.3%[b]	5.4%[b]
Never	21.1%	23.0%	16.9%
Don't know	1.9%[b]	1.8%[b]	2.0%[b]
Reported a plausible POWER account balance	47.1%	46.3%	49.0%

Source: Mathematica analysis of 2013 survey of current HIP members.

[b] These estimates may be unreliable because they are based on fewer than 30 respondents.

Knowledge of POWER Account Rollovers. Forty eight percent of current members who had heard about the POWER accounts reported that they had funds left over in their POWER Account at their last HIP renewal date, which would have made them eligible for a rollover (data not shown). About 22 percent had exhausted their POWER account and did not have any funds to roll over and thirty percent of members did not know if they had funds left in their account at the last renewal date. Because so many of those who did not know may have only recently renewed their coverage at the time of survey, this section assesses respondent's history of POWER account rollovers over their entire membership in the program.

When members who had heard about the POWER accounts were asked specifically if they had ever received a rollover during their HIP membership, 39 percent reported that they had, one-third said they had not, and 28 percent did not know (Table 6.19). Current members were more likely to report receiving a rollover compared to former members (39 percent compared to 24 percent) and members in the higher income group were more likely to receive a rollover than those in the lower income group (among current members it was a 3 percentage point difference between the two income groups compared to a 5 percentage point difference among former members).

Table 6.19. Knowledge of Effect of Rollover on Monthly Contributions, Among Current and Former Members (Weighted Data)

	Current Members Who Had Heard of the POWER Account			Former Members Who Had Heard of the POWER Account		
Knowledge/Effects of Rollover Policies	All	≤100% FPL	> 100% FPL	All	≤100% FPL	> 100% FPL
Number of Members	12,875	8,837	4,038	2,731	1,151	1,160
Ever received a rollover						
Yes	39.2%	38.1%	41.4%	24.1%	22.8%	28.3%
No	32.1%	32.7%	31.4%	60.1%	59.6%	58.9%
Don't know	28.4%	29.2%	26.7%	15.0%	17.7%[b]	12.0%[b]
Of those reporting a rollover:						
Number	5,043	3,370	1,673	537	207	282
Rollover affected size of monthly contributions						
Yes	37.3%	30.6%	50.7%	34.8%	34.9%[b]	38.5%[b]
No	50.3%	55.6%	39.7%	58.9%	61.8%[b]	57.6%[b]
Don't Know	12.4%	13.8%[b]	9.6%[b]	6.3%[b]	3.3%[b]	3.9%[b]
Of those who knew that rollover affected size of monthly contributions:						
Number	1,879	1,032	848	187	72	109
Monthly contributions went down	41.5%	40.1%[b]	43.2%[b]	64.3%[b]	93.0%[b]	48.8%[b]
No longer had to pay	45.0%	41.2%[b]	50.0%[b]	29.7%[b]	7.0%[b]	41.0%[b]
Monthly contributions went up/ Did not know	13.5%[b]	18.7%[b]	7.2%[b]	5.9%[b]	0.0%[b]	10.2%[b]

Source: Mathematica analysis of 2013 survey of current HIP members.

[b] These estimates may be unreliable because they are based on fewer than 30 respondents.

Understanding of Relationship Between Rollovers and Monthly Contributions. Whether a current member remembered that his or her POWER account rollover affected the size of subsequent monthly contribution was closely related to their income. Overall, half of current members who reported receiving a rollover reported the rollover did not affect their monthly contribution, while 12 percent were not sure whether the rollover had affected their contribution (Table 6.19). However, members with income above 100 percent FPL were significantly more

likely than those at or below poverty to report that their rollover had affected their monthly contribution (51 percent versus 31 percent, with a p value of .0018).

Of those current members who knew that their rollover had affected their monthly contribution, most (87 percent) reported that their contribution had been reduced or had been eliminated completely. The rest either did not know how their monthly contribution was affected or reported that their monthly contribution increased as a result of the rollover.

Knowledge of Preventive Services Incentive. The survey data suggest that most current members may not be aware of the HIP policy that would allow them to get no-cost preventive care, but the results are difficult to interpret. This policy, designed to provide a financial incentive for members to obtain preventive services, allows members to obtain preventive services without having the cost deducted from their POWER accounts. When members were asked if they thought "the cost of preventive services like annual exams" would be deducted from their POWER account, 71 percent of members believed they would be deducted (Table 6.20). A similar proportion also thought that "the cost of preventive services like cancer screenings" would be deducted from the account.

Table 6.20. Current Member Knowledge of Preventive Services Policies (Weighted Data)

Knowledge of Preventive Services Policies	All Respondents Who Had Heard of POWER Account	≤100% FPL	> 100% FPL
Number of members	12,875	8,837	4,038
Believe cost of preventive services like annual exams would be deducted from POWER account	71.3%	71.1%	71.6%
Believe cost of preventive services like cancer screening would be deducted from POWER account	72.6%	73.1%	71.3%

Source: Mathematica analysis of 2013 survey of current HIP members.

However, HIP allows the health plans to place a $500 cap on the amount of no-cost preventive services members can obtain. To date, only Anthem has imposed this cap, so members of this plan may be aware of this limit. A breakdown of results by health plans reveals that Anthem members were slightly more likely than MDwise members to believe that the cost of preventive services would be deducted from their accounts (Table 6.21). The number of MHS members in the sample was too small to draw conclusions, though they appeared to be the least likely to believe the cost of preventive exams would be deducted from their POWER accounts.

Table 6.21. Current Member Knowledge of Preventive Services Policies, By Plan (Weighted Data)

Knowledge of Preventive Services Policies, Among Those Who Had Heard of POWER Account	Anthem			MDwise			MHS		
	All	≤100% FPL	>100% FPL	All	≤100% FPL	>100% FPL	All	≤100% FPL	>100% FPL
Total Number	8,998	5,993	3,005	2,803	2,060	743	273	233	40
Believe cost of preventive services like annual exams would be deducted from POWER account	72.4%	72.9%	71.2%	68.7%	67.3%	72.7%[b]	56.9%[b]	49.6%[b]	100.0%[b]
Believe cost of preventive services like cancer screening would be deducted from POWER account	75.0%	77.5%	70.0%	68.0%	66.3%	72.7%[b]	63.9%[b]	57.7%[b]	100.0%[b]

Source: Mathematica analysis of 2013 survey of current HIP members.

[b] These estimates may be unreliable because they are based on fewer than 30 respondents.

Knowledge of Connection Between Preventive Care and Reduction of Monthly Contributions. The knowledge of current HIP members and their understanding of the link between preventive care receipt and POWER account rollovers and the reduction of their monthly contribution is mixed (Table 6.22). When those who had heard about the POWER account were asked how the receipt of preventive care services affected the POWER account rollover, if there was money to rollover to the next year, approximately one-quarter reported that getting preventive services would qualify them for a rollover. More than half indicated that they were not sure how preventive services affected the rollover, while 14 percent thought that preventive services did not affect the rollover.

Table 6.22. Knowledge and Effects of Connection Between Preventive Care and Rollover Receipt Among Current Members Who Had Heard of POWER Account (Weighted Data)

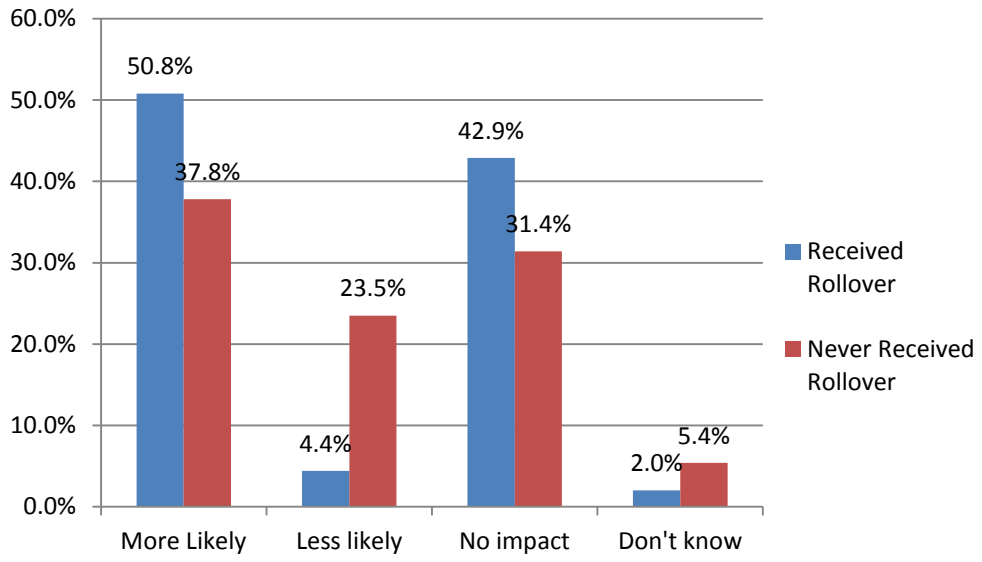
Knowledge/Effects of Rollover Policies	Current Members Who Have Heard of the POWER Account	≤100% FPL	> 100% FPL
Number of members	12,875	8,837	4,038
Understanding of relationship between preventive services and rollover			
Know that preventive services affect POWER account rollover	26.3%	24.4%	30.3%
Not sure how preventive services affect POWER account rollover	53.6%	53.8%	53.5%
Believe preventive services do not affect POWER account rollover	13.7%	14.1%	13.7%[b]
Don't know	6.1%	7.5%	3.0%[b]

Source: Mathematica analysis of 2013 survey of current HIP members.

[b] These estimates may be unreliable because they are based on fewer than 30 respondents.

Among the 39 percent of current members who had experienced a POWER account rollover, about half reported that the rollover had made them more likely to get preventive care and 43 percent reported that it had no effect on their decision to obtain preventive care. Notably, very few members reported that receiving a rollover would make them less likely to get preventive care in the future. Members who reported never having received a rollover were split on whether the experience of not receiving a rollover would incentivize them to get preventive care in the future. Approximately 38 percent reported that not receiving a rollover had made them more likely to get preventive care in the future (Figure 6.5). About one quarter of these individuals reported that the experience of not receiving a rollover would make them less likely to get care in the future, while nearly a third reported it would have no effect. Within this group of member who had never received a rollover, some differences by income were apparent, but the sample sizes are too small for reliable estimates.

Figure 6.5: Likelihood of Seeking Preventive Care by Receipt of a POWER Account Rollover (Weighted Data)



Source: Mathematica analysis of 2013 survey of current HIP members.

Note: The sample of respondents reporting receipt of a rollover represents 5,043 current HIP members and the sample who did not receive a rollover represents 4,157 current HIP members. The estimates for the group that received a rollover and reported that the rollover made them less likely to seek preventive care and those responding they did not know how the rollover affected their likelihood of seeking preventive care may be unreliable because the information is based on less than 30 respondents.

E. EMERGENCY ROOM USAGE

The HIP program requires copayments for non-emergency use of the emergency room. This policy is intended to encourage appropriate utilization of primary care and discourage

inappropriate and costly ER use. In 2012, these co-payments varied from $3 to $25 depending on an individual's caretaker status and his or her federal poverty level (FPL). ER co-payments cannot be deducted from the member's POWER account and must be paid out-of-pocket. Additionally, individuals are provided with Explanations of Benefits for all healthcare services, including ER visits, which increase member awareness of the cost of services.

1. Emergency Room Usage in 2012: Administrative Data

According to 2012 claims data, the top reasons for ER visits were fairly similar across the three MCE's, with abdominal pain, chest, pain, and backache/lumbago emerging as some of the most common (Table 6.23).

Table 6.23. Top 5 Reasons for ER Visits, by Managed Care Entity

Anthem	MDwise	MHS
Abdominal pain	Chest pain, unspecified	Chest pain, unspecified
Chest pain	Abdominal pain, other specified site	Abdominal pain, unspecified site
Backache/lumbago/sciatica	Abdominal pain, unspecified site	Headache
Upper respiratory infection/Bronchitis	Headache	Abdominal pain, other specified site
Pain in limbs or joints	Lumbago	Lumbago

Source: Anthem, MDwise, and MHS.

During 2012, 17,584 unique HIP beneficiaries made one or more trips to the emergency room (32 percent of total enrollees). This figure includes ESP (Enhanced Service Plan) HIP members. ESP is comprised of individuals with the highest risk in the HIP population and was designed to lower health plan risk and reduce capitation rates. Members have high-risk conditions (such as cancer, HIV/AIDs, and hemophilia), or have had an organ transplant or are on the waiting list, and tend to incur high healthcare costs. In contrast, 38 percent of adult Hoosier Healthwise (HHW) members (pregnant women and low-income parents) visited the ER at least once in 2012. HHW members are not required to make co-payments for inappropriate ER use, which may partially explain the overall lower rate of ER use among HIP members.

Table 6.24 illustrates the total number of HIP and HHW member visits to the ER. During CY 2012, HIP members had fewer emergency room visits per 1,000 members than HHW adult members. Additionally, HIP members who were required to make contributions to their POWER accounts visited the ER at a lower rate than those who were not required to make contributions, ESP members, and Hoosier Healthwise members. HIP ESP members likely use the ER at higher rates due to their high-risk conditions.

Table 6.24. Adult Emergency Room Visits, HIP and Hoosier Healthwise, 2012

	Healthy Indiana Plan-ESP	Healthy Indiana Plan-Contributors	Healthy Indiana Plan Non-Contributors	Hoosier Healthwise

Total Members in 2012	2,239	41,329	12,129	203,859
Total number of unique individuals who visited the ER in 2012	992	12,041	4,551	78,194
Percent of unique enrollees who visited the ER in 2012	44%	29%	38%	38%
Total Number of ER Visits, 2012	2,693	22,991	10,541	188,294
Average Visits per Unique Recipient*	2.7	1.9	2.3	2.4
Total Number of Member Months of Enrollment	21,770	360,059	113,174	1,436,641
Average Enrollment (Member months/12)	1,814	30,005	9,431	119,720
Average Number of Months Enrolled	9.7	8.7	9.3	7
Annual Emergency Room Visits per 1,000 members	1,484	766	1,118	1,573

Source: Milliman analysis of 2012 claims, November 2013
*Of those who visited the ER in 2012

2. Emergency Room Usage, As Reported By Members

Among the respondents to the 2013 survey of current HIP members, twenty-eight percent reported that they had made at least one trip to the ER in the six months prior to the survey (Table 6.25). Of those who used the ER, eight percent reported that they had tried to make an appointment with a doctor or clinic, but had not been able to get one fast enough, and chose to go to the ER instead (data not shown). However, the majority of ER care-seekers were not high-frequency users. Of those who used the emergency room, the majority (64 percent) made only one trip, with 22 percent reporting two trips, and only 14 percent reporting three or more trips (Table 6.25).

Table 6.25. Use of Emergency Room In the Past Six Months, Among Current Members (Weighted Data)

Access to ER Care	All Respondents	≤100% FPL	> 100% FPL
Number of members	16,830	11,477	5,353
Percent of members who went to ER in past 6 months	27.8%	27.8%	27.8%
Of those who went to ER in past six months:			

Access to ER Care	All Respondents	≤100% FPL	> 100% FPL
Number	4,670	3,455	1,215
Number of trips made:			
1 trip	64.4%	62.6%	69.5%
2 trips	21.7%	23.9%	16.2%
3 or more trips	13.7%	13.5%	14.3%
Don't know	0.8%	0.0%	1.1%
Number of times admitted to hospital after going to ER			
0 times	72.9%	74.7%	67.9%
1 time	22.1%	20.3%	27.4%
2 or more times	5.0%	5.0%	4.7$
Don't know	0.0%	0.0%	0.0%

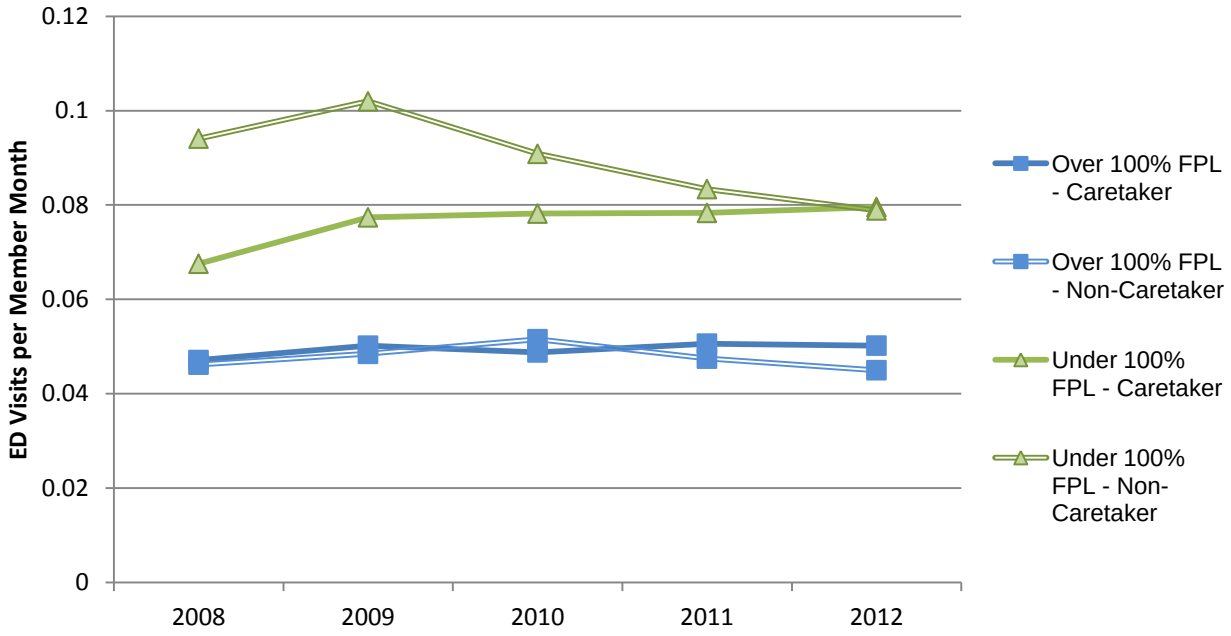
Source: Mathematica analysis of 2013 survey of HIP members.

[b] These estimates may be unreliable because they are based on fewer than 30 respondents.

4. Self-Reported ER usage trends

Although trends in ER use have been relatively steady throughout the demonstration, several aspects of these trends are notable. As Figure 6.6 indicates, ER utilization rates appear to be associated with income and those in the higher income group consistently throughout the five years of the HIP program used the ER at a lower rate than those in the lower income group. We also see that during the first three years, from 2008 through 2010, the non-caretakers with income at or below 100 percent of FPL first increased and then decreased their use of the ER, eventually having a similar ER use rate as caretakers in the same income group. These data are unadjusted and we cannot rule out the possibility that the changes over time or the differences seen across the different groups are related to differences in case mix; they could also be related to program design and the copay requirements for non-caretakers. These data also do not distinguish between emergent and non-emergent visits and we cannot tell whether the changes are due to changes in non-emergent visits.

Figure 6.6 Rate of Emergency Room Visits Per Member Per Month, 2008 through 2012 (self-reported)



Source: Mathematica analysis of 2013 survey of HIP members.

5. HIP Strategies for Reducing ER Use for Non-Emergent Care: Copayments

In an effort to discourage non-emergent use of the ER and encourage members to seek care from a doctor or clinic, HIP asks members to make a copayment each time they seek care in the emergency room. This copayment is then refunded to caretaker adult HIP members if the visit was later determined to be a true emergency (non-caretakers must make the copay in any case). The majority of respondents (68 percent) reported that they had been informed about the copayment by their health plan, and 5 percent indicated that the copayment had caused them to wait to seek care from a doctor or clinic instead of using the ER (Table 6.26).[15]

[15] Respondents to the 2013 survey of current HIP members were asked the following question, "Has the emergency room co-payment ever caused you to wait to get care from a doctor's office or clinic instead of going to the emergency room?"

Table 6.26. Effect of ER Copayments On Care-Seeking Behavior

Effect of ER Copayments	Total	≤100% FPL	> 100% FPL
Number of members	16,830	11,477	5,353
Percent informed by health plan about ER copayment	67.7%	65.9%	71.6%
Of those informed about copayment:			
Number	11,395	7,561	3,834
ER co-payment caused member to wait to get care from doctor or clinic instead of using ER			
Yes	5.4%	6.0%	4.0%
No	92.7%	92.4%	93.3%
Don't know	1.4%	1.2%	2.0%

Source: Mathematic analysis of 2013 survey of HIP members.

[b] These estimates may be unreliable because they are based on fewer than 30 respondents.

Although representatives from Anthem assumed that hospitals regularly collect HIP co-pays, MHS and MDwise staff expressed uncertainty about whether hospitals chose to collect them, due to the administrative burden of collecting small co-payments. Plans also noted the difficulty inherent in refunding copayments after ER visits were determined to be true emergencies. Overall, about one-third of current HIP members reported they were sometimes or always asked to pay the ER copayment and two-thirds were never asked (Table 6.27). The data do not suggest that Anthem members were more likely to be asked to pay the ER copayment relative to members in other plans, but the information is unreliable due to small samples at the plan level.

Table 6.27. Incidence of Requested ER Copayments, By Health Plan (Weighted Data)

Requested to Pay ER Copayment	Total	Anthem	MDwise	MHS
Total Number of Members	4,670	3,194	1,029	57
Sometimes or always asked to make ER copayment	32.9%	34.5%	26.9%[b]	33.3%[b]
Never asked to make ER copayment	64.5%	63.6%	67.2%	66.7%[b]
Don't Know	2.6%[b]	1.9%[b]	5.9%[b]	0.0%[b]

Source: Mathematic analysis of 2013 survey of HIP members.

[b] These estimates may be unreliable because they are based on fewer than 30 respondents.

Table 6.28. Emergency Room Copayments, By Caretaker Status (Weighted Data)

Emergency Room Copayments	Caretaker	Non-Caretaker
Number of members who went to ER in past 6 months	2,381	2,289
Sometimes or always asked to make ER copayment	27.2%	38.8%
Never asked to make ER copayment	69.3%	59.5%

Don't Know	3.5%[b]	1.7%[b]

Source: Mathematic analysis of 2013 survey of HIP members.

[b] These estimates may be unreliable because they are based on fewer than 30 respondents.

6. Health Plan Strategies to Reduce ER Use for Non-Emergent Care

In addition to charging co-payments, each of the MCEs also engages in efforts to reduce non-emergent use of the ER.

Anthem

Anthem implemented two different approaches in 2012 to reduce the number of non-emergent ER visits among their HIP and HHW membership. Anthem's first approach utilizes telephone outreach to encourage appropriate use of the ER. As part of the Emergency Room Daily Census Project, five hospitals identify HIP and HHW members with high ER utilization rates. Calls are made to these members within 48 hours of an ER visit to ensure that members were in contact with their assigned PMP and had sought follow-up care from their PMP. The calls also serve to educate members about the appropriate use of the emergency room. In 2012, 9,783 members (HIP and HHW combined) were identified as high ER utilizers; 8,236 calls were made to these members, with 1,897 members successfully reached. Anthem also makes an effort to contact members 3 to 6 months after an ER visit to remind them and to refresh their earlier education efforts.

Anthem's second approach enlists providers to help keep members from using the ER for unnecessary purposes. PMPs are contacted when their assigned member utilizes the ER to ensure the PMPs are aware of these visits. Further, Anthem has contracted with CVS and Walgreen's pharmacy-based clinics and encourages Anthem members to use these clinics rather than the ER. Anthem reports that it is beginning to see a reduction in ER use, and believes that this decline is a result of their accumulated efforts. They could not quantify the size of the reduction.

MDwise

MDwise's ER initiative is based on information it gets from the Indiana Health Information Exchange (IHIE). The IHIE receives notifications of emergency department (ED) visits on a daily basis from five hospitals in Marion County. ED visits for MDwise members are forwarded to the plan for followup. A registered nurse at MDwise triages all notifications and identifies those with non-urgent symptoms. The nurse assigns a portion of these cases to care management for followup and the remaining are referred for followup by an automated call system.

For the automated call system, MDwise contracts with a vendor that receives a list of those members selected for the call followup. The vendor attempts to contact each member on the list at least three times, within two to four weeks of the ED visit. Once reached, the vendor follows an approved script. The script advises the member that MDwise is following up after an ED visit and identifies the date(s) of the visit. The call is interactive, requiring the member to answer a

question about whether they called their doctor prior to going to the ED. It reminds the member of the plan's 24-hour nurse line and the importance of calling their provider who is available 24/7, to answer their questions. MDwise has been conducting these calls since 2010.

MDwise has studied the effectiveness of these calls with their HHW membership. For calls in 2010, they compared ED visits six months before and six months after the automated call system began. The control group was made up of those members who also had ED visits within the same time period and were referred for the automated call intervention, but were never successfully contacted by the system. MDwise assessed the number of provider office visits six months before the intervention and six months following the intervention and found that ED visits following the introduction of the automated call system were 8.2 percentage points lower for the successful call group compared to the control group. They also saw a corresponding increase (10.2 percentage points) in the number of provider office visits following the introduction of the automated calls. Both differences were statistically significant with $p < .0026$.

In 2011, MDwise expanded this intervention to include their HIP members. Due to the low number of members in the HIP program and subsequent low numbers referred for a call, MDwise has not conducted a similar type of data analysis as they did with their HHW membership. For HIP, MDwise automated call system had the following number of contacts.

- In 2011, MDwise referred 109 HIP members to the automated call system, the system was able to reach 41 members, and of those reached, 51 percent indicated that they had called the PMP prior to the ED visit.
- In 2012, MDwise referred 27 HIP members to the automated call system, the system was able to reach 11 members, and of those reached, 27 percent indicated that they had called their PMP prior to the ED visit.

MDwise also reports that in 2013, MDwise will receive ED reports from more hospitals through the IHIE and these additional hospitals will be from across the entire state of Indiana. They anticipate this change will increase the number of referrals for HIP members.

MHS

MHS case managers receive "ER Bounce Back Reports" detailing information for HHW and HIP members who utilize the ER. Members who are noted to have high rates of ER use are contacted by staff that provide education and check whether the member is enrolled in MHS' case management program. If so, case managers will work with the member to identify root causes of high rates of ER use. During 2012, 58 HIP and HHW members were identified as frequent ER users and were engaged by case managers for this initiative.

In the past, MHS tried to educate its members on proper ER use with an auto-dial program that gave enrollees the option to talk to a case manager. In 2012, MHS' case managers began making proactive calls to members and were able to speak with more people about appropriate ER use. This MCE reported a reduction in ER use, although like Anthem, could not provide concrete data.

6.4 GOAL IV – PROMOTE PRIMARY PREVENTION

HIP encourages the use of preventive services by allowing members to obtain the first $500 worth of services without having to draw on their POWER account funds[16]. It also ties POWER account rollovers, and reductions in future monthly contributions, to the completion of required preventive care.

To determine whether HIP has promoted the use of primary preventive services, the analyses below assess general patterns of preventive care use among different groups of HIP members, using the criteria that the health plans and the State used in the POWER account reconciliation process for members who started eligibility periods in 2009 and beyond – completion of a well physician office visit or any of the age-appropriate preventive services recommended by the State (and listed in Table 6.28).

In addition, Mathematica's 2013 survey of current members asked respondents about their receipt of preventive care and their overall knowledge of preventive care policies. Survey questions asked current members about the length of time since they had received a routine check-up, their knowledge of the preventive services that HIP wanted them to receive, and their plans to obtain these preventive services before the end of their benefit period.

Findings include:

- Women are far more likely than men to receive at least one preventive care service. Among both women and men, the likelihood of receiving at least one service increases with age.
- Members required to contribute to the POWER account receive preventive care at higher rates than those not required to contribute to the POWER account.
- Individuals at or below 100 percent of the FPL are slightly less likely to receive at least one preventive care service compared to those at higher income levels.
- Though 85 percent of survey respondents reported receiving a "routine check-up" in the past year, Milliman's assessment of HIP claims records indicate that 35 percent of current members received a general physical exam within 2012. This discrepancy may be due to a difference in how members perceive a "routine check-up," versus how HIP or physicians may code for their services in a billing record.
- Forty-two percent of members knew that their health plan wanted them to get preventive services, though this number was higher among those above 100 percent FPL as compared to members at or below the FPL.

[16] MDwise and MHS both allow their members to receive unlimited preventive care services, without any amount being deducted from their POWER accounts. Anthem, however, has a $500 limit allowed by the program.

A. RECEIPT OF PREVENTIVE SERVICES

Beginning in 2009, the state required a well physician office visit or completion of any of the seven priority preventive services specified by the State for a POWER account rollover (Table 6.29).

Table 6.29. HIP Preventive Care Services, 2012

Preventive Care Service	Men			Women		
	19-34	35-49	50-64	19-34	35-49	50-64
Annual Physical	X	X	X	X	X	X
Cholesterol Testing		X	X		45+	X
Blood Glucose Screen	X	X	X	X	X	X
Tetanus-Diptheria Screen	X	X	X	X	X	X
Mammogram					X	X
Pap Smear				X	X	X
Flu shot			X			X

Source: Indiana OMPP. "Health Indiana Plan: Coverage for Preventive Services 2008-2009, Full POWER Account Rollover." Revised August 2009.

Note: Preventive care requirements have not changed since 2009

To assess receipt of preventive services among HIP members, encounter records submitted by the health plans were analyzed. A composite measure of preventive services receipt was constructed that utilized encounter records for inpatient, outpatient, and physician office services from February 2009 to December 2012. Table 6.30 lists the codes that were considered evidence of service receipt for each of the seven services considered. The analysis assessed whether each member had *any one* of the services appropriate for his or her age and gender and that were recommended from 2009 onwards.

Table 6.30. Designated Procedure/Diagnosis Codes for Receipt of Priority Preventive Services in 2012

Preventive Service	Designated Procedure Codes	Diagnosis Code Required to Accept Procedure Code
Preventive Care Visit	99385-99387 99395-99397 99401-99404	None
	99201-99205 99211-99215	V70.0, V70.3, V70.5, V70.6, V70.8, V70.9 Women only: V72.3, V72.31, V72.32, V76.2
Breast Cancer Screening	77057 77052 (with 77057) 77055 77056 77051 (with 77055 or 77056)	None
Pap Smear/Cervical Cancer Screening	88141-88155 88164-88167 88174-88175	None

	88150-88154 88164-88167 88142-88143 G0101 G0123-G0124 G0141 G0143-G0145 G0147-G0148	
Cholesterol Screening	83718 83719 83721	None
Blood Glucose Screening	82465 84478 V77.1 83036-83037 82945 82947 82950-82953 G8015-G8026	
Tetanus-Diphtheria	90715 90714 90718	None

The receipt of preventive services was examined over three years of the demonstration: 2010, 2011, and 2012. Each year includes preventive services information for all benefit periods which ended during that year. For example, the year 2010 includes 12 benefits periods (February 2009-January 2010, March 2009-February 2010, etc).

Between 2010 and 2012, rates of preventive services receipt remained the same or rose slightly among all groups except for females ages 19-34 (Table 6.31). Overall, the likelihood of receiving at least one preventive service increased with age, but women were far more likely than men to receive preventive care (69 percent versus 39 percent in 2012).

Table 6.31. Preventive Services Receipt Among HIP Enrollees, 2010-2012

Receipt of Preventive Services	2010	2011	2012
Overall (across entire HIP population)	56%	57%	60%
Contributors	57%	58%	61%
Non-Contributors	51%	53%	53%
Males			
All Ages	34%	35%	39%
Ages 19-34	23%	23%	30%
Ages 35-49	35%	36%	38%
Ages 50-65	47%	51%	53%
Female			
All Ages	68%	68%	69%
Ages 19-34	64%	63%	63%

Receipt of Preventive Services	2010	2011	2012
Ages 35-49	68%	68%	70%
Ages 50-65	73%	75%	78%

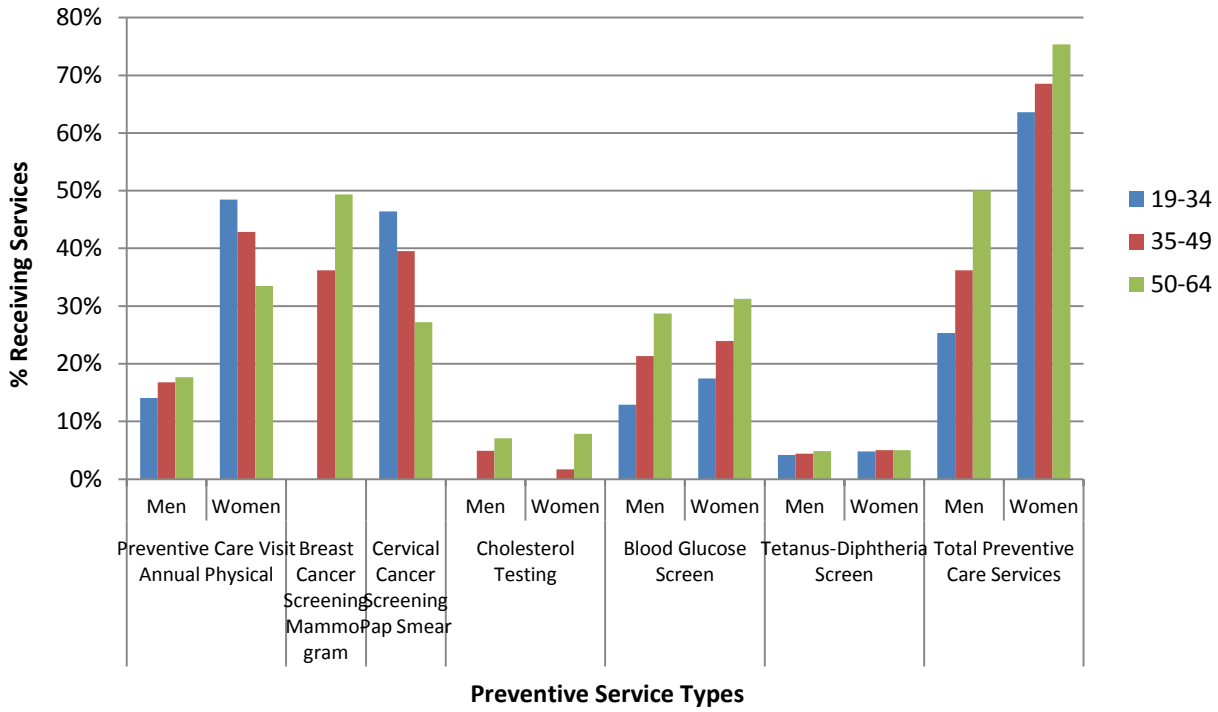
Source: Milliman analysis of preventive care receipt.
Note: Rates above were developed using administrative data only. A chart review would likely show higher rates, as it would include individuals who received preventive care services that were not billed separately but provided as a part of an office visit. In addition, enrollees may have received preventive care as part of an outreach effort, such as a flu vaccination drive, that was not captured in the administrative data.

The HIP program's design creates a financial incentive for its members to receive preventive care. If any State-contributed funds remain in a member's POWER account at the end of the calendar year and he or she has received at least one recommended preventive service, the money carries over to help fund the next year's deductible. This effectively reduces the amount of the member's monthly contribution in the next year.

The majority of HIP members are required to make contributions to their POWER accounts, but some (just under 25 percent in 2012) are exempt due to a lack of income or CMS income counting rules. For these individuals, the State funds the entire $1,100 POWER account contribution. This circumstance creates a comparison group between the group that has a financial incentive to receive preventive services and reduce future monthly contributions and the group that makes no contributions. The HIP design appears to encourage use of preventive care among those who make contributions. Claims data shows that HIP members required to make POWER account contributions received preventive care at higher rates than those who were not required to make POWER account contributions. In 2012, 61 percent of HIP members who were required to contribute to their POWER accounts received at least one recommended preventive service, while only53 percent of those not required to make POWER account contributions received preventive care (Table 6.31).

Though the likelihood of receiving at least one preventive care service increased with age, variations were observed between men and women and across specific services (Figure 6.7). While older men (ages 50-64) were slightly more likely than younger men (ages 19-34) to receive an annual physical, the reverse was true among women. Women ages 50-64 were more likely than younger women to receive a mammogram, but less likely to receive a pap smear/cervical cancer screening. Among both men and women, rates of cholesterol testing and blood glucose screening increased with age. Tetanus/diphtheria screening was rare among both men and women, with little or no variation observed by age group.

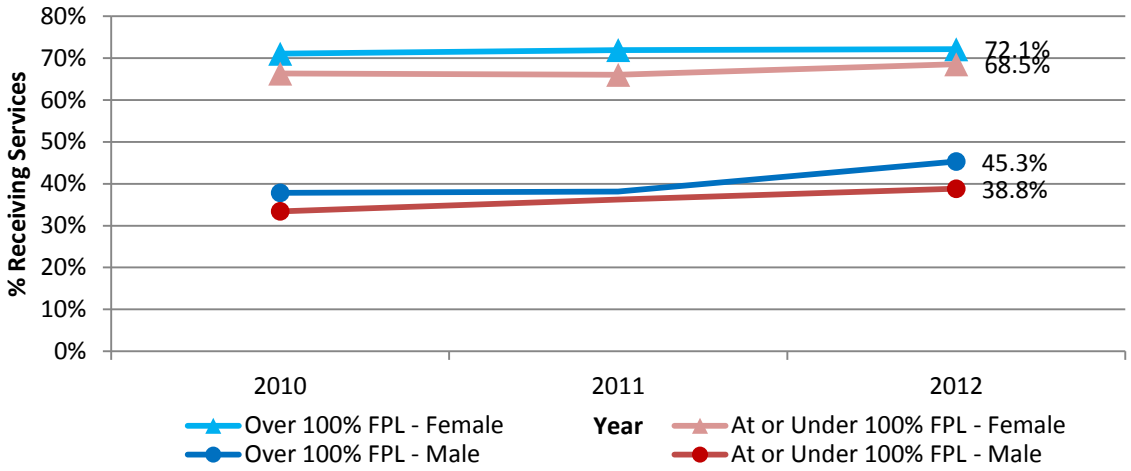
Figure 6.7: Type of Preventive Services HIP Members Received, 2012



Source: Milliman analysis of preventive care receipt.

In 2012, 72 percent of women at or above 100 percent FPL received preventive care services, while 69 percent of those below the FPL did so. The difference among men was slightly larger, with 45 percent of men at or above 100 percent FPL and 39 percent below FPL received preventive services in 2012.

Figure 6.8: Trends in Preventive Services Receipt, 2010-2012



Source: Milliman analysis of preventive care receipt.

2. Self-Reported Use of Preventive Services

The majority of respondents to Mathematica's 2013 survey – 85 percent – reported receiving a routine check-up within the year before the survey (Table 6.32).[17] Among those who reported not receiving a check-up in the past 12 months, nearly a quarter (23 percent) reported that the routine check-up was unnecessary (data not shown). Other prevalent reasons included not having time, not wanting to go, or feeling it was not needed because the respondent already received regular treatment for an ongoing medical condition. Notably, the analysis of claims records by Milliman suggests that 35 percent of current members received a general physical exam within 2012 (data not shown). The discrepancy between self-reported information and claims records may be due to a difference in how members perceive a "routine check-up," versus how HIP or physicians may report or code this type of care in a billing record.

Table 6.32. Routine Check-ups (Weighted Data)

Length of Time Since Routine Check-Up	All respondents	≤100% FPL	>100% FPL

[17] Respondents to the survey of current HIP members were asked how long it had been since they had visited a doctor for a routine check-up, defined as "a general physical exam, not an exam for a specific injury, illness, or condition."

Length of Time Since Routine Check-Up	All respondents	≤100% FPL	>100% FPL
Total number	16,830	11,477	5,353
Within past 3 months	37.9%	39.4%	34.7%
Within past year	46.7%	44.7%	51.0%
Within past 2 years	8.5%	9.4%	6.5%
2 or more years ago	6.5%	6.0%	7.5%
Don't know	0.4%[b]	0.3%[b]	0.4%[b]

Source: Mathematica analysis of 2013 survey of HIP members.

Note: Response options were mutually exclusive groupings.

[b] These estimates may be unreliable because they are based on fewer than 30 respondents.

B. HEALTH PLAN STRATEGIES TO PROMOTE PREVENTIVE CARE

Anthem, MDwise, MHS, and the ESP administrator have promoted the use of preventive services through mailings, newsletters, telephone and other outreach, and a number of incentive programs.

1. Outreach Through Telephone, Mailings, and Newsletters

Anthem

Each new HIP member who enrolls in Anthem receives a welcome call from a Health Needs Specialist to inform them about plan benefits, including preventive care. During the call, the member is given the opportunity to select a PMP. Anthem members also receive customized MyHealth Notes, which remind members to get regular preventive care, encourage the correct use of prescription drugs, and promote overall wellness.

MDwise

MDwise mails letters to all new members explaining the importance of preventive care and the need to complete the preventive care requirements to secure a full POWER account rollover. MDwise also mails monthly POWER Account invoices and statements that provide a listing of all health care services the member has used in the past year.

MHS

During 2012, MHS focused its outreach resources on online publications, and utilized a number of platforms to encourage preventive care and educate members about plan benefits. Sixty-five items were published online to educate HIP and HHW members on various topics, including nutrition, fitness, and general benefit information. These efforts included a series of posts called "Quick Tips for HIP," which reminded members about the benefits of receiving preventive care and other relevant topics. All of the posts were made available on the MHS Web site and on Facebook and Twitter.

During its March 27 Madison County Health Center Diabetic Day/Health Check Health Day, MHS attempted to get HIP and HHW members who had not received their required preventive care in to see their PMP. For the event, MHS contacted members whose claims history indicated they were due for one or more recommended preventive services, and invited those members to see their PMP for a check-up and needed screenings..

2. Incentive Programs

All three plans encourage members to complete a Health Risk Assessment (HRA) through incentives described below.

Anthem

In 2012, Anthem introduced a new incentive program targeting members who approach the end of their benefit period without having received the recommended preventive services. These members are offered a $50 gift card contingent upon receipt of these services within the benefit period. In 2012, mailers were sent to qualifying members encouraging diabetes, breast cancer, and cervical cancer screenings. Breast cancer screening mailers were sent to 2,119 HIP members, 11.1 percent of whom returned the form to claim the gift card, while diabetes screening mailers were sent to 1,840 members (with 10.2 percent claiming the reward), and cervical cancer screening mailers were sent to 4,880 members, with 7.9 percent receiving the incentive.

During Anthem's welcome calls, new members are encouraged to complete an HRA and are offered incentives to do so. Those who complete an HRA online receive a $20 CVS gift card, while those who complete it over the phone receive a $10 card (with a limit of one per household). In 2012, 2,673 HIP members completed an HRA.

MDWwise

The MDwiseREWARDS program uses incentives to encourage members to seek preventive care. Members earn points that can be redeemed for a gift when they complete a HRA, visit the doctor for an annual exam and health screening, or register to receive monthly statements online. MDwise promoted the incentive program in its main brochure, member handbook, on its Web site, and through postcards mailed to all members. Several of these promotion efforts proved successful in increasing the program's reach. In December of 2012, a mailing was sent to all HIP/HHW households, after which the REWARDS Web site saw a 206 percent increase in unique pageviews, and there was a 313 percent increase in HIP member gift card redemption. MDwise also created a business card-sized promotional card for providers to hand out to members. After use of the card began, MDwise REWARDS saw a 50-100 percent increase in gift card redemptions.

MHS

MHS has created the CENT-Account Rewards program that provides incentives for various activities. Incentive money is loaded directly onto the member's HIP debit card and can be used to purchase health supplies or pay co-pays. Members can receive $10 for visiting their assigned PCP within the first 90 days of MHS membership. In 2012, a new incentive was added in which members can receive $30 for completing a telephone HRA within the same time period. Of MHS members who maintained at least 90 days of coverage and could be contacted during that period, 49 percent completed a new member health screening.

C. MEMBER KNOWLEDGE AND EFFECTS OF HIP PREVENTIVE CARE POLICIES AND OUTREACH

Many current HIP members knew their health plan wanted them to get preventive care and reported either getting the care or planning to get preventive care services before their next renewal period. When asked by Mathematica's 2013 survey, 42 percent of current HIP members knew that their health plan wanted them to get preventive services, though this number was higher among those above 100 percent FPL as compared to members at or below the FPL (48 percent versus 39 percent) (data not shown).

Of those who knew their health plan wanted them to get preventive services, 80 percent reported that they had been encouraged by their health plan by letter, email, or phone call to receive preventive care (Table 6.33). Some variation was observed by health plan, with Anthem members more likely than MDWise members to report having been contacted by their plan about preventive care (83 percent versus 74 percent) (data not shown). Overall, 60 percent of these members said they had received at least one preventive service since their last renewal. Of those who had not, 78 percent said they planned to get them before their next renewal. Most of those individuals who did not plan to get these services reported that they felt it was unnecessary, did not have time to go, or did not want to go (data not shown).

Table 6.33. Preventive Care Knowledge and Self-Reported Receipt of Preventive Services (Weighted Data)

Preventive Care Knowledge and Receipt	Members Aware Health Plan Wanted Them to Get Preventive Services	≤100% FPL	>100% FPL
Number of members	7,013	4,443	2,570
Knew that health plan wanted them to get:			
Blood Glucose Screen	60.2%	56.9%	65.8%
Cholesterol Screen	65.2%	61.4%	71.9%
Flu shot	61.4%	57.6%	67.9%
Mammogram[a]	58.4%	54.9%	64.6%
Pap Test/Pap Smear[a]	61.3%	58.3%	66.5%
Routine physical exam	84.4%	85.3%	83.0%
Tetanus shot	30.2%	29.0%	32.4%
Other service	6.6%[b]	7.5%[b]	5.2%[b]
Don't know	1.5%[b]	0.5%[b]	3.2%[b]
Have been encouraged by health plan via letter, email, or phone call to get preventive			

Preventive Care Knowledge and Receipt	Members Aware Health Plan Wanted Them to Get Preventive Services	≤100% FPL	>100% FPL
care			
Yes	79.7%	78.6%	81.7%
No	18.6%	20.1%	16.1%[b]
Don't know	0.8%[b]	0.4%[b]	1.5%[b]
Have gotten any of these services since last annual renewal			
Yes	59.5%	59.5%	59.4%
No	37.3%	38.2%	35.8%
Don't know	3.3%[b]	2.3%[b]	4.9%[b]
Of those who have not gotten services since last annual renewal:			
Number	2,616	1,696	919
Plan to get services before next renewal			
Yes	78.3%	77.2%	80.4%
No	14.0%[b]	13.3%[b]	15.3%[b]
Don't know	3.8%[b]	5.9%[b]	0.0%[b]

Source: Mathematica analysis of 2013 survey of HIP members.

[a]All respondents were asked whether their health plan wanted them to get the services listed, including mammograms and pap test/pap smears. The percentages of people who accurately reported that their health plan wanted them to get these two services is therefore underreported, because the denominator includes men.

[b] These estimates may be unreliable because they are based on fewer than 30 respondents.

Having an awareness that the plan wanted them to get services does not appear to have an effect on a member's likelihood to report having received services since the last renewal. Sixty percent of individuals in both groups – those aware and those unaware that their plan wanted them to get preventive services – reported that they had received services since their last renewal. Of those who were unaware that their health plan wanted them to get services and had not already done so, 64 percent said they planned to get preventive care before their next renewal (Table 6.34).

Table 6.34. Preventive Care Receipt Among Current Members Not Aware That Their Health Plan Wanted Them To Get Preventive Services (Weighted Data)

Preventive Care Receipt	Members Not Aware Health Plan Wanted Them to Get Preventive Services	≤100% FPL	>100%FPL
Number of members	9,798	7,015	2,798
Have been encouraged by health plan via letter, email, or phone call to get preventive care			
Yes	29.4%	27.1%	35.1%[b]

Preventive Care Receipt	Members Not Aware Health Plan Wanted Them to Get Preventive Services	≤100% FPL	>100%FPL
No	67.3%	70.0%	60.5%[b]
Don't know	0.6%[b]	0.6%[b]	0.8%[b]
Have gotten any of these services since last annual renewal			
Yes	60.4%	59.0%	63.1%[b]
No	34.5%	37.7%	28.5%[b]
Don't know	2.9%[b]	3.3%[b]	2.1%[b]
Of those who have not gotten services since last annual renewal:			
Number	1,056	756	299
Plan to get services before next renewal			
Yes	63.7%	57.4%	79.7%[b]
No	25.0%[b]	32.1%[b]	7.0%[b]
Don't know	11.3%[b]	10.5%[b]	13.3%[b]

Source: Mathematica analysis of 2013 survey of HIP members.

[b] These estimates may be unreliable because they are based on fewer than 30 respondents.

6.5 GOAL V - PREVENT CHRONIC DISEASE PROGRESSION WITH SECONDARY PREVENTION

By lowering cost and access barriers to care and encouraging members to be more engaged patients, HIP aims to slow disease progression among members with chronic conditions. Detecting the extent to which HIP is slowing the progression of chronic disease is extremely difficult and the data currently available do not provide a clear answer. The following analyses used diagnosis codes found on HIP service records to assess the occurrence of different categories of chronic conditions and used health plan reports to document ways in which the MCEs are helping members manage chronic conditions.

Analyses indicate that:

- Chronic disease is prevalent among members, and approximately 30 percent of HIP members had three or more chronic conditions (Table 6.35). The most common chronic conditions in 2012 were cardiovascular, psychiatric, skeletal and connective, and gastrointestinal. As in past years, non-caretakers were more likely than caretakers to be diagnosed with chronic disease.
- All three MCEs provide disease management programs to help members manage chronic conditions, but none offered participation incentives in 2012.

A. PREVALENCE OF CHRONIC CONDITIONS

To assess the prevalence of chronic conditions among HIP members, the Chronic Illness and Disability Payment System (CDPS) algorithm was applied to inpatient and outpatient encounter records of those enrollees with 6 or more months of enrollment in HIP during 2012. The CDPS is a diagnostic classification system developed to describe different burdens of illness among Medicaid beneficiaries. Using ICD-9 codes, the CDPS categorizes diagnoses into 20 major categories, which correspond to body systems. Each of the major categories is subdivided according to the degree of increased expenditures associated with the diagnosis. The CDPS analysis was supplemented with the Medicaid Rx (MRx) algorithm, which was designed to identify chronic conditions among beneficiaries who receive pharmacotherapy but do not have a qualifying CDPS diagnosis in their encounter records.

Chronic disease was prevalent among HIP members, which may partly explain why many members exhaust their POWER account funds and are not eligible for POWER account rollovers. Among those enrolled in HIP for at least six months during 2012, the most common chronic conditions classified by the CDPS algorithm were cardiovascular (32.3 percent), psychiatric (23.8 percent), skeletal and connective (20.1 percent), and gastrointestinal (19.0 percent) (Table 6.34). Non-caretakers were much more likely than caretakers to have chronic conditions, which is consistent with the differences in demographic characteristics and that non-caretakers tend to be older than caretakers (see Table 6.1).

The MRx algorithm identifies an additional 7.4 percent of members who were treated with medications for cardiovascular conditions, but did not have an inpatient or outpatient visit with a cardiac diagnosis. Similarly, it flagged more than 40 percent of HIP members as having a psychiatric condition; 23.8 percent were identified as having a psychiatric diagnosis on an encounter record and an additional 16.7 percent were identified in this group because they filled a prescription for a psychotropic medication during 2012.

Table 6.35. Percent of HIP Enrollees with 6+ months of enrollment in 2012 with Chronic Conditions

Category	All HIP Members N=42,986	HIP Caretakers N=27,408	HIP Non-Caretakers N=15,578
CPDS			
Cardiovascular	32.3%	24.5%	46.0%
Psychiatric	23.8%	23.1%	25.1%
Skeletal and Connective	20.1%	17.0%	25.4%
Gastrointestinal	19.0%	16.3%	23.6%
Pulmonary	16.1%	13.1%	21.4%
Diabetes	12.9%	9.5%	18.8%
Ear	10.3%	10.4%	10.2%
Nervous System	8.1%	6.6%	10.7%
Skin	6.7%	6.1%	7.8%
Metabolic	5.9%	4.8%	7.9%
Genital	5.2%	5.6%	4.4%
Substance Abuse	4.6%	3.4%	6.9%
Renal	3.6%	2.7%	5.0%
Infectious Disease	2.9%	2.1%	4.3%
Eye	2.2%	1.0%	4.4%
Cancer	8.9%	7.5%	11.4%
Hematological	1.2%	1.0%	1.6%
Cerebrovascular	0.6%	0.4%	1.0%

Category	All HIP Members N=42,986	HIP Caretakers N=27,408	HIP Non-Caretakers N=15,578
Developmental Disability	0.1%	0.0%	0.1%
MRx			
Psychosis/Bipolar/ Depression	16.7%	16.0%	17.9%
Cardiac	7.4%	7.0%	8.2%
Seizure disorders	2.8%	3.0%	2.4%
Anti-coagulants	1.2%	1.1%	1.5%
Diabetes	1.3%	1.4%	1.2%
Malignancies	1.0%	0.9%	1.2%
Parkinsons / Tremor	0.8%	0.6%	1.2%
Inflammatory /Autoimmune	0.3%	0.3%	0.3%
Infections, high	0.2%	0.2%	0.2%
Hepatitis	0.2%	0.1%	0.3%
Tuberculosis	0.1%	0.1%	0.1%
HIV	0.0%	0.0%	0.0%
ESRD / Renal	0.0%	0.0%	0.0%
Multiple Sclerosis / Paralysis	0.0%	0.0%	0.0%
Hemophilia/von Willebrands	0.0%	0.0%	0.0%

Source: Milliman, Inc, May 16, 2013.

Multiple diagnoses were common. Approximately 30 percent of HIP members had three or more chronic conditions. However, most of these diagnoses reflected low-cost conditions. Considering only subcategories associated with medium or higher costs, only 1.6 percent had three or more CDPS diagnoses.

For all CDPS categories except genital conditions, prevalence among non-caretakers was higher than among caretakers, often by substantial margins (Table 6.35). For example, 46 percent of non-caretakers had cardiovascular conditions, compared to 25 percent of caretakers. Indeed, about one-third of caretakers had no CDPS chronic condition, compared to only 21 percent of non-caretakers (Table 6.35). The differences between groups persist when only medium- and high-cost conditions were considered. About thirty percent of non-caretakers were diagnosed with at least one higher-cost condition, as compared to 20 percent of caretakers. These patterns are summarized by each group‘s average CDPS risk score, which is a summary index of the relative expected medical costs for each member given their identified chronic conditions. The CDPS risk score for the population as a whole is 1.00. The average score among caretakers was 0.84, indicating that as a group they are expected to be 16 percent less costly than the HIP average. The average score among non-caretakers was 1.27, indicating that as a group they are expected to be 27 percent more costly than the HIP average. See Table 6.35.

Table 6.36. Chronic Illness and Disability Payment System (CDPS) Risk Score and Number of Conditions Identified, by Enrollee Group, HIP Members 2012

Characteristics	HIP Members	Scored HIP members	Normalized CDPS Risk Score	All CDPS Identified Conditions, Percent with:			CDPS Identified Conditions with "Medium" or Greater Expected Cost Impact: Percent with:		
				No Conditions	1-2 Conditions	3 or More Conditions	No Conditions	1-2 Conditions	3 or More Conditions
All HIP Members	55,701	42,986	1.00	29.1%	41.2%	29.7%	76.8%	21.6%	1.6%
HIP Caretakers									
All	38,190	27,408	0.84	33.9%	42.5%	23.6%	80.2%	18.8%	1.0%
19-34	13,050	8,544	0.70	39.9%	43.0%	17.2%	83.2%	16.4%	0.4%
35-49	20,409	15,166	0.86	33.1%	42.3%	24.5%	80.1%	18.8%	1.1%
50-64	4,671	3,668	1.07	23.5%	41.7%	34.8%	73.5%	24.4%	2.1%
65+	60	30	1.24	23.3%	50.0%	26.7%	73.3%	23.3%	3.3%
HIP Non-Caretakers									
All	17,511	15,578	1.27	20.6%	38.9%	40.5%	70.9%	26.5%	2.6%
19-34	2,440	2,098	0.88	37.0%	41.6%	21.4%	79.6%	19.4%	1.1%
35-49	4,785	4,252	1.34	20.6%	37.1%	42.2%	69.7%	27.6%	2.6%
50-64	9,798	8,964	1.31	16.6%	39.2%	44.2%	69.3%	27.7%	3.0%
65+	488	264	1.39	22.4%	36.4%	41.3%	73.1%	22.0%	4.9%

Source: Milliman, Inc, May 16, 2013.

Note: Scored members had at least 6 months of HIP eligibility. For Normalized CDPS Risk Score, Concurrent Risk scores were used, weighted by HIP Member Months. Table excludes "not well defined" and "super low" CDPS flags. Percentages may not add to 100 due to rounding.

B. HEALTH PLAN MANAGEMENT OF CHRONIC CONDITIONS

The health plans provide support to their members with chronic conditions primarily through focused disease management programs, which use a telephone-based case management approach to help these members manage their health.

1. Disease Management

All three plans participate in Right Choices, a care management program for members with unusually high service utilization, particularly of emergency room and prescription drug services. This program limits the pharmacies, providers, and hospitals where the member may receive care, while also providing outreach services from care managers at each plan. In addition, Anthem, MHS, and MDwise all offer disease management programs for members identified as having certain chronic conditions.

The MCEs reported that consolidating their HIP and HHW call centers increased their ability to provide disease management services. Plan representatives noted that if a person enrolled in either HHW or HIP placed a call to the call center, staff could view the records of the person's entire family. They could note if someone in the family was enrolled in a disease management program but had not recently received services, and immediately transfer the member to a case manager.

Anthem

Anthem's disease management program, known as 360 Condition Care, is available for members with medium- to high-risk asthma, coronary artery disease (CAD), heart failure, chronic obstructive pulmonary disease (COPD), diabetes, end stage renal disease (ESRD), and chronic kidney disease (CKD). The plan analyzes its service records to identify members with these conditions, rate their risk, and refer them to the disease management program when appropriate. Members with medium- and high-risk conditions are assigned to case managers, who provide clinical support by connecting patients to providers, goal setting, offering help keeping appointments, and offering strategies to help the member adhere to physician instructions. In 2012, Anthem continued offering disease management services to all members diagnosed with one of its identified conditions, but began targeting members who were diagnosed with a condition and were identified as experiencing a clinical gap in care (such as, members diagnosed with diabetes who had not received the recommended blood glucose test).

In 2012, Anthem's asthma and diabetes programs were the largest in terms of number of enrollees as compared to other programs, though enrollment in all disease management programs decreased during the year. Anthem reported that 78 enrollees in its CAD program received cholesterol screenings during 2012. Of those in its diabetes program, 142 received a hemoglobin A1C screen, 99 received kidney disease monitoring, 176 received cholesterol screening, and 335 received a retinal exam.

Enrollment in Anthem's chronic disease management programs decreased over the year. A small percentage of the decrease can be attributed to graduation from the program. However, the majority of the decrease was due to program dropout or the inability of Anthem staff to contact the member due to an incorrect phone number.

Table 6.37. Anthem's Disease Management Programs

Disease Management Program	Members Enrolled January 1, 2012	New Members Enrolled During 2012	Members Enrolled December 31, 2012	Percent change during 2012
Asthma	2,201	196	1,236	-43.8%
CAD	57	7	36	-36.8%
Heart Failure	235	54	117	-50.2%
COPD	1,615	94	870	-46.1%
Diabetes	2,664	282	1,381	-48.2%

Source: Anthem, 2012.

Note: More limited data were available for those in the ESRD and chronic kidney disease disease management programs. Three individuals were identified as having ESRD in 2012, and 2 were placed in case management. Four individuals were identified as having CKD, and 1 was placed in case management.

Anthem also offers a Depression Program, which conducts outreach to members who began taking medication for depression. This program sends members personalized health information brochures containing information on depression medication, as well as the importance of medication adherence. Members in the program also receive automated calls when they began taking their medications, and regular calls afterward to remind them to refill their prescriptions.

MDwise

MDwise's disease management program is known as INcontrol. It uses a case management approach to help certain members at higher risk manage their chronic conditions. The six diseases managed in the program include asthma, diabetes, congestive heart failure, coronary artery disease, chronic kidney disease, and chronic obstructive pulmonary disease.

Table 6.38 . MDWise INControl Program Enrollment, 2012

INControl Program	Members Enrolled
Asthma	432
Diabetes	452
Congestive Heart Failure	102
CAD	101
Chronic Kidney Disease	6
COPD	479

Members are identified and referred to this program when they complete the Health Needs Assessment at enrollment and annually at re-enrollment. They may also be referred by a provider, or through a call to the health plan. Those referred receive educational materials about their disease and access to case management services. MDwise also offers information to members on its WEIGHTwise and SMOKEfree programs.

MDwise focuses its outreach by sending provider outreach teams to meet with HIP providers and discuss the HEDIS quality measures. Occasionally, teams will also hold meetings with groups of providers to discuss specific disease management topics.

MHS

In 2012, MHS offered disease management programs for members with asthma, diabetes, catastrophic/trauma/multiple co-morbidies/transplant care, coronary artery disease, chronic obstructive pulmonary disease, congestive heart failure, chronic kidney disease, depression, and bipolar disorder. To enroll members in its disease management programs, MHS examines encounter data to identify high-risk individuals with one or more of the selected conditions. In addition, the plan sends representatives to meet with HIP providers and encourage them to refer appropriate individuals to the disease management programs.

Table 6.39 . MHS Disease Management Program Enrollment, 2012

Disease Management Program	Members Enrolled
Asthma	18
Diabetes	2
CAD	1
COPD	1
Depression	113
Bipolar	53

In September 2011, MHS also introduced a pilot obesity/weight management pilot program. Candidates for this program are identified based upon BMI, co-morbidities, and willingness to address weight-related behaviors. Participants are provided with a coach, who offers nutritional counseling, education about exercise programs, and ongoing support. The 28 participants who have enrolled in the program have remained enrolled for an average of 158 days. Slightly more than half (54 percent) experienced weight loss, with an average weight loss of 17.8 pounds. Members are asked to show continued active commitment to the plan of care, and can remain enrolled as long as they are actively participating and showing progress. At the point when it is evident that they are no longer engaged in the process, they are disenrolled from the program.

In August of 2012, MHS began to augment its asthma and diabetes programs to transform them into “higher touch” programs. Rather than simply sending newsletters to members in these

programs, it began making outbound calls to assess each person's needs and provide a higher level of personal attention.

2. Incentive Programs for Disease Management

None of the plans offer incentives for participation in disease management programs.

6.6 GOAL VI – PROVIDE APPROPRIATE AND QUALITY-BASED HEALTH CARE SERVICES

A critical goal for HIP is to provide appropriate and quality-based health care services. Although the State is ultimately responsible for ensuring the quality of services delivered to HIP members, much of the day-to-day responsibility rests with the contracted MCEs: Anthem, MDwise, and MHS. The analyses that follow use a number of data sources to evaluate the MCEs' ability to provide quality health care services, including (1) plan performance information abstracted from a March 2013 report completed by Burns & Associates, Inc., the program's external quality review organization (EQR); (2) member experience with care data gathered from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) data that the health plans submit to the State (these CAHPS surveys were of HIP members only, not the plans' other Medicaid, commercial, or Medicare populations); and (3) satisfaction information Mathematica collected in 2013 through a survey of current HIP members; and (4) aggregate data on inquiries reported by the State.

Findings include:

- All three MCES received high overall scores across all EQR-assessed areas related to organizational structure and performance in calendar year 2011.
- CAHPS surveys indicate a high level of member satisfaction with HIP MCEs.
- Among current HIP members surveyed by Mathematica in 2013, 95 percent reported that they were satisfied with their health coverage.

A. OVERALL HEALTH PLAN PERFORMANCE-EXTERNAL QUALITY REVIEW

Calendar Year 2011

In 2012, Burns & Associates, Inc. conducted an external quality review (EQR) of Anthem, MDwise, and MHS for calendar year 2011. At the time of this report, the 2011 EQR represented the most recent available report.

In January 2011, the MCEs entered into a new contract period with the State. As such, the 2011 EQR included a comprehensive organizational assessment of the three MCEs to assess their compliance with federal requirements for Medicaid MCEs. Areas assessed included (1) member services and enrollee rights, (2) grievances and appeals, (3) covered benefits and coordination of

care of physical and behavioral health, (4) provider selection, contracting, and access, (5) utilization management, (6) quality management, (7) information systems, (8) subcontracted relationships and delegations, (9) corporate governance, and (10) billing and POWER account tracking. In addition, Burns & Associates and the State selected three other focused activities for the 2011 EQR, which included (1) validation of performance measures collected in the HHW and HIP reporting manuals, (2) review of inpatient psychiatric stays, and (3) review of the Right Choices Program, a program that aims to reduce inappropriate outpatient hospital and pharmacy use and improve care coordination.

Organizational Assessment and Structure Performance. In total, 259 review items drawn from language in the MCEs' contract with the State were scored. For each item, an MCE could receive 2 points if it met at least 90 percent of the criteria evaluated, 1 point if it met at least 50 percent of the criteria, and 0 points if it did not meet at least 50 percent of the criteria. Of these review items, 108 were directly related to CFR requirements. These were given a weight of "3" in the scoring methodology, while other items related only to contractual requirements were assigned a weight of "1."

All three MCEs received very high overall scores across all assessed areas related to organizational structure and performance, with Anthem receiving a score of 97.2 percent, MDwise scoring 98.4 percent, and MHS scoring 98.4 percent.

Table 6.6.1. Summary of Scores Related to MCE Organizational Assessment and Structure Performance

Review Topic Area	Maximum Score	Anthem Score	MDwise Score	MHS Score
Member Services and Enrollee Rights	248	237	246	245
Grievances and Appeals	120	120	120	120
Covered Benefits and Coordination of Care (other than Behavioral Health)	62	54	55	53
Covered Benefits and Coordination of Care (Behavioral Health)	20	19	18	18
Provider selection, contracting, and access	124	123	124	124
Utilization Management	130	128	129	129
Quality management	48	46	48	48
Information systems	48	48	48	48
Subcontracted relationships and delegations	32	32	31	32
Corporate Governance	56	55	56	56
Billing and POWER Account Tracking	62	61	60	62
Total	**950**	**923**	**935**	**935**
		97.2%	**98.4%**	**98.4%**

Source: Burns & Associates Calendar Year 2011 EQR

Performance Measures. In previous EQRs, Burns & Associates identified three ongoing issues with the reporting of performance measures. On some occasions, the MCEs have interpreted the reporting instructions differently, thereby causing differences in results across MCEs that are related to differences in the methodology used to calculate the measures rather than true

differences in results. In other cases, errors were observed in measure reporting. For example, measures that must be reported on a quarterly basis were not always aligned with year-to-date or four-quarter rolling average results. As a result, THE STATE had three meetings with the MCEs during 2012 to address these issues. After these meetings, Burns & Associates redesigned the HHW and HIP reporting manuals, and these redesigned manuals became effective January 1, 2013.

Review of Inpatient Psychiatric Stays. Beginning January 1, 2011, the State required all MCEs to enroll any HHW or HIP member with an inpatient psychiatric hospitalization into case management for a minimum of 180 days after discharge. In CY 2011, Burns & Associates conducted a review of the rate of readmissions for an inpatient psychiatric stay to assess the outcome of this requirement. This review found that case management had not improved the readmissions rate among this population to any significant degree, and Burns & Associates encouraged the MCEs to work with the State to conduct further research to better understand this population.

Review of the Right Choices Program. The Right Choices Program is intended to reduce inappropriate outpatient hospital and pharmacy use, reduce medical expenditures related to inappropriate use of services, improve an individual's health status through care coordination and utilization control, and increase provider participation in and satisfaction with the Right Choices Program. The calendar year 2011 review of the program resulted in a number of recommendations to the MCEs and the State, which are currently under consideration.

Calendar Year 2012

In early 2013, the State and Burns and Associates (B&A) identified two focus studies that would be completed for the 2012 External Quality Review, in addition to validation (auditing) of performance measures and performance improvement projects for the MCE's. Both focus studies included the HIP population and providers. The two focus studies covered: (1) access to primary care and (2) mental health care utilization and care coordination.

Access to Care. In consultation with the State, B&A constructed a focus study on access to care which included both a quantitative and qualitative component. This analysis expanded the population studied beyond the limits as defined by the HEDIS® measures for access to primary care but limited the study to primary care office visits conducted in a physician office, at a federally qualified health clinic (FQHC), or at a rural health clinic (RHC). Analyses using these parameters were also examined by age, race/ethnicity and region of the state.

The qualitative component to this focus study included interviews with the MCE Provider Services staff in June to learn more about their approach to conducting outreach. B&A then conducted 59 interviews with provider entities contracted with the MCEs over a ten week period from July to September. The interviews included representation of all provider specialties in each region of the state. In total, interviews were conducted at 29 primary medical provider

(PMP) offices, 10 FQHC (Federally Qualified Health Centers), 10 RHCs (Rural Health Centers), and 10 community mental health centers (CMHCs).

The study revealed that MHS provided the greatest access to primary care among the three MCEs. Interestingly, according to the study, access to primary care for African-American members in HIP was higher than other race/ethnicities. There were fewer differences in the rate of access to primary care for adults across the regions than was found for children. Further, the access rates were usually similar across the MCEs within a region. The access rate among HIP adults was higher for every MCE in every region than the corresponding age/region cohort in HHW. This is probably due to the higher provider reimbursement rates provided in HIP.

Provider feedback pertaining to the HHW and HIP programs in general and with MCEs in particular ranged from satisfaction to frustration. B&A analyzed the key factors related to provider satisfaction which included the quality of the MCEs' provider field staff, the quality of assistance and training the office staff received from the MCEs and the ease in getting paid by the MCE. The key factor related to frustration from providers related to consistency across MCEs and programs (i.e., prior authorization submission and adjudication, a single Medicaid manual rather than one for fee-for-service (FFS) Medicaid and separate manuals for each MCE, consistent and accurate claims processing, and consistent responses from customer service representatives). B&A has identified 15 specific recommendations to the State covering many of the topics brought up by providers in the meeting on ways to improve the providers' experience with the program through MCE contract requirements. B&A has also developed 13 recommendations for all of the MCEs as well as some recommendations specific to each MCE.

Mental Health Care Utilization and Coordination. B&A developed a focus study for the 2012 EQR which is a continuation of the work conducted for the 2011 EQR. In this year's EQR, a review of mental health utilization was conducted more broadly for all members of HHW and HIP. Additionally, B&A reviewed the first submissions of the new complex and moderate case management reports for mental health conditions covering 1st Quarter 2013 that were implemented January 1, 2013.

Of all HIP members enrolled in CY 2012, 28.9 percent had a mental health diagnosis reported on an encounter[18]. A greater proportion of white HIP members were diagnosed with a mental health disorder than other races and ethnicities: 31.3 percent of Caucasian members were diagnosed with mental health diagnosis on an encounter compared to 20.2 percent of African-American and 16.6 percent of Hispanics. Among the HIP population, three diagnoses comprised half of all

[18] Milliman's analysis of 2012 claims (MRx algorithim) shows that 23.8 percent of HIP members who had been enrolled in the program for six months or more had a psychiatric diagnosis reported on an encounter record, while B&A's analysis showed 28.9 percent of HIP members enrolled in 2012 had a mental health diagnosis on an encounter. The slight discrepancy in the rate of psychiatric diagnosis on encounters can be attributed to the composition of the claims analysis population. Milliman only considered individuals who had been enrolled for six months or more in 2012 in their analysis, while B&A considered all individuals enrolled in 2012.

mental health diagnoses—tobacco use disorder (19.6% of total), attention deficit disorder (15.5% of total), and major depressive or bipolar disorder (14.9) of total). Outpatient mental health clinics and CMHCs play an important role in the delivery of these services since more than 80 percent of all services were billed by these two provider types. Community mental health providers delivered less than 10 percent of the services (except in Anthem HIP). It is interesting to note that in MDwise HIP, primary care providers rendered a larger proportion of mental health services than the other MCEs.

A sample of cases was reviewed by the EQR Clinical Review Team of two MDs and three RNs, focusing on the care plans developed for the members—whether they contained measurable goals, if they incorporated patient diagnoses, and if the care plan was sent to either PMPs or mental health providers. In addition to the care plan reviews onsite at each MCE in August, the doctors on the clinical team interviewed MCE staff responsible for implementing the MCE's behavioral health program on items required in the contract, the staffing of the behavioral health team, and policies and procedures around case management.

Overall, B & A noted that care plan goals often did not include measures, were not specific to a particular need, and did not address the main physical or mental health diagnosis of the member. Seldom did they address things such as substance abuse, medication compliance, steps to prevent future hospitalizations, ways to ensure and coordinate follow-up with PMP and/or mental health provider appointments, or ways to build toward a healthier lifestyle. The care plan is more focused on helping with appointments, assigning PMPs, etc. While these are important tasks, the function of the care plan should be coordination, medication compliance, and steps to take towards a healthier lifestyle. At all three MCEs, there was little documentation of coordination and integration of information between the PMPs and the mental health providers. The EQR team made recommendations to the State to work with the MCE's to improve the required mental health care plans and case management.

B. SELF-REPORTED SATISFACTION FROM HEALTH PLAN CAHPS DATA

1. MCE Ratings and Benchmarks

CAHPS data indicate a high level of member satisfaction with MCEs (Table 6.6.2). In 2012, all three MCEs received ratings of health care, personal doctor, ability to get needed care, ability to quickly get care, doctor communication, and health education that were higher than the benchmarks selected by the MCEs.

Table 6.6.2 CAHPS Ratings and Benchmarks

CAHPS Rating	Anthem		MDwise		MHS[a]	Benchmark Rates[b]		
	2012 Plan Average	2011 Plan Average	2012 Plan Average	2011 Plan Average	2012 Plan Average	Anthem 2012 DSS	Anthem 2012 WP	MDwise and MHS
Rating of Plan Overall	**82.2***	79.2	**76.0**	75.5	**72.8**	*72.9*	*73.4*	*73.6*
Rating of Health Care	**77.2***	74.7	**70.6**	73.3	**72.7**	*69.1*	*70.6*	*69.3*
Rating of Personal Doctor	**81.0***	78.6	**76.3**	78.8	**79.9**	*76.9*	*77.3*	*76.4*
Rating of Specialist	**77.9**	73.6	**79.8**	75.0	**73.5**	*76.6*	*74.5*	*76.9*
Customer Service	**84.2**	89.3	**82.3**	79.4	**80.2**	*80.0*	*82.8*	*80.5*
Getting Needed Care	**85.1***	85.8	**83.4***	80.6	**79.5**	*75.2*	*77.9*	*77.1*
Getting Care Quickly	**86.6***	86.5	**83.0**	83.6	**83.7**	*79.3*	*81.3*	*81.0*
Doctor Communication	**91.6***	92.6	**88.4**	90.5	**90.0**	*87.7*	*89.1*	*87.7*
Shared Decision Making	**58.2**	65.2	**65.8***	63.2	**66.3**	*59.0*	*59.5*	*59.6*
Health Education	**63.3***	61.4	**60.5**	61.7	**64.5***	*58.3*	*57.2*	*58.9*
Coordination of Care	**77.0**	79.8	**77.2**	77.7	**75.6**	*76.0*	*77.0*	*76.6*

Source: Anthem data are from "2012 CAHPS 4.0H Member Survey prepared for Healthy Indiana Plan" 2012; DSS Research , MDwise data are from "2012 Medicaid Adult CAHPS 4.0H Final Report: MDwise Healthy Indiana Plan" 2012; The Myers Group, and MHS data are from "2012 Medicaid Adult CAHPS 4.0H Final Report: Managed Health Services Indiana, Inc" 2012; The Myers Group

[a]2011 CAHPS data were unavailable for MHS.

[b] Anthem benchmark rates are 2012 WP (WellPoint) averages and 2012 DSS averages (from the 2012 DSS Adult Medical Book of Business averages. The DSS Book of Business is made up of 37 adult Medicaid plans with a total of 15,559 Respondents). MDwise and MHS benchmark rate comes from 2011 Medicaid Adult Public Report.

* Indicates significant difference when compared to corresponding benchmark rates.

CAHPS = Consumer Assessment of Healthcare Providers and Systems; DSS = 2012 DSS Adult Medical Book of Business averages; WP = WellPoint average.

2. Characteristics of CAHPS Respondents

The MCE's were able to obtain samples of respondents that were fairly representative of the overall HIP membership, though survey response rates were approximately 50 percent (Table 6.6.3). Respondents to the CAHPS surveys were more likely to be white than the overall HIP population, and less likely to be black (with the exception of MDwise survey respondents), although assessing the racial mix is challenging because the administrative data do not allow for

multiracial members, but the CAHPS does. Women appeared to be over represented among the survey respondents, particularly among respondents to the MHS CAHPS.

Table 6.6.3 Demographic Characteristics of CAHPS Respondents, by Health Plan

Demographic Characteristics	HIP Members	Anthem Survey Respondents	MDwise Survey Respondents	MHS Survey Respondents
Number	56,245	620	722	421
Response Rate	n/a	47%	56%	47%
Race/Ethnicity				
White	82.0%	86.8%	84.1%	90.9%
Black	10.5%	8.3%	12.3%	6.4%
Hispanic	3.4%	2.3%	4.6%	2.5%
Asian	2.1%	3.9%	1.5%	3.0%
Native American / Alaskan Native	0.1%	1.8%	2.4%	1.7%
Other	1.9%	3.2%	4.5%	2.8%
Gender				
Female	67.6%	69.8%	72.2%	77.8%
Male	32.4%	30.2%	27.8%	22.2%

Source: Anthem data are from "2012 CAHPS 4.0H Member Survey prepared for Healthy Indiana Plan" 2012; DSS Research , MDwise data are from "2012 Medicaid Adult CAHPS 4.0H Final Report: MDwise Healthy Indiana Plan" 2012; The Myers Group, and MHS data are from "2012 Medicaid Adult CAHPS 4.0H Final Report: Managed Health Services Indiana, Inc" 2012; The Myers Group. Data on HIP members are from OMPP.

Note: Race and ethnicity were separate questions in CAHPS surveys, and respondents were able to choose more than one race. Therefore, responses will not equal100 percent. HIP Member data produced by OMPP.

C. SELF-REPORTED SATISFACTION FROM MATHEMATICA'S 2012 SURVEY OF HIP MEMBERS

Mathematica's 2013 survey of current HIP members included questions about satisfaction with HIP. Overall, 76 percent of members reported that they were very satisfied with HIP, while an additional 19 percent said they were somewhat satisfied (Table 6.6.4). Further, 98 percent reported that they would choose to re-enroll in HIP if they left but then became eligible again. Of the small number of individuals who said they were somewhat or very dissatisfied, reasons included lack of coverage of certain benefits (such as dental, vision, or certain procedures), dissatisfaction with choice of doctors, and dissatisfaction with a payment or administrative issue (data not shown). However, the group of individuals asked about their reason for dissatisfaction was too small to provide reliable data.

Table 6.6.4 Satisfaction with HIP

Level of Satisfaction	Total	< 100% FPL	> 100% FPL
Total number	16,830	11,477	5,353
Overall level of satisfaction with HIP			
Very satisfied	76.2%	75.7%	77.1%

Level of Satisfaction	Total	< 100% FPL	> 100% FPL
Somewhat satisfied	18.5%	18.9%	17.7%
Neither satisfied nor dissatisfied	2.1%[b]	2.0%	2.2%
Somewhat dissatisfied	3.0%[b]	3.3%	2.3%
Very dissatisfied	0.2%[b]	0.2%	0.4%
Don't know	0.0%[b]	0.0%	0.0%
Would try to re-enroll in HIP if they left but became eligible again:	16,830	11,477	5,353
Yes	98.2%	98.3%	98.2%
No	0.5%[b]	0.4%[b]	0.7%[b]
Don't know	1.2%[b]	1.2%[b]	1.1%[b]

Source: Mathematica analysis of 2013 survey of HIP members.
[b] These estimates may be unreliable because they are based on fewer than 30 respondents.

D. HEALTH PLAN INQUIRIES

The State maintains a consumer issue management system known as the "Internet Quorum" or "IQ," which permits the State to monitor and manage formal and informal inquiries. In each year, the total number of inquiries has been lower than in the previous years (see Table 5.2 in the Consumer Issues section).Overall, the number of inquiries has fallen by 79 percent between 2008 and 2012.

As in previous years, most inquiries in 2012 were questions of a general nature about HIP (See Table 5.3 in the Consumer Issues section). Eighteen percent of inquiries were about buying into HIP, six percent related to the waiting list, and the remaining were questions regarding specific HIP plans, including the ESP. These percentages are similar to those seen in 2011 (data not shown).

6.7 GOAL VII – ASSURE STATE FISCAL RESPONSIBILITY AND EFFICIENT MANAGEMENT OF THE PROGRAM

The enabling state legislation requires that HIP be a fiscally sound program. While an increase in hospital reimbursement rates effective July 1, 2011 meant that the program did not maintain budget neutrality within DY5, the waiver margin is measured cumulatively, over the course of the five years, the program remained budget-neutral. In 2012, no new cost-saving measures were implemented, and DSH funding allocations remained consistent with previous years.

A. FEDERAL FINANCING ISSUES AND BUDGET NEUTRALITY.

In 2011, the Indiana General Assembly enacted Public Law 229-2011, Section 281, which established a hospital assessment fee program. Under this program, the State collects an assessment fee from certain hospitals, and uses part of the resulting funds to increase hospital reimbursement rates. These new reimbursement rates cannot exceed the Medicare upper payment limits in the aggregate. In May 2012, CMS approved the State Plan Amendment and waivers needed to implement these changes with an effective date of July 1, 2011. All changes are retroactive to this date and will continue until June 30, 2013 (legislation has now extended the fee through June 30, 2017).

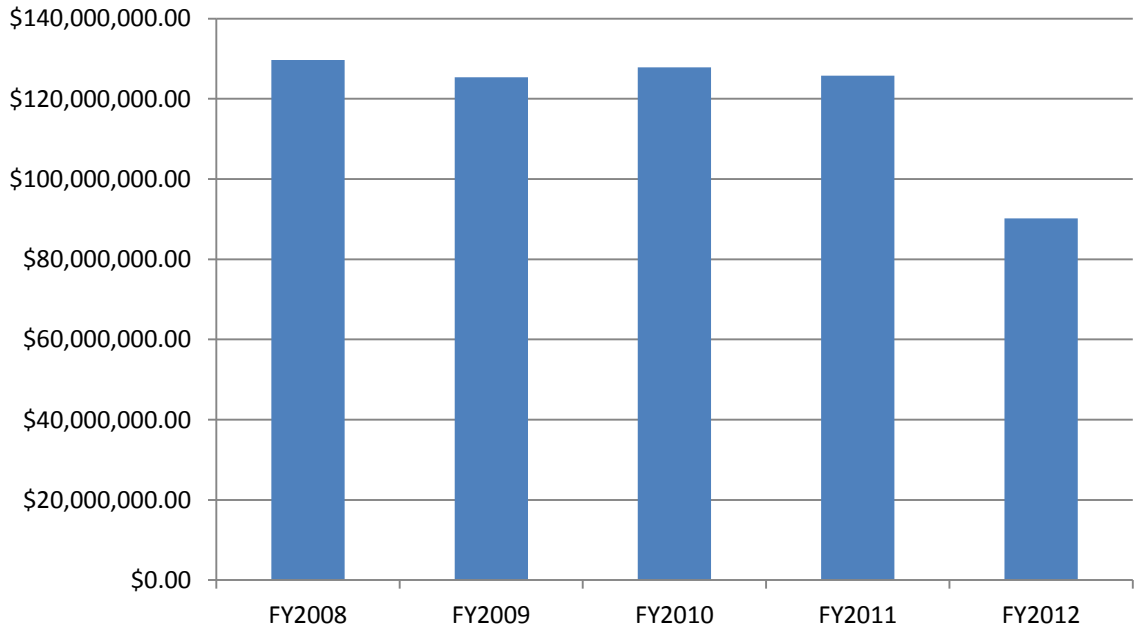
According to estimates by the HIP actuary, Milliman Inc., the state maintained waivers margin well above the total CMS-approved limit from DY1 through DY4. These margins were based on PMPM costs for HHW caretakers, children, and pregnant women, which grew at a slower rate than the projected Medicaid spending established in the Special Terms and Conditions of the HIP waiver. In DY5, however, the waiver margin was negative $73 million due to the increased hospital reimbursement rates described above. These increased rates have led to higher PMPM expenditures for HHW caretakers, children, and pregnant women. PMPM expenditures for HIP caretakers and non-caretakers in DY5 aligned closely with DY4 expenditures for these groups. However, the waiver margin is cumulative, and was maintained across the five years of the demonstration.

B. STATE FINANCING ISSUES

1. Cigarette Tax Revenues

By design, cigarette tax revenues are the dominant financing mechanism for HIP. To date, HIP has collected nearly $599 million in revenues from the cigarette tax implemented in 2007 (Figure 6.6). Cigarette taxes have fluctuated, but have hovered between $120 and $130 million each year.[19] HIP is required to channel $11 million into an immunization fund each year. These payments were not made in FY2010 and FY2011, resulting in a lump sum of $31 million deposited into the fund in FY2012 and a lower level of tax revenues dedicated to HIP during this fiscal year.

Figure 6.6.1 Indiana Revenues from State Cigarette Taxes Allocated to HIP



Source: Mathematica calculations based on data provided by Milliman, May 2013.

2. DSH funds

In 2012, the State continued to reallocate about $50 million in existing Disproportionate Share Hospital (DSH) dollars to HIP. This is the same amount that had been reallocated in each previous year of the waiver However, the 2012 waiver extension included a request to restore DSH funding, since the State had achieved its waiver margins.

3. Power Account Contributions

The monthly contributions that HIP members make to their POWER accounts are the third mechanism for funding HIP. POWER accounts are set at $1,100 per year. The monthly contributions are based on income and a sliding scale. Members may pay as much as 5 percent of their income. Mathematica estimates that the maximum POWER account contributions for 2008 and 2009 were on average less than $20 million per year, but for 2010 were closer to $30 million. In 2011 and 2012, total estimated POWER account contributions were again less than $20 million.

SECTION 7: CONCLUSIONS

The HIP program has proven to be a promising model for expanding access to healthcare for low-income populations who are otherwise not eligible for Medicaid coverage. As demonstrated throughout this report, a consumer-driven health model promotes more conscious healthcare utilization and engagement in decision-making. HIP members overwhelmingly report that they value their health coverage, would be willing to make higher POWER account contributions to remain enrolled, and prefer paying "up front" (funding the POWER account) to making copayments each time they seek medical care. Eighty-five percent of members feel that their required contributions are either the right amount or below the right amount, and only a small proportion (14 percent) of former HIP members reported that cost-sharing had been their reason for leaving the program. Overall initial POWER account contribution rates have increased steadily over the course of the demonstration, indicating that contribution amounts are affordable and that members value having coverage. HIP members continue to report high overall satisfaction with the program, and demand for HIP coverage continues to grow, as evidenced by the rate at which the non-caretaker waitlist has grown until it was closed in December of 2012.

Overall uninsurance rates for the HIP-eligible population have increased slightly over the years of the demonstration, likely due to external factors such as the national recession and higher rates of unemployment. However, the uninsurance rates for those Hoosiers under 50 percent of the FPL have actually *decreased* approximately four percentage points from 2007 (before the program was first implemented) until 2012. HIP has very plausibly been a primary driver of that outcome. Additionally, if HIP had not been available, the state uninsurance rate would likely have increased more during the demonstration period than it actually did due to general economic conditions.

HIP has accomplished all of these goals while maintaining fiscal soundness. Over the course of the five years of the demonstration, HIP has cost approximately $1 billion. The overall five-year waiver margin is $1.1 billion. With the exception of the cigarette tax revenue used to fund the program, HIP has no other impact on Hoosier taxpayers.

Over the life of the program, challenges with MCE provider networks and process issues in providing care have been addressed. Provider networks have improved significantly for both primary and specialty care in the five years of the demonstration. There are still areas where improvements can be made, including increased member awareness of how the POWER account works and understanding of the connection between receipt of preventive care, account rollovers, and reduced contributions. The State continues to work with the MCE's to meet quality metrics and implement effective chronic disease management programs.

Overall, HIP has experienced marked success in making healthcare accessible to a vulnerable, low-income population which otherwise would have had no avenue to public coverage in the past five years. The State anticipates continued accomplishments and improvements over the extension years. Additionally, the State continues to seek guidance on the future of the HIP program from CMS in the context of the Affordable Care Act of 2010.