Alternative Benefit Plan

State Name: Indiana

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0003

OMB Expiration date: 10/31/2014

Enrollment Assurances - Mandatory Participants ABP2c

These assurances must be made by the state/territory if enrollment is mandatory for any of the target populations or sub-populations.

When mandatorily enrolling eligibility groups in an Alternative Benefit Plan (Benchmark or Benchmark-Equivalent Plan) that could have exempt individuals, prior to enrollment:

☑ The state/territory assures it will appropriately identify any individuals in the eligibility groups that are exempt from mandatory enrollment in an Alternative Benefit Plan or individuals who meet the exemption criteria and are given a choice of Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan, not subject to section 1937 requirements.

How will the state/territory identify these individuals? (Check all that apply)

☒ Review of eligibility criteria (e.g., age, disorder/diagnosis/condition)

Describe:

For the initial rollout of HIP 2.0, the State will use the data available through the individual's addendum to the eligibility application or existing data on record to determine medically frail status. This includes whether the member was previously enrolled in HIP with eligibility for the Enhanced Services Plan, which served individuals with serious medical conditions, or if they have a disability determination from the Social Security Administration. Individuals that meet this criteria will be considered medically frail.
Individuals have the right to appeal all medically frail determinations through the state.

☒ Self-identification

Describe:

The use of self-identification to determine medically frail individuals will mostly be utilized for the newly enrolled at initial enrollment or after enrollment due to a change in the member's health status. This identification method may be utilized at the time of enrollment for the newly enrolled since the state will not have historical data, such as claims available. The addendum to the application for HIP will include questions that will screen for medically frail status. The following outlines the Self-Identification Process:
• State to analyze responses received from the addendum to the application to identify the medically frail.
• Individual preliminarily flagged as medically frail.
• Managed Care Entity (MCE) to validate applicant data to confirm medically frail status. The validation period is 60 days for calendar year 2015, and 30 days for subsequent years.
During this period, individuals that self identify will be eligible for the State Plan ABP.
Confirmation may occur through applicant interview or follow-up, health risk assessment, current treatment (claims) and/or physician medical attestation.
• MCE confirms medically frail status when a member has a condition listed on the medically frail condition listing and meets the following point threshold using the Milliman Underwriting Guidelines (MUGS):
- 150 debit points for indicated medical conditions; or,
- 75 debit points for indicated behavioral health conditions; or,
- 75 debit points for indicated substance abuse conditions; or,
- Needs assistance with one of the activities of daily living.
The debit point system above provides the minimal points a member would meet to be identified as medically frail. For example, individuals who are infected with the hepatitis C virus, but have no signs of the virus, receive no medications and have normal liver functions, will be assigned 50 debit points and not qualify as medically frail. However, an individual that has abnormal liver function will be assigned 150 debit points or higher for conditions such as cirrhosis of the liver at 650 debit points. From these examples, an individual must meet 150 debit points or higher and have a condition listed on the medically

frail condition listing to be considered as having a medical condition identified as medically frail. A medical condition that falls below the 150 threshold and/or is not a condition listed on the medically frail condition listing would not be considered medically frail. A medically frail determination would be effective for 12 months. The debit point system, threshold range, and extensive tables of medical conditions each assigned debit points was developed from the Millliman Underwriting Guidelines and is the methodology that will be utilized to determine a medically frail identification.
The Milliman Underwriting Guidelines have been used in the state as part of the current process to identify medical conditions that require extensive care. Those individuals receive benefits from the Enhanced Services Plan. This plan will be replaced with the State Plan ABP, but the identification process is relatively the same in utilizing the debit point system for appropriately identifying an individual as medically frail and for the renewal or monitoring on an on-going basis those meeting the criteria.
To develop the debit point system, a code list and software tool from leveraging medical codes and pharmacy NDC codes was used. The use of medical and pharmacy codes in assessing claims data allows for an automated process when screening individuals for medically frail conditions on an ongoing basis. The debit point system is developed to be consistent with the Milliman Underwriting Guidelines.
In addition, during the enrollment period, any member may report to the plan that they want to be screened for medically frail status due to a change in health condition. MCEs will screen any individual that identifies as medically frail after enrollment. For members that self-identify on the addendum to the application, or self-identify to the MCE after enrollment prior to the receipt of billed claims that confirm their frail status, a risk assessment will be conducted by a Medicaid enrolled provider. The risk assessment will determine if the member meets the medically frail criteria. Members that meet the medically frail criteria will receive the ABP that is the State Plan benefits.
Individuals have the right to appeal all medically frail determinations through the state.

☒ Other

Describe:

On an ongoing basis, health and pharmacy claims data and data from medical professionals including lab results will be used in the identification and conformation of medically frail status using an automated process. Similar to verification that occurs with the self-identification, members that have pharmacy or medical claims that demonstrate conditions that may qualify them for medically frail status will have their claims checked against the Milliman Underwriting Guidelines. Those that have claims over the point threshold will be designated as medically frail and receive the ABP that is the State Plan. For individuals that do not meet the medically frail threshold based on claims alone, medical records and lab results may be utilized to verify medically frail status.
Individuals have the right to appeal all medically frail determinations through the state.

☐ The state/territory must inform the individual they are exempt or meet the exemption criteria and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

☐ The state/territory assures that for individuals who have become exempt from enrollment in an Alternative Benefit Plan, the state/territory must inform the individual they are now exempt and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

How will the state/territory identify if an individual becomes exempt? (Check all that apply)

☒ Review of claims data

☒ Self-identification

☒ Review at the time of eligibility redetermination

☒ Provider identification

☐ Change in eligibility group

☐ Other

How frequently will the state/territory review the Alternative Benefit Plan population to determine if individuals are exempt from mandatory enrollment or meet the exemption criteria?

○ Monthly

○ Quarterly

○ Annually

○ Ad hoc basis

◉ Other

Describe:

Managed Care entities will continually assess their enrolled population to determine if an individual has claims that qualify them for medically frail status. The Managed Care Entities will alert the state when an individual qualifies for medically frail status to initiate the activation of benefits of the Alternative Benefit Plan (ABP) that is the State Plan.

Managed care entities determination of frail status is subject to review by the state.

☑ The state/territory assures that it will promptly process all requests made by exempt individuals for disenrollment from the Alternative Benefit Plan and has in place a process that ensures exempt individuals have access to all standard state/territory plan services or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

Describe the process for processing requests made by exempt individuals to be disenrolled from the Alternative Benefit Plan:

Individuals that meet the medically frail criteria will not receive the HIP Basic and HIP Plus benefits described in the Alternative Benefit Plans (ABPs) and do not have the option to opt into these plans, because they are less generous. Individuals that self-identify, or are identified by claims as medically frail after enrollment in the HIP Basic or Plus Plans will be enrolled in the the ABP that is the State Plan. The benefits will be active and effective the first of the month following the report and/or verification of frail status. These benefits will be provided through the same Managed Care Entities that provide the HIP Basic and HIP Plus ABPs with Essential Health Benefits (EHBs). The benefits of the ABP that is the State Plan as provided to HIP eligible individuals through managed care are at least as generous as the HIP Basic and Plus benefits in each benefit offered and offer additional benefits in excess of what is covered in these plans.

Other Information Related to Enrollment Assurance for Mandatory Participants (optional):

To ensure accurate and fair identification methods are in place when determining a member's medical condition, such as medically frail, the state will establish an oversight process. The State utilizes external quality control measures to ensure proper identification for medically frail individuals. The type of quality control measures utilized depends on the identification method used by the MCE. When the MCE identifies a member as medically frail, they must document and notify the State. The notification must include (1) the medically frail designation; (2) the date of the determination; and (3) the method used to make the medically frail determination. The following outlines the State audit procedures based on the identification method used.
• MCE identifies member as medically frail based on the Milliman Underwriting Guidelines by using the Milliman tool that conducts analysis of claims data. The tool analyzes claims to determine if the member has accrued sufficient debit points to meet the debit point thresholds that designate a member as frail. The State will review the determination and claims data on an ongoing basis throughout the enrollment period, however, determinations made by the MCEs through the use of the Milliman tool based on member claims are considered to be non-partial.
• MCE identifies member as medically frail based on supplemental data. All supplemental data used to support a frail designation must

be indexed to the Milliman Underwriting Guidelines. The Milliman tool provides an automated way to analyze claims for indications of frail status, however if claims have not yet been filed, the Milliman Underwriting Guidelines may also be met through a manual process. When meeting the Milliman Underwriting Guidelines points thresholds through a manual process, the MCE must complete a generic description of the information utilized by the MCE to support the medically frail designation. This information will be reviewed by the State or its designated vendor to independently confirm these medically frail designations. The State will also conduct audits of the MCE's medically frail determinations to ensure the Milliman Underwriting Guidelines are appropriately applied.

Medically frail audits will include review of data to form a complete picture of the health of the member. This data review could include, but not be limited to: output files from the Milliman Renewal MUGs tool indicating the number of debit points the member accumulated; completed Health Risk Assessments; documentation of attempts to make contact with their member and/or physician(s); recorded responses and supporting information indicating member impairment in Activities of Daily Living (ADLs); and supplemental information gathered by the MCE in order to make a complete decision (such as lab results, physician notes or lifestyle factors). To ensure accurate and timely review of members, the State will also monitor the average time and determination completion rate for each MCE as well as complete in depth reviews surrounding member state appeals (e.g. rate of appeals, appeals outcome statistics, number of State Fair Hearings requested) and Internet Queries (IQs).
In addition, to the specific methods described, the State's audit procedures are ongoing. The State will conduct regular audits of the MCE's Medically Frail Supplemental File to determine and verify appropriate placement of medically frail members including the use of Milliman Underwriting Guidelines. If the member does not meet the medically frail criteria based upon the State's review, the State will request additional information from the MCE. The State anticipates that approximately ten percent (10%) of the total HIP population will be designated as medically frail. If at any time the State finds that a significant amount more or less than ten percent (10%) of an MCE's total HIP population is designated as medically frail, the State will initiate a random audit of the MCE population to ensure that the Milliman Underwriting Guidelines are being applied appropriately or supporting data was used properly. If any MCE is found to have a consistent issue applying the Milliman Underwriting Guidelines in a uniform fashion, the State's will take the appropriate corrective actions.
The State's oversight processes, as explained, focus on ensuring the member receives the proper health services needed which include the appropriate health designation.

PRA Disclosure Statement

V.20140415