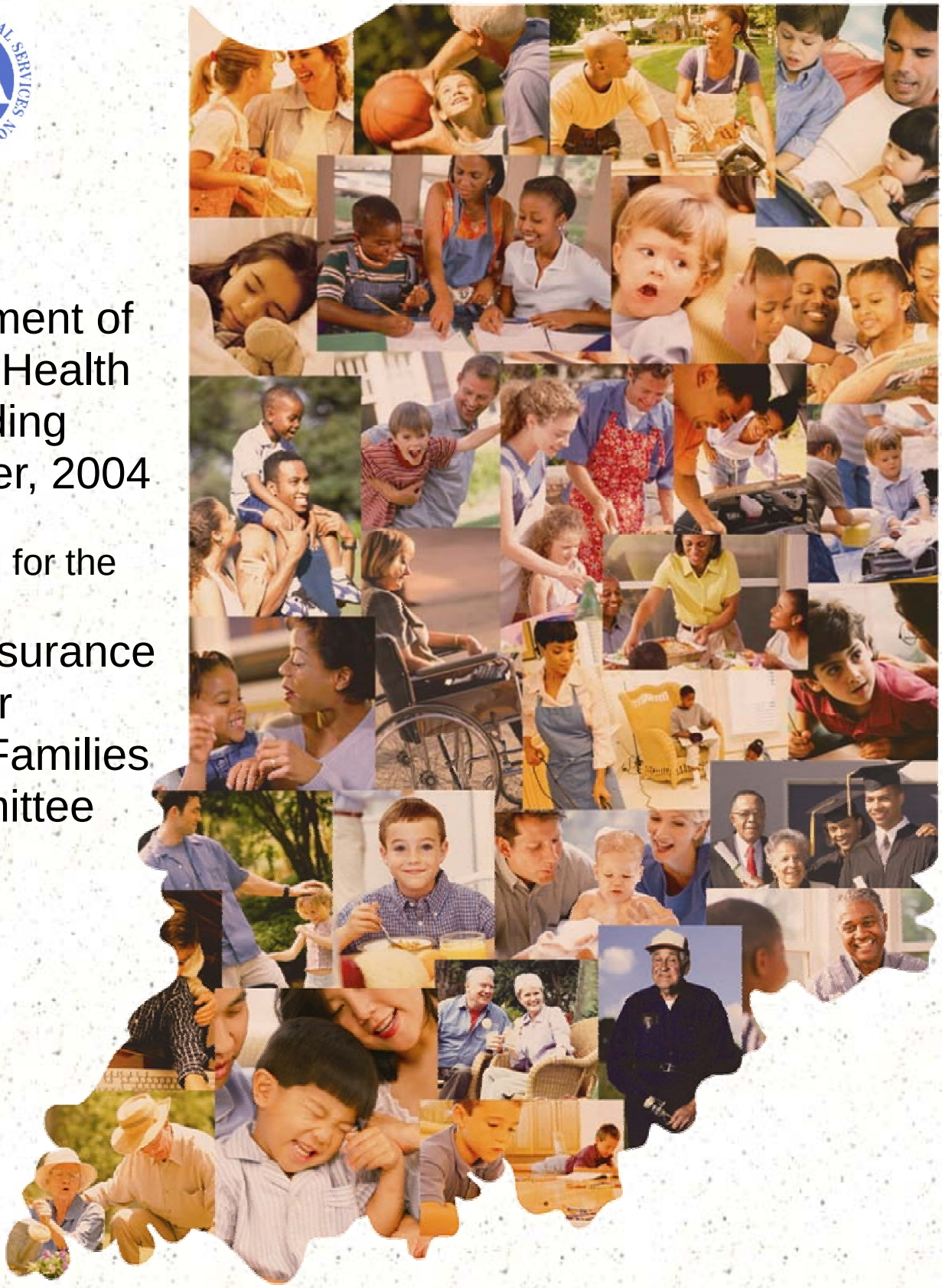
Assessment of Indiana Health Funding November, 2004

prepared for the

Health Insurance for Indiana Families Committee



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FOREWARD

Hoosiers and people around the United States are paying more for health care than ever before. Increases in health care premiums have left some Hoosiers without insurance, underinsured, or on the verge of losing coverage. Employers face double-digit increases in premiums. Rising health care costs undermine the ability of individuals, businesses, and the state to purchase health care coverage.

There are approximately 45 million uninsured Americans. In Indiana, the percentage of Hoosiers without coverage is lower than the national average. The Family and Social Services Administration (FSSA) telephone survey reached more than 10,000 people and showed an uninsured rate of 9.2%. National studies put Indiana's rate at 12.9%. This means more than 600,000 Indiana citizens do not have health insurance.

The face of the uninsured has changed. It includes mostly working families and larger numbers of the middle class. Being uninsured has a great impact on individuals, families, communities and the economic vitality of the state. People without health insurance often have poorer health status, which affects their ability to work. Lack of health insurance is one of the leading causes of personal bankruptcy. Uninsured patients often delay care ultimately receiving costly emergency room treatment. Safety net hospitals and other institutions created to provide care for the indigent are struggling.

With great concern for these issues, the Indiana Family and Social Services Administration (FSSA) competed for and was awarded a $1.1 million State Planning Grant from the Health Resources and Services Administration (HRSA) in July 2002. The grant provided Indiana the opportunity to study its uninsured population and develop viable policy options for providing access to affordable coverage.

The Indiana State Planning Grant work was guided by the Heath Insurance for Indiana Families committee, a bi-partisan group that included public and private officials, representatives from small and large businesses, insurers, physicians, hospitals, the Indiana University School of Medicine, safety net providers, and advocates that developed options to address the needs of uninsured Hoosiers.

State Planning Grant funds were used to support data collection to aid committee members in their deliberations. The data collected was unparalleled in its scope and depth in providing information on the uninsured and the Indiana health care system.

The following reports were received by the committee. The contents are not endorsed or recommended by the committee.

I. 10,000 Person Household Survey

Over 10,000 Indiana residents were surveyed between February and April 2003 to understand key characteristics of the uninsured. The survey identified who the uninsured

are, where they live, where they receive care, their age, race, employment and health status.

II. Focus Groups of Businesses, Uninsured, Brokers, and Providers

The purpose of the focus groups was to gain insight from those affected by this issue and to understand the local dynamics of how people access care or experience barriers. Forty-seven focus groups were conducted throughout the state with more than 350 individuals. The stakeholder groups included uninsured and underinsured individuals, physicians, hospital administrators, businesses, insurance brokers, and community group. They were asked about cost, the consequences of no coverage, what should be in a basic plan, and their experience with government health programs.

III. Assessment of Indiana Health Funding

This report attempts to catalogue the major funding sources, eligibility requirements, and restrictions on funding. It also examines Indiana's current financing mechanisms and outlines additional opportunities for leveraging federal dollars. The report lays out issues that must be considered in determining whether the options presented are feasible.

IV. Safety Net Assessment

This report is intended to broadly identify and assess the major providers of safety net services in Indiana. It reviews the availability of primary, specialty, mental health, hospital and dental health care services and their financing. The information in the report was derived, in part, from the results of a survey of the Indiana Step Ahead Councils, as well as from interviews with the Indiana Primary Health Care Association (IPHCA), the Rural Health Association, and others. The report also discusses the Indiana Medicaid program and its significance to safety net providers.

V. Assessment of National & State Efforts to Address the Uninsured

This report focuses on the variety of options most commonly used by other states to expand health coverage. The report examines public program expansions, health insurance market reforms and initiatives, tax-based reforms, community-based programs, and strengthening the safety net.

VI. Indiana Market Assessment and Drivers of Health Care Costs

This report examines Indiana's demographic and economic changes that have affected the affordability and structure of private health insurance. The report provides an overview of Indiana's health care sector, the economic impact of cost reduction, Indiana's health insurance market, employer coverage, and cost drivers.

VII. Indiana Market Assessment & Drivers of Health Care Costs

A. Indiana's Health Care Sector and Insurance Market: Summary Report

This report examines Indiana's demographic and economic changes that have affected the affordability and structure of private health insurance. The report provides an overview of Indiana's health care market place including its impact on the overall economy. The report compares Indiana to neighboring states and identifies cost drivers.

B. Indiana's Health Care Sector and Economy Report

Understanding the impacts of rising health care costs on the economy is important, but it can be difficult to measure. In this report, health care services are considered as a source of employment. Finally, this report includes two analyses: a simulation of the impacts of rising health care costs in Indiana, and estimation of the possible impact of greater insurance coverage on hospital uncompensated care.

C. Indiana's Health Insurance Market

This report reviews the literature on state regulation of the small group and individual health insurance markets and describes three types of small-group insurance regulation.

D. Employer Sponsored Coverage in Indiana

This report reviews coverage rates overall (including both private- and public-sector workers and their families), as well as rates of employer offer, eligibility and take up. This report considers aspects of employer-based coverage that have cost implications.

E. Factors That Drive Health Care Costs in Indiana

This report examines trends in health care spending in Indiana for various types of services, changes in service utilization and price data. Several factors that may drive cost increases are considered, including changes in demographics, health insurance, service supply, and population health status.

VIII. Actuarial Analysis of Policy Options

This analysis estimates the number of people eligible and enrolling in the program at various income eligibility levels up to 250 percent of the Federal Poverty Level (FPL). The report also estimates the cost of coverage under three alternative benefits packages. The actuarial analysis of alternative benefits packages addresses the selected expansions in eligibility, program costs under alternative benefits packages, minimizing crowd-out, the impact of premium contribution requirements, and buy-in.

ACKNOWLEDGMENTS

The final report of the Health Insurance for Indiana Families represents the work of many individuals who donated their time, expertise, and energy to oversee the data collection efforts and to develop policy recommendations. The committee and subcommittees met monthly for more than two years and their efforts are sincerely appreciated. Additionally, we would like to thank members of the FSSA Technical Assistance Group which included Kathy Moses, Kari Kritenbrink, Joe Shelton, Judy Tonk and Michelle Geller.

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The HIIF Reports and Recommendations Are Online At :

http://www.in.gov/fssa/programs/chip/insurance/index.html

ASSESSMENT OF INDIANA HEALTH FUNDING

A Report to the Health Insurance for Indiana Families Committee, Indiana Family and Social Services Administration

By

Evelyn Murphy
Health Evolutions
February 4, 2004

FINAL

Health Evolutions was retained by the Indiana Family and Social Services Administration (FSSA), on behalf of the Health Insurance for Indiana Families Committee (HIIF Committee), to provide an inventory of existing program funding, their purpose, function, limitations, and provide recommendations for enhanced funding.

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EXECUTIVE SUMMARY

A critical issue for Americans today is the ability to obtain affordable healthcare. Between 1997 and 2000, health insurance costs increased at an alarming rate. Group insurance premiums between 1997 to 2000 rose by 33 percent. During the same period, individual premiums increased by 71 percent. During the same time, states found themselves with significant shortfalls with public programs unable to adequately support the growing health care needs of poor, working families. Between 1995 and 2000, the percentage of low-income parents who are uninsured by Medicaid, which makes up more than one-quarter of national health care spending, fell by almost one-quarter.

Indiana provides several publicly-funded programs through a variety of federal, state, and local funding streams, and a variety of public and private healthcare entities.

Table 1: Summary of Health Funds--All dollars are in millions. (Funding is shown for the year in which information was readily available for purposes of this report).

Agency/Program	Allocation/Expenditures SFY2002	SFY2003	SFY2004	Notes
A. STATE AND FEDERALLY-FUNDED PROGRAMS				
1. Public Health Programs				
a. Community Health Centers			$16.0	Grants available through ISDH from Tobacco Master Settlement funds; some of which is duplicated in FQHC funding below
b. Children with Special Health Care Needs			$22.0	State general funds and dedicated funds
c. Services for HIV/AIDS (including Rx)			$3.2	Includes $2.3 from Tobacco Master Settlement and $1 pass-through from FSSA
d. ICHIA premiums			$0.5	
e. Other			$3.4	Includes other funding not included in above such as HIV/AIDS care coordination pass through from FSSA, newborn, breast and cervical cancer and other screenings, cessation programs for pregnant women, etc.
Sub total for public health services			$45.0	Includes all ISHD funding less surveillance and administrative dollars (Appendix B detailed inventory of State Department of Health funding)
f. Health Facilities			$61.0	Includes $7.4 for Silvercrest, $10 for Soldier's and Sailor's Children's Home and $43.6 for Veteran's Home (Total includes operations and services)
2. FSSA				
a. Medicaid	$3, 789.1	$3,946.6	$4,367.9	Includes all Medicaid services, HCI and DSH payments, and CHIP (Appendix C--Medicaid Expenditure forecast). Generally constitutes 62% federal and 38% state $.
b. Hoosier Rx	$6.7	$7.1		Wholly funded through appropriated funds from the Tobacco Master Settlement funds. Will be potentially federally funded through Medicaid if waiver is approved.
c. Mental Health				
i. Community Mental Health	$80.2			Represents total interagency transfer to Medicaid for Medicaid Rehabilitation Option program and is included in Medicaid total. This represents state portion only.
ii. Substance Abuse Prevention/Tx	$30.4			

Agency/Program	Allocation/Expenditures SFY2002	SFY2003	SFY2004	Notes
iii. Psychiatric Hospitals	$197.4			
Total Mental Health	$308.0			
d. DDARS				
i. DD Centers		$126.7	$172.0	
ii. Day Services			$67.0	
iii. Residential Services			$31.0	
Total DDARS			$270.0	Includes interagency transfers to Medicaid to support home and community-based waiver programs. Also duplicated in Medicaid total. This represents state portion only.
e. Home care for the elderly (CHOICE)			$48.7	Includes $7.4 million intergovernmental transfer annually to fund home and community-based waivers for elderly
f. DFR--First Steps		$56.9		
3. School Corporations		$5.4		Medicaid payments to school corporations, also duplicated in total Medicaid
4. FQHCs				
a. Medicaid payment		$11.4		Duplicated in Medicaid total
b. Federal Grant (HRSA)	$8.3			
c. State grant	$5.5			Amount for 2004 (not shown here) is duplicated in Public Health total
d. All other sources	$11.6			(WIC, local, private pay, private insurance, donations)
Total FQHCs	$36.8			Medicaid payment is for SFY03 and is duplicated in Medicaid total for SFY03. All other sources are for SFY02.
5. Rural Health Clinics		$3.7		Total is duplicated in Medicaid SFY2003 total
6. Prison Health Systems				
a. DOC Medical Services Payments			$25.0	Represents appropriations for medical services for committed persons under jurisdiction of ISDH, DOC, DMHA, Blind School, Deaf School, and DDARS provided outside DOC institutions. Funding does not support services covered through appropriations for those agencies or Medicaid.
b.County Jail Maintenance Contingency Fund			$17.5	Funding is used to reimburse Sheriffs for medical services provided to State prisoners housed in county jails
c. Drug Abuse Prevention for DOC inmates			$0.037	Funding used by DOC to provide drug abuse therapy for offenders under Ind. Code 11-8-2-11
Total Prison Health Systems			$42.5	
7. Tobacco Master Settlement			$96.5	Most of these funds are appropriated for health care services under other programs, including CHIP, DD client services, public health programs, Hoosier Rx and Tobacco Use Prevention and Cessation Board
8. ICHIA			$89.4	This represents one-year period beginning 12/1/02-11/30/03
9. State Employee Benefits			$160.0	Excludes COBRA and early retirees. Represents annualized expenditures (Appendix G).
B. COUNTY/LOCAL FUNDING				
1. Health and Hospital Corporation tax levy				Used to fund DSH payment, Health Advantage, nursing home and hospital UPL payments
2. County tax levies for Hospital Care for Indigent Trust Fund			$55.2	$42 which represents intergovernmental transfer for HCI add-on payment to hospitals is included in Medicaid total

Agency/Program	Allocation/Expenditures SFY2002	SFY2003	SFY2004	Notes
3. CMHC County Tax	$23.5			
4. Healthcare Expenses for County Jails			Unknown	County jail health services are funded locally, however, the amount of funding was not determinable to include in this report
5. Health Insurance for City and County Employees			Unknown	This includes health insurance for city and county employees as well as for retired teachers and spouses which is funded out of the public employee's retirement fund. Health care funding for city and county employees is a significant pool of health care funding, however, the total amount is not determinable for purposes of this report. For example, in FY03, the city of Indianapolis's budget alone includes close to $16 million for group health insurance expenditures.

Among these funding streams, Medicaid is the largest. Medicaid programs across the nation have continued to increase their rolls, and with a national recession, played a role in increasing program shortfalls. On the bright side, increasing enrollment in the Medicaid program likely plays an important role in Indiana's reducing the uninsurance rate. The Current Population Survey (CPS) 2001 estimate of uninsurance in Indiana was 11.8% while the 2003 Household Survey shows a 9.2% uninsurance rate. Despite increases in overall enrollments, Indiana's Medicaid program lags behind many states in providing affordable health care coverage for working adults, low income families:

- With the exception of children, Indiana's Medicaid program serves individuals with monthly incomes significantly below the poverty level (as low as 25 percent of FPL).
- Indiana has one of the lowest income thresholds (about 31 percent of FPL) for a working parent with two children.
- Indiana is one of four states with an asset limit of $1,000 which is more restrictive asset test for low income adults and families (the SSI asset limit of $2,000 for an individual/$3,000 for couples). The other three states are Idaho, Georgia and Alaska. Sixteen states have eliminated the asset test for low income adults and families.

Indiana has made significant efforts in the last few years to provide more financial support for healthcare services for adults in poor working families by leveraging more federal funding with limited resources. However, none of these efforts have created significant opportunities for Indiana's ability to serve poor working families. Indiana's income poverty level and asset test is still one of the lowest in the nation.

There are still opportunities for the state to provide health care coverage for poor working families. However, most of them constitute a significant public program expansion which the state's budget is not able to currently support. Others involve shifting costs from one program to the other in an effort to provide health care services for a greater number of individuals. There are some that require accessing already available federal funding and others that require legislative action. Options discussed briefly in this report include creating state tax incentives, seeking waiver approvals from the federal government for high-risk pools, accessing federal community health funding, creating provider taxes, looking at

premium assistance programs, and evaluating the feasibility of adopting the Katie Beckett Option under Medicaid for covering disabled children both from a cost and enrollment perspective, to name a few. These are by no means short-term solutions, but rather provide an array of currently unexplored longer-term means to provide additional resources to serve poor working families in Indiana.

I. INTRODUCTION

Health insurance is a critical part of our economy. Individuals without health insurance tend to wait too long to get needed health care. The uninsured seek health care when their condition has declined significantly, resulting in lost days of work and requiring care in urgent or emergency settings at a higher cost. Individuals who have insurance and employers, bear the burden of these higher costs through increased premiums and/or reduced benefits.

The downturn in the economy in the late nineties to early two-thousands, as well as a number of national policy changes such as migration of jobs overseas for cheaper labor has intensified the health insurance crisis for working families. During this period, health insurance costs have increased at an alarming rate. *AcademyHealth* reports the following health insurance statistics for the period of 1997-2001:

- The volume of total group premiums rose by 33 percent or 7.4 percent annually.
- Total individual premiums increased by 71 percent or about 14 percent annually.
- The number of workers and their families covered by group health insurance declined slightly by 0.2 percent.
- The number of people reporting individual coverage fell by 1.2 percent.[1]

Nationally, between 1995 to 2000 the number of uninsured rose by 7 percent.[2] In the public sector, with all states facing significant budget shortfalls, health care coverage fared much worse. However, Medicaid programs have seen increasing enrollments as individuals as state programs have expanded to absorb more children and working adults and families who are unable to afford private insurance or do not have employer-sponsored coverage. Medicaid has become the nation's largest health care program which takes up more than one-quarter of the total national health care spending.

There are a variety of health care coverage programs for Indiana families, based on a number of eligibility factors, including age, income, work status, as well as health status (e.g., pregnancy, HIV/AIDS, hemophilia, etc.). Likewise, there are multiple funding sources for healthcare services for various populations, as well as locality of service. Unfortunately, Indiana lags behind many states in providing affordable healthcare coverage for working adults and low income families:

- With the exception of children, Indiana's Medicaid program serves individuals with monthly incomes significantly below the poverty level (as low as 25 percent of the federal poverty level [FPL]).

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[1] Chollet, D. et al., *Mapping State Health Insurance Markets, 2001: Structure and Change,* Robert Wood Johnson Foundation State Coverage Initiatives Program, September 2003, page 2.
[2] Broaddus, M. et al., *Expanding Family Coverage: States' Medicaid Eligibility Policies for Working Families in the Year 2000,* Center on Budget and Policy Priorities, February 2002, page 1.

- Indiana has one of the lowest income thresholds (about 31 percent of FPL) for a working parent with two children.
- Indiana is one of four states with an asset limit of $1,000 which is a more restrictive asset test for low income adults and families (the SSI asset limit of $2,000 for an individual/$3,000 for couples). The other three states are Idaho, Georgia and Alaska. Sixteen states have eliminated the asset test for low income adults and families.

This report attempts to catalogue the major funding sources, eligibility requirements, and restrictions on funding where applicable. Because there is a multitude of possible funding, this report only discusses major pools of funding. However, readers will note several references to other funding streams and information on obtaining further information.

This report also examines Indiana's current financing mechanisms and outlines additional opportunities for growing existing pools of funding through leveraging federal dollars that could be explored. More detailed research and analysis would be needed to determine the feasibility of each of the financing opportunities presented; however, the report lays out some of the issues that must be considered in determining whether the options presented are feasible for Indiana.

II. INVENTORY OF PROGRAM FUNDING AND PROGRAM SUMMARY

The federal government and states share in the cost of health care services in number of public health programs, as well as health care programs for individuals living below the FPL. This section discusses the various programs, funding sources, eligibility requirements, and services supported by the funding.

A. STATE AND FEDERALLY-FUNDED PROGRAMS

1. Public Health Programs

The Indiana State Department of Health (ISDH) administers public health program funding in Indiana and provides public health education focused on prevention of unhealthy behavior and changing or abating existing unhealthy behavior. The following provides a brief description of these programs.

Community-based health services funded by ISDH include physician services, nurse practitioner services, health education, drug assistance, counseling, supportive services, case management, nutrition education, immunization, and comprehensive primary and preventive health care services for all age groups. Community-based healthcare services have a primary care focus as opposed to an institutional or acute care focus. Services are generally provided by nurses and physicians' assistants under the supervision and guidance of a physician.

ISDH funds help support 24 Community Health Centers (CHCs) across the state located in rural and underserved communities that lack access to primary

care, and serve more than 116,000 patients. (Appendix A—Community Health Center Facts) Their primary focus is to improve the health status of the uninsured, low-income working individuals and underserved populations through prevention and primary healthcare. Public health programs provided through the CHCs, include, but are not limited to:

- Supplying vaccines to immunization providers and conducting outbreak control activities when related diseases are reported.
- HIV Care Coordination which provides specialized case management.
- HIV/AIDs prevention program which provides counseling, testing, referral and partner notification service, and blood screening.
- Maternal and child health services for improving the health of women, infants, children, and adolescents by providing education and prevention services.
- Minority Health Initiatives that focus on underserved and culturally diverse populations.
- Childhood Hazards Education and Prevention which includes lead prevention.
- Other services like breast and cervical cancer screening, sexually transmitted disease prevention, and funding critical access hospitals (such as tuberculosis facilities).
- The ISDH Office of Tobacco and Health (OTAH) works to prevent tobacco use by young individuals and to decrease youth tobacco use through education, prevention, and cessation efforts.

Total appropriations for public health programs (excluding funds for administrative and data collection/survey activities) in SFY2004 is **$45 million**. Of this total, more than **$19.3 million** comes from the Tobacco Master Settlement fund. (Appendix B—ISDH Inventory of Funding) ISDH also provides an additional **$61 million** in funding for the operation health facilities. The following describes some of the major public health funding categories.

a. Community Health Centers

Community Health Centers (CHCs) are local, non-profit organizations that provide comprehensive primary and preventive healthcare services by establishing a medical home for uninsured and underinsured residents of underserved communities. CHCs are staffed with interdisciplinary teams of health professionals and are linked with other providers for their patient's specialty and inpatient care needs. They also provide community health education, outreach, and translation services. An underlying goal of health center programs is to help communities and their residents assume more responsibility for their health. With respect to funding, the programs seek ways to ensure the cost-effective use of public and private resources in enabling communities themselves to meet local health needs.

Since 1995, the ISDH has provided financial support for CHC operations and services through state general fund appropriations and federal grants statewide. In SFY2004, **$16 million** is available in grants from the ISDH from Tobacco Master Settlement funding for CHC primary care services.

b. Children with Special Health Care Needs

Other significant funding pools through ISDH are state general funds and dedicated funds for medical services for children with special needs. Total funding for this category for SFY2004 is almost **$22 million**. Funding is used to pay health care providers for medical services provided to children with special needs who are not Medicaid eligible or for any services that are covered by the Medicaid program. Historically, there has been significant coordination of medical policy between ISDH and the Office of Medicaid Policy and Planning (OMPP) to assure that all services that could be covered by the Medicaid program are in fact covered; although there may still be few services covered through the Children with Special Health Care Needs program. Most of these state funds are used for care provided to children who are not Medicaid-eligible.

c. Services for HIV/AIDS Population

ISDH directly funds services for HIV/AIDS services and prescriptions either through direct payments to providers or payment of premiums under the Indiana Comprehensive Health Insurance (ICHIA) program.

In SFY2004, a total of **$3.2 million** is available for HIV/AIDS prescription drug coverage. Of this total **$2.3 million** comes from the Tobacco Master Settlement fund and almost $1 **million** is provided as a pass-through from Family and Social Services Administration.

d. Health Facilities

There are three health facilities under the jurisdiction of the ISDH. These facilities receive general fund appropriations for operations and services. SFY2004 appropriated funds for each of these facilities are as follows:

Table 2: ISDH Health Facility Funding

Silvercrest Children's Developmental Center	**$7.4 million**
Soldier's and Sailor's Children's Home	**$10 million**
Indiana Veteran's Home—Lafayette	**$43.6 million** ($12.5 million from general fund appropriations. Remainder from Comfort – Welfare Fund.)

2. Medicaid Services, Aging and Disabilities Services, and Mental Health & Addiction Services

The Indiana Family and Social Services Administration (FSSA) administers programs and funding for health care services for pregnant women and children, low income families, and individuals who are elderly, physically or developmentally disabled, and individuals with mental illness or addiction. Programs and services are administered through three specialized agencies:

- OMPP administers the Medicaid program under Title XIX of the Social Security Act which includes home and community-based waivers, the Children's Health Insurance Program (CHIP) under Title XXI, and HoosierRx, the prescription drug program for low income seniors. OMPP shares responsibilities for the Medicaid program with the other agencies below through Memoranda of Understanding. In order to expand health care coverage for low income individuals, the OMPP operates a number of Medicaid Upper Payment Limit (UPL) financing mechanisms allowing additional payments to nursing homes and hospitals. These include Health Care for the Indigent (HCI) add-on payments to hospitals and Disproportionate Share Hospital (DSH) payments to hospitals and additional medical assistance payments to nursing homes.
- The Division of Disabilities, Aging and Rehabilitative Services (DDARS) administers programs and funding for elderly individuals and individuals with physical or developmental disabilities, or mental retardation.
- The Division of Family Resources (DFR) administers programs and funding for low income families and children, and is responsible for Medicaid eligibility determination.

a. Health Care Services for low income individuals administered by the Office of Medicaid Policy and Planning

Medicaid

The Medicaid program (a state and federally-financed program) is one of the most comprehensive programs of health care services nationally. It provides funding for a variety of federally-mandated services, as well as optional medical services which vary state-by-state for low income individuals and families. In State Fiscal Year (SFY) 2003, Indiana's total Medicaid program budget was **$3.9 billion** (state and federal dollars). Total expenditures are anticipated to reach **$4.4 billion in SFY2004.** (Appendix C—Medicaid Expenditure Forecast)

Mandatory services provided by the Medicaid program include: hospital services, physician services, Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) services, laboratory and x-ray services, nursing facility and home health services for individuals 21 years and older,

nursing services, family planning services and supplies, and Early Periodic Screening, Diagnosis and Treatment (EPSDT) for individuals under 21 years.

In addition, Indiana's Medicaid program benefit package covers a number of optional services, including but not limited to: drug coverage, services provided in Intermediate Care Facilities for Mentally Retarded (ICFs/MR), case management services, hospice services, therapy services, transportation to and from medical services, and rehabilitative services.

Individuals are eligible for Medicaid if they fall in one of five major eligibility groups and meet the financial requirements for that group. The five eligibility groups are members of families with children, pregnant women and children, aged, blind, and disabled individuals.

For more detail about each eligibility group, benefit package, and spending by major services or recipient categories, see the Health Management Associates report presented to the Committee, titled *Assessment of State Options for Expanding Health Coverage*, at www.in.gov/fssa/programs/chip/insurance/index.html.

Home and Community-Based Waivers

Other programs funded through Medicaid include the Medicaid Home and Community-based Waivers under section 1915(c) of the Social Security Act. These programs provide a variety of home care services (such as attendant care services, adult day services, and respite care services) to eligible individuals in lieu of institutional care. All home and community-based waiver programs in Indiana have been initiated by the Indiana General Assembly and approved by the Centers for Medicare and Medicaid Services (CMS - formerly, the Federal Health Care Financing Administration [HCFA]). Section 1915(c) waiver programs are not an entitlement, as such States can only serve a limited number of individuals as approved by the CMS.

To be eligible for a home and community-based waiver program, an individual must be otherwise eligible for Medicaid (i.e., aged, blind, disabled, or an eligible child) and must require institutional care (i.e., acute hospital, psychiatric care hospital, nursing home or intermediate care facility for mentally retarded individuals [ICF/MR]). Individuals who are receiving services under a Medicaid waiver are also eligible to receive all the mandatory and optional services under the Medicaid State Plan. The cost-containment feature of home and community-based services is that they are limited by the approved number of individuals served, and by federal regulation which must be no more costly than serving the population in an institutional setting. The cost-effectiveness includes a comparison of community services costs, in addition to all other Medicaid costs (such as hospitalizations and drug costs).

Indiana currently has seven (7) waiver programs, all of which are statewide:

- The Aged & Disabled waiver for aged (65 years or older), blind and disabled Medicaid recipients of any age who otherwise would require nursing facility services.
- The Traumatic Brain Injury Waiver program for Medicaid recipients of any age who have had a traumatic brain injury who otherwise would require care provided in a nursing facility.
- The Developmental Disabilities waiver for disabled Medicaid recipients of any age who otherwise would require services in an ICF/MR.
- The Autism waiver for Medicaid eligible individuals of any age who are autistic and would otherwise require services in an ICF/MR.
- The Assisted Living waiver for aged (65 years or older), blind, and disabled Medicaid recipients of any age who otherwise would require services in a nursing facility.
- The Support Services waiver for disabled Medicaid recipients of any age who otherwise would require services in an ICF/MR.
- The Medically Fragile Children's waiver for Medicaid eligible individuals under 18 years of age who would otherwise require treatment in a hospital or skilled nursing facility.

In SFY2003, expenditures in Medicaid's waiver programs totaled about **$301 million (state and federal $).** The breakdown by specific waiver is as follows:

- **Aged & Disabled** **$28,727,559**
- **Assisted Living** **$73,806**
- **Autism** **$10,322,746**
- **Developmental Disabilities** **$246,427,140**
- **Medically Fragile Children** **$1,596,876**
- **Support Services** **$10,858,346**
- **Traumatic Brain Injury** **$3,478,914**

Expenditure and enrollment information is available at www.state.in.us/fssa/statistics, under DDARS reports. Home and community-based waivers are estimated to grow to **$365 million in SFY2004 and almost $410 million in SFY2005 (state and federal $)**. (Appendix C—Medicaid Expenditure Forecast). The costs of these waiver services are included in the total Medicaid expenditures mentioned above.

Medicaid for Employees with Disabilities

The Medicaid program also supports healthcare for individuals with disabilities who are working through the Medicaid buy-in program known as Medicaid for Employees with Disabilities or MED Works. Beginning July 1, 2002, working individuals with disabilities with incomes too high for regular Medicaid can be eligible for health coverage by buying into the

Medicaid program. MED Works members whose income is more than 150 percent of the FPL are charged a premium on a sliding-fee scale based on income. Premiums range from $48 for a single individual with income between 150-175 percent FPL to $254 for a married individual with income greater than 350 percent FPL.

MED Works members receive the full-range of traditional Medicaid mandatory and optional services under Indiana's Medicaid State Plan. They are required to pay the same co-payments for certain services as other Medicaid recipients.

In the first year, SFY2003, almost 6,000 individuals received Medicaid covered services through the program, with a total cost of **$83.6 million (state and federal $).**[3] The costs of these services are reflected in the Medicaid total above.

HoosierRx

HoosierRx is Indiana's Prescription Drug Program for low-income seniors, funded solely through Tobacco Master Settlement Agreement Fund.

To be eligible an individual must be:

- 65 years old or older
- An Indiana resident (living in the state at least 90 days out of the last 12 months)
- Have no prescription drug coverage through an insurance plan, Medicaid or Medicaid with a spend-down.
- Have a monthly income of $1,011 or less, if single, or $1,364 or less, if married

Enrollees receive a HoosierRx Drug Card to be used at their local pharmacy which entitles them to receive 50% off of the cost of their medications, up to a yearly benefit cap, based on the family's monthly income. Once the cap is met in any given year, enrollees can continue to use their Drug Card to receive a small discount on prescriptions.

Total spending in the HoosierRx program services was **$6.7 million in SFY2002 and $7.1 million in SFY2003 (state $ only).** Total enrollment was 16,659 in SFY2002 and 16,181 in SFY2003. As of December 1, 2003, enrollment is at 17,129.[4] Indiana has applied for a Pharmacy Plus 1115 Demonstration Waiver from the federal government which would allow federal financial participation through the Medicaid program. The waiver application increases income eligibility standards from 135 percent to 185

[3] Andrea Vermeulen, MED Works Program Director
[4] Grace Chandler, Director, Prescription Drug Program, Hoosier Rx

percent of the federal poverty level; however, there has been no final action on the waiver application at the federal level.

Medicaid Rehabilitation Option (MRO)

Federal Medicaid dollars support the provision of case management services, day treatment services, and other therapeutic or rehabilitative services collectively referred to as Medicaid Rehabilitation Services. These services are optional services provided under the Medicaid Rehabilitation Option under the State Plan, and are targeted to adults and children with mental illness or addiction.

MRO services are provided only through 31 Community Mental Health Centers (CMHCs) statewide. The state share of the services under this program is supported by state appropriations for the Division of Mental Health and Addiction and by local county tax dollars provided by the CMHCs.

Total expenditures for MRO services under the Medicaid program was **$186.9 million in SFY2002 and $228.2 million in SFY2003**. Expenditures are forecasted to be **$265 million in SFY2004 and $302.8 million in SFY2005**. (Appendix C—Medicaid Expenditure Forecast) Medicaid MRO expenditures are included in Total Medicaid expenditures above. A detailed discussion of MRO services is provided in Section B of this report under Mental Health and Addiction Services.

Health Care for the Indigent Financing

All 92 counties in Indiana pay a tax levy to finance healthcare for the indigent. These tax collections are deposited into the Indigent Care Trust Fund. The Trust Fund has three general uses:

- Funding services for indigent individuals provided by physicians and transportation providers;
- Making hospital add-on payments to support services provided by hospitals to indigent individuals; and
- Supporting DSH payments for hospitals.

This section describes uses under the Health Care for the Indigent (HCI) program.

Indiana's HCI program is a state program that pays for urgent and emergency hospital care for low income individuals provided in an Indiana hospital. Eligibility is based on Indiana residency; however, individuals who are not Indiana residents are also eligible if the onset of the medical condition that required hospital care occurred in Indiana. Criteria for eligibility is that the hospital care was necessitated by the onset of a medical condition that manifested itself by symptoms of sufficient severity that the

absence of immediate medical attention would probably result in placing the person's life in jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Hospitals, physicians, and transportation providers are reimbursed for the care provided to eligible HCI recipients. There are two types of payments under HCI:

- Payments to physicians and transportation providers (which include non-Medicaid providers). This payment is funded purely from the county property taxes paid into the Hospital Care for the Indigent Trust Fund. This is a non-Medicaid payment.
- HCI Medicaid add-on payments, the most significant portion of HCI payments, are payments to hospitals enrolled in the Medicaid program. The state portion of the HCI Medicaid add-on payments is supported by the Hospital Care for the Indigent Trust Fund. Medicaid HCI add-on payments totaled **$50.6 million in SFY 2003.** It is estimated to reach **$53.1 million in SFY2004**.

The total amount appropriated by the Indiana General Assembly into the Hospital Care for the Indigent Trust Fund is **$55.2 million for SFY2003** and **$56.9 million in SFY2004**.[5] A portion of this amount is what is utilized as the transfer amount to support the State match for the HCI Medicaid add-on payment. The remainder is used for HCI payments to physicians and transportation providers.

The HCI fund transfer amount in **SFY2003 is $40.9 million** and is estimated to be **$49.1 million in SFY2004**. The transfer from the Indigent Care Trust Fund was **$15.6 million in SFY2003** and is estimated to reach **$25 million in SFY2004**. Excess transfers not needed to fund the Medicaid HCI add-on payments and the HCI payment to physicians and transportation providers is used to help fund the Medicaid program in general and to help fund DSH payments. (Appendix C—Medicaid Expenditure Forecast).

Disproportionate Share Hospital (DSH) Financing

This federal financing mechanism under both Title XVII (Medicare) and Title XIX (Medicaid) of the Social Security Act, requires payments to certain hospitals to account for the disproportionate number of low income patients served. Under the Medicaid program, the state augments regular Medicaid payments to DSH hospitals. State general fund appropriations are used to fund the non-federal portion of DSH payments to psychiatric hospitals, as well as a portion of the non-federal share of DSH payments to acute care hospitals. The remainder of the non-federal

[5] 2003-2005 Biennial Budget, Section 8

share of DSH payments to acute care hospitals is funded through intergovernmental transfers.

Disproportionate Share Payments totaled **$105.5 million in SFY2003**. Forecasted DSH expenditures are expected to decline to **$94.2 million in SFY2004**. (Appendix C—Medicaid Expenditure Forecast) A detailed discussion of DSH financing is provided in Section C of this report under Indiana Revenue Enhancement programs.

b. Mental Health and Addiction Services, including State Psychiatric Hospitals

Hoosier Assurance Plan Funding

There are multiple federal and state sources of funding for inpatient and outpatient mental health services in Indiana. Most of the funding is administered by the Division of Mental Health and Addiction (DMHA) Services. Other funding, administered locally, is discussed in Section B of this report, under Local Funding.

Community Mental Health Services funding is funded by the Hoosier Assurance Plan (HAP) funding system. The HAP is the primary comprehensive funding system for mental health and addiction services for adults, children and adolescents, persons with drug or alcohol addition, and persons with gambling addition. It includes funding from a variety of federal sources, as well as from state appropriations administered by DMHA.

The HAP is not an entitlement program. Managed care providers certified by DMHA receive a payment for each enrollee up to the limit of available funding. They are in turn responsible for providing an array of services for the population, for which they are certified, including:

- Individualized treatment planning
- 24-hour crisis intervention
- Case management, including assertive case management
- Outpatient services
- Acute stabilization
- Residential services
- Day treatment
- Family support services
- Medication evaluation and monitoring
- Other services to prevent unnecessary, inappropriate treatment, hospitalization, and deprivation of one's liberty[6]

[6] 460 IAC 4-3-1

Individuals at or below 200 percent of the federal poverty level who are uninsured or underinsured for mental health or addiction services, and who are eligible based on diagnosis and functional status under each of the population categories above, are eligible for HAP funding, up to the limit of available funding.

In SFY2002, DMHA contracted with 36 MCPs to provide mental health, substance abuse and addiction services as follows (Appendix D—DMHA Contract Funding):

- Substance Abuse Prevention and Treatment: $30.4 million
- Community Mental Health Services: **$80.2 million**

Of the total dollars, **$47.8 million** is set aside on behalf of CMHCs and is transferred to Medicaid to support the MRO match. For substance abuse prevention and treatment, state funding includes general appropriations and dedicated funds such as Gallonage and Gambler's assistance funds. Federal sources include Social Services Block Grant and Substance Abuse Prevention and Treatment Block Grant.

Community mental health services include services for both adults and children. The federal portion includes general appropriations for mental health services, as well as some dedicated funds such as cigarette taxes. Federal dollars are generally from the Social Services Block Grant.

Funding for both substance abuse and community mental health services includes funds for intergovernmental transfers to leverage Medicaid funding under the Medicaid rehabilitation program. Because mental health centers, in the aggregate, exceed the estimated MRO expenditures from year to year, the centers usually supplement the required intergovernmental transfer with local funds.

State Psychiatric Hospitals

CMHCs serve as the gatekeepers for individuals who need psychiatric institutional services in a state facility. There are six state psychiatric hospitals which are located in Evansville, Logansport, Madison, Richmond, and Indianapolis (Larue Carter). State psychiatric hospitals are funded by Medicaid and state general funds.

Funding for state psychiatric hospitals comes from the general fund and the Medicaid program. In SFY2004 and 2005, appropriations for state hospitals' operations total **$122 million** (excluding capital budgets) annually and an additional **$21 million** annually in the mental health fund where Medicaid and other revenues are deposited.

Community Mental Health Center Services

CMHCs are designated by DMHA and, unlike managed care providers, are required to serve a broad population. The mandatory populations are adults with serious mental illness, children with serious emotional disturbance, alcohol and drug abusers, and older adults. Services they provide include inpatient and outpatient services, residential services, consultation and education services, and community support programs. CMHCs also are the only recipients of MRO funding, which they support with local tax dollars in addition to state funds received from DMHA and federal Medicaid funds. MRO services include case management services, day treatment services, and other therapeutic or rehabilitative services that can only be provided by certified CMHCs.

CMHCs also receive federal funding from DMHA in addition to local funding (addressed below).

Other Mental Health and Addiction Services Funding

From time to time, DMHA receives federal grants for prevention initiatives and to develop best practices in the mental health and substance abuse arena. In SFY2001-2002 biennium, **$7.5 million** was awarded by the Substance Abuse and Mental Health Services Administration (SAMHSA) for alcohol, substance and drug use prevention. DMHA distributed this funding among 16 communities in Indiana to implement new policies, practices, and programs to engage private citizens in developing new solutions to drug problems in their communities.

c. Aging and Developmental Disabilities Services

The DDARS manages the day-to-day operations of Medicaid waiver services for the elderly and persons with physical or development disabilities. They also partly fund the non-federal share of the services. Services for elderly and disabled individuals who are not Medicaid eligible are funded with state appropriations. Services for this population may include non-health care related services, such as nutrition and transition services to and from institutions, however, these costs are included in this report as these services are necessary in lieu of institutional services which could be Medicaid covered if the individual is otherwise Medicaid eligible.

Services for Elderly and Physically Disabled Individuals

In SFY2004, **$48.7 million** is appropriated for services under the Community and Home Options to Institutional Care for the Elderly (CHOICE) program. Since the inception of the Aged & Disabled waiver, a portion of the CHOICE state line item has been designated by the legislature to serve as state match. For the SFY2003-2005 biennium, of the

total CHOICE appropriation, **$7.4 million annually** is earmarked specifically for intergovernmental transfers to support home and community-based waiver services for elderly and physically disabled populations.

Services for Developmentally Disabled Individuals

Two accounts within the Division of Disability, Aging and Rehabilitative Services fund residential services as well community-based services for individuals with developmental disabilities. Funding for the Residential Account comes from state general fund appropriations funds for DD client services. A portion of these appropriations come from Tobacco Master Settlement dollars. In SFY2004, the total in the Residential Account is **$67 million**. This fund is used to pay for residential services, as well as to support the non-federal portion of the Medicaid waiver for individuals with Developmental Disabilities (DD Waiver), as well as the Medicaid waiver for individuals with Autism (Autism Waiver).

Funding for the Day Services Account comes from Title XX funds and is used to pay for Adult Day Services, as well as to support the non-federal share of the Medicaid Support Services Waiver. In SFY2004, the Day Services Account totals **$31 million**.

An estimated **$89-$91 million** of the total $98 million from Title XX and DD client services will be used to support the non-federal portion of Medicaid home and community-based waiver services. This amount is also duplicated in the Medicaid expenditure totals.

Intermediate Care Facilities for Individuals with Mental Retardation (ICFs/MR)

ICFs/MR include small private group homes, as well as state operated facilities. Services provided to eligible individuals in private facilities are funded by Medicaid. State operated facilities are funded by state general fund appropriations (for operations) and Medicaid. Over the last few years, the state has focused on downsizing state operated facilities with more individuals being served in small group homes or through Medicaid home and community-based waivers. It is anticipated that continued transition to community-based services would significantly reduce or eliminate state appropriations that direct support facility operations, thereby diverting such funding to services in the community for these individuals.

Total Medicaid spending for services provided in state facilities in SFY2003 was **$93.6 million** and is estimated to be **$101 million in SFY2004**. Medicaid spending for private facilities in **SFY2003 totaled $244 million** and there is little change expected in SFY2004. These totals are reflected in

total Medicaid expenditures. (Appendix C-Medicaid Expenditure Forecast).

Due to downsizing efforts, the DDARS was able to transfer $1 million of Fort Wayne State DD Center operating costs to support community placements. DDARS estimates to be able to transfer about $3 million for community placements in SFY2004. Likewise for Muscatatuck DD Center, DDARS was able to utilize $4.5 million of that facility's operating expenses for community placements with an expected transfer of $7.5 million in SFY2004.[7]

d. Division of Family and Children

The First Steps program provides early intervention services for families and children (0-3 years) with developmental delays, or who are at risk of developmental delays. Services include therapies, assistive technology, diagnostic services, social work services, family support, vision services, transportation, special instruction, and psychological services. Families are charged a co-payment based on income. Total program spending for SFY2003 was almost **$57 million**.

3. Department of Education

School health services are generally funded by the Medicaid program for Medicaid eligible children. Only 86 of the 293 school corporations in the State seek Medicaid reimbursement for services. In SFY2003 Medicaid payments to the 86 school corporations totaled **$5.4 million (state and federal $)**. (Appendix E—SFY2003 IndianaAIM, FSSA School Corporation Expenditures)

The non-federal share of Medicaid payments is supported through tuition support payments transferred to the Medicaid program from the Indiana Department of Education. The total transfer amount for SFY2004 is estimated to reach **$1.5 million**. Legislation in the budget bill passed during the 2003 session of the Indiana General Assembly provides that 3 percent of the federal reimbursement for Medicaid paid claims that are submitted by school corporations, are to be distributed to the General Fund for program administration. As such, schools receive 59 cents of the federal financial participation under the Medicaid program for each dollar billed.

Schools are currently reluctant to bill Medicaid for services provided to eligible children, for a variety of reasons. It is possible to increase such payments with education and technical assistance to schools. However, the amount of increased payments that may be generated is unknown at this time.

[7] Bureau of Developmental Disabilities, November 18, 2003 Cost Containment presentation at www.in.gov/fssa/servicedisabl.

4. Federally Qualified Health Centers and Rural Health Clinics

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are important primary care safety net providers for uninsured individuals in the State. They primarily provide primary care services. However, FQHCs also have specific mandates to provide certain ancillary services, as well as linkage to specialty care services. While FQHCs are required to serve all uninsured individuals as well as Medicaid and Medicare patients, RHCs are only required to serve Medicare patients. Funding sources for the two types of providers also vary primarily in that FQHCs receive grant funding from federal Health Resources Services Administration (HRSA) through the Bureau of Primary Care.

Table 3 shows the breakdown of funding sources for FQHCs.[8] Typically for FQHCs, one-quarter of their patients are Medicaid, and 3 to 5 percent are Medicare. However, the percent of revenue they receive from Medicaid is higher than their Medicaid patient population ratio because of the required cost-based reimbursement that they receive. In addition about one-quarter of FQHC funding is a federal grant from the Bureau of Family Health Care of the Health Research Services Administration. FQHCs also receive state-funding from ISDH. The remainder of their revenues is made up from patient revenues, foundations, other grant funding like WIC, Children with Special Needs, and Breast and Cervical program funds from ISDH. Total Medicaid payments in SFY2003 were **$11.4 million for FQHCs** and **$3.7 million for RHCs**. (Appendix F—Health Clinic Payments)

Table 3. FQHC 2002 Funding

Funding Source	Percent Patients	Percent Revenue	Total Funding in 2002 (in millions)
Medicaid	27%	31%	$11.4
Medicare	4%	4%	$1.47
Uninsured	41%		
Federal grant (HRSA)		22.6%	$8.31
State grant		15%	$5.52
Private pay		4%	$1.47
Private insurance		4%	$1.47
WIC		3%	$1.10
City-county		3%	$1.10
Foundations		5%	$1.84
Donations		7%	$2.57

[8] Data provided by Alice Rae, Indiana Primary Health Care Association.

RHC's reimbursement varies from FQHC reimbursement. While they do receive cost-based reimbursement, unlike FQHCs, it is capped at a Medicare rural rate. IPHCA states that based on RHC self-reporting, other revenue for RHCs are mostly patient fees.

RHCs have different requirements. They are not required to take Medicaid patients; they are required to take Medicare patients. They also are not required to have a sliding fee scale or see uninsured patients. Oftentimes, they are a physician's office in a medically underserved area or other health care shortage area. FQHCs in contrast are clinics.

Total Medicaid payments for RHCs in SFY2003 were **$3.7 million**. (Appendix F—Health Clinic Payments).

5. Prison Health Services

Health services for prisoners are funded either locally or through state general fund appropriations.[9] In SFY2004, **$25 million** is appropriated to pay for medical services for incarcerated individuals who are under the jurisdiction of ISDH, the Department of Corrections (DOC), DMHA, the Blind School, the Deaf School, and DDARS. These funding is utilized for any services not covered through appropriations from any of those agencies and Medicaid. Medicaid payment for medical services provided to incarcerated individuals (the 590 program) is funded through general fund appropriations and are not eligible for federal financial participation.

In addition, there is an available **$37,000** in state Drug Abuse Prevention Fund, to be used for personal services by the DOC for drug abuse therapy for DOC.

Finally, **$17.5 million** state funds are available in County Jail Maintenance Contingency Fund to reimburse county sheriffs for medical services provided to state prisoners housed in county jails.

Prison health services for county jails are funded locally through county tax levies.[10]

6. State Employee Benefits

As one of the largest employers in the state, the state of Indiana provides employer-sponsored health insurance coverage to a large number of people.

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[9] 2003-2005 Biennial Budget, Section 4 and discussion at the January 7, 2003 HIIF Committee meeting

[10] Discussion at the January 7, 2003 HIIF Committee meeting provided that Prison Health Services has a contract to provide medical services across the state to county jails. Amount of funding was not determinable for purposes of this report. Additional information may be available through each county, Marion County property tax uses is available at www6.indygov.org/treas/taxesgo.htm.

As of August 2003, 36,401 were enrolled in one of six health plans. Health Plans include M-Plan, Humana, Anthem-Traditional and HMO, Advantage, Welborn, Cigna, and Arnett. Total expenditures (employee and employer contributions) for the same period were about **$160 million** (excluding COBRA and early retirees). (Appendix G—State Employee Benefits)

7. Tobacco Master Settlement Agreement Funded Health Programs

Beginning in 1994, many states brought suit against major tobacco companies asserting several theories of liability under state antitrust and consumer protection laws. The states alleged substantial costs that the negative health impact of smoking has imposed on their budgets, including their Medicaid program budgets. A series of settlement agreements led to the final 1998 Master Settlement Agreement which was entered in each state's court with jurisdiction over the case. The Master Settlement Agreement addressed many subjects in the consumer protection and public health arena, including, but not limited to, advertising restrictions and public health education. It also provided significant payments to states between 1999-2025 valued at an estimated $206 billion at the time of the settlement. A detailed summary of the Master Settlement Agreement can be found at www.in.gov./attorneygeneral/tobacco/introduction.

In the SFY2004-2005 biennium, tobacco funds have been used to support the following programs and administration of programs:

Table 4. Tobacco Master Settlement

	Master Settlement Agreement Funds (in millions)	
Programs	**SFY2004**	**SFY2005**
CHIP	$23.8	$26.2
DD Client Services[a]	$21.3	$21.3
ISDH[b]	$32.6	$32.6
HoosierRx	$8.0	$8.0
Tobacco Use Prevention & Cessation Board	$10.8	$10.8
Total	**$96.5**	**$98.9**

a. Total appropriation for biennium is $42.6 million which is divided equally in the table.
b. This amount represents a 50 percent shift of ISDH budget from general fund to Tobacco Master Settlement Agreement fund. Programs funded with MSA include cancer registry, minority health initiative, sickle cell, aid to county tuberculosis hospitals, AIDS education, HIV/AIDS services, testing for drug-afflicted babies, chronic diseases program, WIC, maternal and child health, breast and prostate cancer education and diagnosis, minority epidemiology, and CHCs.

8. Indiana Comprehensive Health Insurance Association

The Indiana Comprehensive Health Insurance Association (ICHIA), a non-profit entity, offers health insurance coverage to Indiana residents who do not

have insurance coverage due to a medical condition, or who are otherwise unable to obtain insurance coverage. All carriers, health maintenance organizations (HMOs), limited service HMOs, and self-insurers are required by statute to be members of ICHIA.

In general, an individual who has lived in Indiana for 12 months immediately before applying is eligible for coverage if the individual meets the following requirements:

- Not eligible for Medicaid;
- Not eligible for an insurance plan; and
- By federal law, has had continuous creditable coverage for at least 18 months under a group health plan and has exhausted COBRA benefits.

A spouse is eligible for coverage. A child is also eligible for coverage if the child is:

- Less than 19 years old and unmarried;
- Unmarried and enrolled full-time at an accredited educational institution—the child in this case is eligible up to age 25; or
- Incapable of working due to a mental or physical disability and is chiefly dependent upon the parent for support or maintenance—the child in this case is eligible for coverage beyond the age of 19.

Premium rates vary by geographic area of residence, age, and sex and are the same for the primary individual covered and for spouse or dependent coverage.

Coinsurance and deductibles vary between three plans offered. Deductibles range between $500 and $1,500. With respect to coinsurance, ICHIA pays 80 percent of in-network (60 percent of out-of-network) covered charges once the deductible has been satisfied. The member is responsible for the coinsurance amount of 20 percent for in-network (40 percent for out-of-network) of covered charges. When using an out-of-network provider, coinsurance amounts are in addition to any charges incurred (such as charges over the usual and customary allowance).

Under each ICHIA Plan, there is an out-of-pocket maximum—a limit based on how much your share of eligible expenses is per year (deductible plus coinsurance) before the Plan pays 100 percent of the allowable expenses for the remainder of the calendar year.

Benefits include physician, hospital, mental illness and substance abuse services, dental and other services. The ICHIA health care plan also gives members access to a nationwide network of pharmacies. Members receive a prescription identification card which entitles them to discounts on your prescription drugs.

Financing Background

ICHIA is financed through individual premiums, assessments paid by insurance companies in the state and state appropriations. Premiums cannot be more than 150 percent of the average premium rate charged for the five largest carriers with the largest premium volume in the state. Annually, an amount equal to total expenditures less premiums (i.e., the net loss) is assessed against member carriers in proportion to their share of total health insurance premiums or claims paid (for HMOs, limited HMOs, and self-insurers). Carriers take a credit against state premium taxes, adjusted gross income, or a combination thereof, equal to the amount of the assessment paid. The credit can be taken up to the amount of tax due each year and succeeding year until the assessments have been offset by such credits.

The ISDH pays the premiums for about 1,300 individuals with HIV/AIDS totaling about **$7.8 million** from the federal AIDS Drug Assistance Program (ADAP) and Title II of the federal Ryan White Care Act. ISDH also receives state appropriations to pay ICHIA premiums for this population. In SFY2004, the amount was **more than one-half million dollars ($536,516)**. Total ISHD premiums from federal and state funds **exceed $8 million**.

During the 2003 Session of the Indiana General Assembly, House Enrolled Act 1749 was passed to address the financing problems for ICHIA. The fiscal impact statement to HEA 1749 provides that the total expenses of the ICHIA program for CY**2001** were **$93.1 million** with premium contributions of $31.7 million and assessment receipts of $61.4 million. It also provides that based on ICHIA program enrollment in August 2002 of 9,779, it is estimated that the assessments for 2003 are projected to exceed the $100 million threshold by approximately $5.6 million. Beginning October 31, 2002, insurers were required to report the amount of assessments paid and tax credits taken each year. The fiscal impact statement provides that preliminary data indicate that ICHIA assessments in 2001 exceeded tax credits taken by approximately $10.3 million. (Appendix H—Legislative Services Agency Fiscal Impact Analysis)

More current data about ICHIA enrollment and payments for one year beginning December 1, 2002, and ending November 30, 2003, are as follows:

Table 5. ICHIA Enrollment

Age Group	Enrollment
0-18 yrs	546
19-64 yrs	8,878
Over 64 yrs	11
Total Enrollment	**9,435**
Total Payments	**$ 89.4 million**

Source: www.onlinehealthplan.com

A significant cost factor for ICHIA is prescription coverage and other costs for individuals with blood related disorders. For the 12/1/02-11/30/03 period, ICHIA paid almost $13 million claims for 643 patients with blood related disorders. For the same time period, prescription claims totaled more than $15 million for 2,210 patients. Together these claims account of 36 percent of total ICHIA claim payments. (Appendix I—ICHIA data)

To address the financing problems that the ICHIA program faces, HEA 1749 mandates the following:

- That ICHIA and the OMPP consider the development of payment programs related to ICHIA and Medicaid coverage and provide for provider reimbursement, assessment determinations, and distribution of net gains following implementation of a payment program.
- That the OMPP and ICHIA cooperatively investigate methods to decrease ICHIA hemophilia costs and report to the legislative council.

The bill also introduces cost-reduction measures, including changes in how the premium charged is determined, changes in sliding scale premiums as well as elimination of referral fees paid to agents. However, savings that these changes could bring are not significant.

B. LOCALLY-FUNDED PROGRAMS

1. County Hospitals

County hospitals, Wishard Hospital being the largest, are funded in the following ways:

- County tax levies
- Financial institutions' tax dollars
- Medicaid, Medicare
- Private insurance

Of all the county hospitals, only Health and Hospital Corporation (HHC) has statutory authority to levy its own tax dollars; all other county hospitals receive a distribution from local county real estate tax. Private insurance funding also supports healthcare services provided by county hospitals. In SFY2003 the HHC tax levy totaled almost **$88 million**.

County tax levies are used to support a number of Medicaid UPL financing mechanisms such as DHS payments. Currently, it is estimated that most, if not all, hospitals have reached the UPL limitation (based on how the UPL is aggregated not by individual hospital); therefore, there are no new opportunities for increasing financing under these this mechanism.

Opportunity may exist under primarily Medicaid administration; Wishard, for example, leverages administrative match for administrative activities performed in support of the Medicaid program (e.g., assistance with Medicaid application,

referral and service coordination, etc.). Wishard provides the non-federal share for the administrative claim through an intergovernmental transfer or non-federal match certification. This could be an opportunity for other county hospitals if non-federal funding can be identified to support the federal claim.

See Appendix J—DSH Payment History provides hospital specific DSH payments history through SFY2003.

2. Health Advantage

Health Advantage (initially titled Wishard Advantage) is a managed care program for the low income and uninsured residents of Marion County, established in 1997 by HHC and modeled after the Indiana's Medicaid managed care program, Hoosier Healthwise. This program is supported in large part through the HHC county tax levy.

Under Health Advantage, HHC contracts with a primary care physician group, the Indiana University Medical Group (IUMG), and pays them a per member per month fee. The physician group is at risk for all primary care needs. Members choose a primary care physician and receive a personalized membership card, member handbook, 24-hour access to a nurse on-call hotline, and other service components found in most commercial insurance plans. The per member per month fee is intended to create an incentive for IUMG physicians to build a relationship with their patients and encourage appropriate primary and preventive care services within the Health Advantage delivery system.

In order to further improve provider accessibility, HHC expanded the Advantage network to include other Marion County providers of indigent care such as HealthNet and Citizen's Health Center (federally qualified health care centers), Raphael Health Center, Shalom Health Center, St. Francis Neighborhood Clinic, and St. Vincent Health Services.

Residents of Marion County with incomes at or below 200 percent of the federal poverty level, and do not qualify for any other assistance program, are eligible for Health Advantage. Based on the eligibility criteria, Health Advantage provides healthcare coverage for the parents of Medicaid and Children's Health Insurance Program (CHIP) recipients, as well as other low-income and uninsured populations.

In SFY2003, Health Advantage membership totaled about 40,000 patients. Total annual expenditures were not available for this report.

3. Prison Health Systems

Health Services for county jails are funded locally, although the amount is not readily available at the time of this report. However, as mentioned in the

"State Funded Programs" section, general fund dollars contribute to services for state prisoners held in county jails to defray the county sheriff costs.

4. Community Mental Health Centers (CMHC)

There are 33 CMHCs certified by the Division of Mental Health and Addiction across the state. Each CMHC has a mutually exclusive geographic primary service area (see attached map). Their area is designated by the Division and impacts local funding from property taxes that the CMHC obtains. CMHCs are obligated to provide all services within the continuum of care to individuals in their primary service area with certain limitations (e.g., funding limitations).

Local funding for CMHCs comes from property taxes. In general, CMHCs receive about one cent on each $100 of taxable property for the counties within their primary service area to provide services. In 2002, CMHCs received a total of **$23.5 million** in local county tax dollars. Total CMHC dollars by county is provided in Appendix K.

5. Schools

Healthcare services provided in schools through school-based clinics are primarily funded through the Medicaid program when provided to children who are Medicaid eligible and when the services are covered by the Medicaid program. However, schools in Indiana have historically not billed the Medicaid program for a variety of reasons.

In Marion County, private funding from foundations, as well as some state and federal grant opportunities help in funding school health services. Learning Well is a model program in Marion County schools established to develop a coordinated approach to school-based health services and funding. Learning Well is a collaborative of healthcare providers in Marion County and Marion County school corporations incorporated as a nonprofit entity in October of 2002. Its mission is to expand healthcare services in their member schools. Since its inception, Learning Well's funding has included:

- $5.5 million grant from the Legacy Health Foundation
- $100,000 grant from the ISDH for childhood obesity
- $90,000 in federal grant funds to initiate an integrated health services delivery system
- Some funding from HHC

With these funds, Learning Well has been able to establish 32 school-based nurse practice clinics serving Marion County schools. However, in Marion County alone, there are 310 schools, which include 17 Indianapolis Public Schools. If this model is successful, it could be replicated across the state depending on funding availability.

A potential source of funding not currently accessed in Indiana is Medicaid administration in schools to reimburse schools for the costs of administrative activities (e.g., outreach, assistance with Medicaid application, and referral, coordination and monitoring of Medicaid-covered medical services) which support the Medicaid program. These school expenses, if reimbursed, can be utilized to augment medical services provided to other low income children. In Marion County, Learning Well has an arrangement with schools to participate in administrative claiming, and funding from Medicaid will be utilized to fund expansion of school based clinics in Marion County.

6. Township Trustees

The trustee is charged with overseeing the poor and distributing poor relief funds by the most economical means available and to ensure that the necessary needs of an individual or family are met under Title 12, Article 20 of the Indiana Code. The applicant must show that they are unable to provide those needs through personal effort and that they have exhausted all other means. Many trustees creatively cooperate with other agencies and churches in their areas, keeping costs controlled and delivering services needed.

A township trustee can only provide funding for medical assistance under the poor relief act if the individual could not qualify for medical assistance for the same service under any Medicaid, other government medical program, or under private insurance. However, a township trustee may provide interim medical services during the period that the individual has an application pending under Medicaid or other government assistance program.

The poor relief act allows the trustee to pay for a 30-day prescription drug supply at a time, over-the-counter drugs, physician visits, dental visits, replacement or repair of dentures, emergency room care, pre-operation testing, lab and x-rays, physical therapy, eyeglasses, repair or replacement of a prosthesis, and insulin (including insulin supplies) for up to a 30-day period at a time.

Funding for poor relief is provided through county property tax levies. In Marion County, poor relief funding (including medical assistance) administered by the townships totaled **$2.7 million in 2003**.[11]

7. Healthcare for City and County Employees

This is another significant pool of funding for health services in Indiana, although the total funding was not readily available for purposes of this report. It includes health insurance costs for current employees of cities and counties across the state, as well as for retirees. The FY2003 budget for the city of Indianapolis alone includes close to $16 million in group health insurance expenditures. Healthcare services for retirees are also funded through the public employee retirement funds.

III. ADEQUACY AND EFFECTIVENESS OF INDIANA HEALTHCARE FUNDING

A. Coverage in Indiana

This section provides a comparative summary of the eligibility requirements for the major healthcare funding streams in Indiana discussed above for uninsured and underinsured Hoosiers. It is intended to highlight eligibility and attempt to identify any gaps in populations for whom coverage initiatives may be explored, depending on financing and available programs not yet implemented in Indiana. Because of the complexity of plans, this section does not attempt to discuss adequacy of coverage in terms of types of services, amount, duration or scope of service coverage. It focuses on populations and income limits as a percent of the poverty level, that have no coverage—i.e., those that are falling through the cracks.

The following table provides a brief eligibility overview of programs for low income individuals in Indiana:

Table 6. Programs Eligibility and Coverage Summary

Program	Non-Financial Criteria	Monthly Income Limit	Coverage
Medicaid	Pregnant Women Low income families Children SCHIP Aged, Blind, Disabled	23% FPL 23% FPL 150% FPL 150%-200% FPL 55% FPL (same as SSI standard)	Pregnancy coverage only; full Medicaid benefits for all other groups listed
MED Works	Indiana resident; disabled; and working	Up to 350% FPL; and working (i.e., individual is considered "working" if monthly earnings = federal min wage x 40 hrs); premiums applicable between 150% FPL and higher	Full Medicaid coverage
Hoosier Rx	Indiana resident; 65 years or older; and no Rx coverage through insurance or Medicaid (including Medicaid with spend-down)	Up to $1,011 single/$1,364 married (up to 145% FPL)	50% reduction in Rx costs up to benefit cap; continued small reductions if individual exceeds benefit cap
Medicaid Rehabilitation Option (MRO)	Adults with serious mental illness; or children <18 years of age with serious; or emotional disturbance adults and children with addiction	Medicaid eligible (see Medicaid Eligibility Overview)	Counseling, crisis intervention, medication management, ADL training day services, and case management
First Steps	Indiana Resident; up to 3 years old; diagnosed with a condition that has a high probability of resulting in	No income limit; co-payment based on family income	Assistive technology, family support, vision, therapy, nursing,

	developmental delays; and at risk of having substantial developmental delays if no intervention	less documented health care expenses	psychological services, transportation, social work, diagnostic services, nursing services, nutrition, and special instruction
HCI	Indiana resident; and need for emergency hospital services in an Indiana hospital or non-resident who required emergency services in state	$193 (27.7% FPL)	Emergency hospital care
Health Advantage	Indiana resident; and no other insurance coverage	Up to 200% FPL with co-pays	Comprehensive: physician, hospital, Rx, therapy, mental health, DME, other specialty care
Hoosier Assurance Plan	Indiana resident; and adults with serious mental illness; or children <18 years of age with serious; or emotional disturbance adults and children with addiction	Up to 200% FPL (no monthly redetermination)	Access to full continuum of care
ICHIA	Indiana resident; not eligible for Medicaid or other insurance plan; and has had continuous creditable coverage for at least 18 months under a group health plan and has exhausted COBRA benefits	Premium based on income	Comprehensive health services, including, but not limited to, physician, hospital, mental illness, substance abuse, dental, and Rx

Indiana's health funding issues are similar to those in many other states given the increasing costs of insurance which makes health care unaffordable for many working individuals and families living below the federal poverty level. State Medicaid programs have become the de-facto funding stream for many of these individuals, especially children. Since the creation of SCHIP in 1997, all states have expanded coverage of children through Medicaid programs, thereby greatly improving overall access to healthcare services for children. And even though overall enrollment in Medicaid programs has significantly increased across the nation, coverage for low income families and individuals still remains well below the federal poverty line. Indiana's coverage of low-income parents is one of the lowest in the nation.

Indiana's Medicaid program serves individuals with monthly incomes significantly below the poverty level (currently as low as 25 percent of FPL). Although there has been no program expansion for low income families, expansions for the disabled population such as Medicaid buy-in and parental income and asset protections for 1915(c) waiver applicants, has allowed the state to provide coverage to some, though limited, working disabled individuals and disabled children in higher income households. In addition, Hoosier Rx (funded with tobacco dollars) focuses on critical pharmacy benefits and if the demonstration waiver is approved, would allow expansion of Medicaid eligibility for the elderly to 185% FPL.

Despite these program expansions, compared to other states, Indiana still ranks among the lowest when it comes to coverage of low income working adults. Indiana has one of the lowest income thresholds (about 31 percent of FPL) for a working parent with two children. It is one of four states with the most restrictive asset test for low income families (asset limit of $1,000).[11]

With respect to coverage for children, Indiana is one of many states that have expanded eligibility to 200 percent of FPL, although Indiana has fared considerably better in outreach and enrollment of children in SCHIP. However, upon examining basic income eligibility standards alone (without regards to enrollment) several states have expanded eligibility for children beyond 200 percent of FPL though a number of initiatives like Section 1115 waivers and SCHIP employer buy-ins. Maryland's Children's Health Program expanded coverage through an employer buy-in to 200-300 percent of FPL. Connecticut's HUSKY program covers children at higher than 300 percent of FPL through a full cost SCHIP buy-in program. New York's Child Health Plus, also a full cost buy-in program, covers children greater than 230 percent of FPL. State's coverage summary information through SHCIP, buy-ins, HIFA section 1115 waivers, etc. is available at www.statecoverage.net.

For individuals who do not qualify for Medicaid, they have nonetheless received services from public safety net providers such as county hospitals, FQHCs, RHCs, and county health departments. These health care services are supported through a variety of UPL financing mechanism and leveraging local dollars (such as Indiana's Health Care for the Indigent program).

The critical question is how can Indiana provide comprehensive, yet affordable healthcare coverage for working individuals? With no new moneys available, states are becoming more creative in finding financing mechanisms that allow them to shift costs and leverage additional federal dollars, thereby freeing up state resources to fill in the gap.

Since 1996, changes in federal law and policy have provided greater flexibility to states to expand coverage for low income families in the Medicaid program. A detailed discussion of these options is provided in the Health Management Associates report titled *Assessment of State Options for Expanding Health Coverage*, at www.in.gov/fssa/programs/chip/insurance/index.html.

- *The old TANF eligibility standard*: Congressional action in 1996 while delinking welfare and Medicaid eligibility, created a new "family coverage" category under Section 1931 of the Social Security Act. Effectively, states were able to use their AFDC eligibility standards in effect in 1996 as the minimum Medicaid family eligibility standard. Many states expanded income eligibility for families with children to 100 percent or higher of FPL.

[11] Broaddus, M. et al., *Expanding Coverage: States Medicaid Eligibility Policies for Working Families in 2000*, Center on Budget and Policy Priorities

- *Section 1115 Medicaid Waivers*: States are able to expand eligibility under this research and demonstration waiver for parents of Medicaid eligible children. This option allows states the flexibility to have a less generous benefit package than their traditional Medicaid program, as well as pay premiums and other cost sharing not applicable in their Medicaid program.
- *Section 1115 SCHIP Waivers*: Beginning in 2000, states were allowed to use any unspent SCHIP funds to expand coverage for parents after expanding coverage for children to 200 percent of FPL.
- *HIFA Waivers*: Starting in August 2001, provided even greater flexibility for states to expand eligibility while paring down benefit packages in increasing cost-sharing.

IV. STATES EXPANSION PROGRAMS

In an effort to cover more uninsured and underinsured individuals while managing significant budget shortfalls, states have taken two avenues. One method is to maximize existing state or local funds by seeking financing mechanisms that would increase the amount of federal dollars coming into the state. The other is expanding eligibility by paring down existing programs (in order to be cost neutral) by virtue of the flexibilities provided by federal initiatives discussed in the *Assessment of State Options for Expanding Health Coverage* report.

A. Description of the Revenue Maximizing Programs and the Health Services Programs Which They Fund

1. Disproportionate Share Hospital Payments

This federal financing mechanism requires payments to hospitals to take into account the situation of hospitals that serve a disproportionate number of low income patients with special needs. Under the Medicaid program, states are able to augment payment to these hospitals. Medicare inpatient hospital payments are also adjusted for this added burden.

In response, Indiana's Medicaid State Plan includes provisions for its DSH payment program.[12] Each hospital's eligibility for DSH payments is based on one year historical utilization and revenue data. This data is used to calculate the hospital's Medicaid Inpatient Utilization Rate (MIUR) and its Low Income Utilization Rate (LIUR), which determines whether a particular provider would qualify for DSH.

In Indiana, the type of facilities that may qualify for DSH are: acute care hospitals, state mental health institutions private psychiatric institutions, municipal acute care hospitals, and CMHCs.

[12] Indiana Medicaid Assistance Programs State Plan Attachment 4.19A, beginning on page 2. The Indiana State Plan is available at www.indianamedicaid.com. Please note the link to the State Plan on the right hand side of the homepage

DSH payments are subject to several limits. By federal statute, the total DSH payments to a provider may not exceed the Hospital Specific Limit (HSL).[13] Each hospital's HSL is the total costs for services provided to uninsured patients, less any cash payments made by them, (referred to as the "uninsured shortfall") and the total costs for services provided to Medicaid patients, less the amount paid by the state under the non-DSH payment provisions of the State Plan, (referred to as the "Medicaid shortfall"). Also, federal statutes set forth a state limit on DSH payments and determine a state limit on DSH expenditures for Institutions for Mental Diseases (IMD).[14]

Because either the state limit or IMD limits are usually reached prior to each hospital's DSH payments reaching their HSL, the State Plan requires that payments be made in a specific order as follows: state mental health institutions, private psychiatric institutions, municipal hospitals, acute care hospitals, and CMHCs.

State mental health institutions receive DSH payments up to their HSL. Private psychiatric institutions share in a $2 million pool, which is distributed in the proportion that each hospital's MIUR bears to the total of the MIURs of all hospitals in the pool. Municipal hospitals receive DSH payments up to their HSL.

Acute hospitals' DSH payment amounts are based on whether the hospital is a "historical DSH provider" or not. An acute care hospital, which was eligible for a DSH payment for the State Fiscal Year (SFY) ending on June 30, 1998, and which is eligible for a DSH payment in the year for which payments are being calculated, is considered a historical DSH provider. In addition, if a hospital has been eligible for a DSH payment for each of the two SFYs preceding the SFY for which DSH payments are being calculated, the hospital is deemed to be a historical DSH provider. Historical DSH providers can receive up to their HSL in DSH payments. If a hospital is eligible for DSH, but is not a historical DSH provider, the hospital receives about one-third (33 1/3 percent) of its HSL in DSH payments for its first two years of eligibility and about two-thirds (66 2/3 percent) of its HSL in DSH payments if the hospital has been eligible for two consecutive eligibility periods.

Finally, CMHC DSH payments are calculated based on each CMHC's HSL, and the amount of funds made available by counties that have been certified as expenditures eligible for financial participation.

Indiana Medicaid general fund appropriations provide the non-federal share of DSH payments to private psychiatric facilities and the first $26 million of acute DSH payments. For all other DSH payments, the non-federal share is

[13] 42 U.S.C. 1396r-4(g)
[14] 42 U.S.C. 1396r-4(f)(2) and (h)

provided by the hospitals through the use of an intergovernmental transfer (IGT). An IGT is a payment exchange among or between different levels of government. Funds are transferred from state psychiatric facilities, university hospitals, and county or municipal hospitals to the state Medicaid agency.

As a general condition of participation, municipal hospitals and county hospitals and CMHCs must have made an IGT or, in the case of a CMHC, must certify that expenditures have been made that are eligible for federal financial participation.

The only entities that need to provide an IGT for acute DSH payments are the HHC of Marion County and the Indiana University Trustees. Private, acute care hospitals do not provide an IGT. Municipal and county hospitals that participate under the acute DSH payment may, but are not required, provide an IGT in order to receive a payment. Other sources are used to provide the non-federal share for acute DSH payments including county property tax funds deposited in the Hospital Care for the Indigent fund and IGTs received from municipal hospitals through the municipal DSH payment and the municipal Medicaid shortfall payment.

A provider that provides an IGT to the Indiana Medicaid program must submit the IGT funds prior to receiving their DSH payment from OMPP.

Total DSH payments for SFY2001 were as follows:

Table 7. DSH payments

Provider	SFY2001 DSH Payment
State mental health institutions	$117,561,942
Acute care hospitals	$196,661,965
Private psychiatric hospitals	$2,000,000
Municipal DSH payments	$16,332,762
Total	**$332,556,669**

A listing of historical DSH payments can be accessed through the Myers and Stauffer LC website, www.mslcindy.com.

2. Upper Payment Limit Financing

The Upper Payment Limit (UPL) for any provider category (e.g., hospitals, nursing homes, and other institutions) is defined as the Medicare allowable payment for the provider category. For purposes of UPL financing mechanisms, certain providers can receive additional payments from a state equivalent to the difference between the aggregate Medicaid payment the provider category receives and the aggregate payment that could have been made using Medicare payment principles for that same provider category.

The economic downturn of the last decade and competition among public service programs for funding has created an incentive to leverage federal dollars wherever possible to expand the fiscal reach of state and local dollars for public programs. According to a February 2002 Kaiser report, the Medicaid program is the largest source of federal funding to states, accounting for more than 40 percent of all federal grants-in aid dollars.[15] As such, maximizing federal revenue and substituting state or local dollars whenever possible has become a means to support a broad range of public health programs.

Under UPL financing, a state can pay nursing homes, hospitals or other institutions that have an agreement with the state an amount greater than the actual costs the facilities incur for medical services they provide. The state draws down federal matching funds on the inflated, allowable payments it has made to the providers. The non-federal portion of these payments is supported through IGTs or permissible certifications of non-federal funds by the provider. IGTs serve as financing mechanisms by which the states and local governments are able to share in providing non-federal funding necessary to draw down federal dollars in a number of programs.

Likewise, state and local governments have the ability under federal regulations to certify public funds as eligible for Federal Financial Participation (FFP). Such funds cannot be federal funds, unless they are federal funds authorized by federal law to be used to match other federal dollars.

The ability of state and local governments to enter into IGTs and to certify the non-federal share can greatly increase the pool of dollars available by these governmental entities for leveraging opportunities in the Medicaid program and to expand coverage for low income and other eligible populations. As a result, the state collects additional federal money without contributing any state funds. The major federal limitation on these transactions is that this UPL financing mechanism must not cause the state to exceed the provider-specific UPL limit.

A simplified example of how this financing mechanism works is as follows:

- A provider that has an agreement with the state makes an IGT of $5 million and certifies another $5 million in non-federal share as non-federal funds eligible for FFP. This provides a total non-federal share of $10M.
- The state makes a payment of $25M to the provider. This constitutes $10 million which is the non-federal share supported by the provider IGT and certification and $15 million of FFP which will be claimed by the state. (Assumes a 60% Federal Medical Assistance match rate.)

[15] Andy Schneider and David Rousseau, *Upper Payment Limits: Reality and Illusion in Medicaid Financing*, Kaiser Commission on Medicaid and the Uninsured, February 2002

Although Congress has not imposed any limitations on the use of the additional federal Medicaid funds by states, federal agencies (CMS, CBO, and OIG) have frowned on the use of these funds for purposes that are not related to the Medicaid program or to health care. However, in some cases, these financing arrangements have been used to provide important additional resources to safety net providers that care for the uninsured or underinsured populations.

Based on the significant impact that UPL financing has on the federal budget, it is not surprising that the federal government is paying greater attention to UPL transactions through regulation or national audits. In 2001, CMS published revised regulations on UPL transactions to close certain "loopholes" in the federal regulation such as capping how the aggregate UPL is determined for provider categories. So far, as expressed in the comments to the regulations, CMS has not and does not intend to regulate arrangements between the states and providers that facilitate UPL financing. Having said that, states must be mindful in structuring their UPL transactions and agreements as CMS is now closely monitoring any of these financial mechanisms through nation-wide audits initiated in 2003 to monitor state UPL/IGT transactions (including DSH). An audit of Indiana was initiated in the spring of 2003.

3. Provider Tax

In 1991, Congress passed the "Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991," the first piece of stand-alone Medicaid legislation in the program's history. This law set out strict conditions that states must meet in order to use taxes levied on health care providers as part of their state dollars eligible for federal Medicaid matching funds. Under federal statute, the taxes must meet the following conditions:

- Broad based or applied to all members of a definable group; for example, they must apply to all hospitals, not just psychiatric hospitals.
- Uniform with all providers within the group being taxed at the same rate.
- Not part of a "hold harmless" agreement where the funds are returned to the providers either directly or indirectly.

According to Thomas Scully, CMS administrator, HHS found that in 1989, three states were drawing a combined total of $23 million from federal funds through provider taxes and donations. Furthermore, this number increased to eight states drawing an additional $300 million in 1990, and by 1991 more than half of the states were drawing an incredible $12 billion.[16]

[16] Presentation before the House Energy and Commerce Subcommittee on Health, on challenges facing the Medicaid program, released October 8, 2003

Provider taxes can be levied across a variety of provider classes specified in the federal regulations. The major categories are physician, hospitals, pharmacy, nursing homes, and more recently health maintenance organizations in some states. One of the limitations of provider taxes under the federal regulations is that the amount of the tax must be less than 6 percent of the total revenues for the provider class. The larger the tax base, the larger the amount of tax that can be collected. Hence, provider classes with significant revenue base, like hospitals, HMOs or physicians, and nursing homes are more likely to be taxed.

The provider class that is taxed more often than not receives a portion of the tax back through enhanced reimbursement. The higher the Medicaid utilization for a particular provider, the higher the proportion of the tax the individual provider is likely to receive back in enhanced reimbursement. So providers with close to 100 percent Medicaid utilization would be reimbursed almost all of the taxes paid, subject to any limitations in the particular reimbursement methodology.

Usually, with the exception of providers that have no to little Medicaid utilization, provider classes may favor paying a tax in return for the increased reimbursement that they might receive. A provider tax can also generate additional FFP for additional healthcare services or program expansions, depending on the financing agreements between the state Medicaid agency and the provider class.

Wisconsin HMO Tax Proposal

The SFY2003-2005 proposed budget includes an HMO tax of one percent of the HMO's gross revenue. The proposed tax is estimated to generate around $80 million. Proposed uses of new revenue generated include offsetting the state's Medicaid and BadgerCare programs, provide HMO rate increases, and make supplemental payments to HMOs that serve Medical Assistance and BadgerCare participants.

3. Health Care for the Indigent (HCI)

HCI allows states to recoup, through the Medicaid program, a portion of their expenditures for hospital services provided to the uninsured. Indiana's HCI program is discussed in detail earlier in this report.

B. Description of Program Expansions

1. Community-based Programs

Medicaid home and community-based waivers under 1915(c) allow states to provide community-based services in lieu of more costly institutional care. Oftentimes, these waivers allow states to expand services or serve more individuals in a population that is receiving services through state funded

programs. An added benefit is that these waivers serve as the entry into the Medicaid program for medical services to children in higher income families who may not otherwise be eligible for Medicaid. Over the last biennium, Indiana has been able to expand services to many children with developmental disabilities by leveraging existing state program funds to serve more children in families with higher incomes (e.g., DD waiver and Support Services waiver). This has been accomplished by raising the income standard to 300 percent of SSI and disregarding parental income for children applying for waiver services. These children also have access to medical services in addition to the waiver services.

2. Coverage of High-risk Pools

These are typically state-created, non-profit associations that offer comprehensive health insurance benefits to individuals who are unable to obtain coverage at affordable prices through the private insurance market and who do not qualify for government programs such as Medicaid. Thirty-one states currently provide this type of coverage. For a complete listing, go to www.stategoverage.net/highrisk. These programs are funded through assessments on insurers, government revenues, and premiums charged to members.

The Trade Act of 2002 appropriates funds for state high-risk pools. Specifically, $20 million was appropriated for start-up grants for states that do not have qualifying high-risk pools. Eligible states can receive up to $1 million (by the end of FFY2004) and funds can be used for any beneficiaries, not only those affected by the Trade Act. CMS is the administering entity and it is anticipated that as many as 27 states may be eligible for the grant. A second wave of high-risk pool funds worth more than $80 million will cover FFY2003-2004. Indiana recently received a grant through the Trade Act with benefits to be administered through Blue Cross Blue Shield.

As mentioned in the previous section on ICHIA, the program's solvency is at risk in the state due to high costs of drugs and other costs associated with HIV/AIDs populations and individuals with hemophilia. HEA 1749 (2003) is a legislative attempt at containing ICHIA program costs. The options proposed include applying for a Medicaid demonstration waiver for individuals with hemophilia. The following are examples of state waivers for high risk pools.

Maine HIV/AIDS 1115 Demonstration waiver

Maine's 1115 demonstration proposal to provide a limited set of Medicaid benefits to individuals with HIV/AIDS who would not otherwise be eligible for Medicaid was effective July 1, 2002. The demonstration expands access to health care services to working individuals without health insurance, without a spend-down. Financial eligibility is based on family income below 250 percent of the FPL. The original application requested a 300 percent FPL financial

eligibility standard. The intent of the demonstration is to provide more effective, early treatment of HIV disease by making available a limited but comprehensive package of services, including anti-retroviral therapy, physician and case management services. Individuals are responsible for monthly premium and co-payment charges. Since this is a demonstration waiver, there is a cap on the number of individuals to be served under the waiver.

Illinois HIFA waiver

In addition to providing coverage for uninsured parents of the Illinois KidCare program, Illinois's HIFA waiver provides coverage to individuals with renal diseases, individuals with hemophilia and individuals in the comprehensive health insurance program at an income level of 185 percent of FPL.

C. Indiana Revenue Enhancement

1. Existing Revenue Enhancement Programs and Those in Process

For a long time, Indiana has made significant strides in taking opportunity of financing mechanisms to leverage federal dollars to fund its public healthcare programs. Because the Medicaid program is the single largest federal-state program for financing health services, all of the programs have so far been designed to maximize federal financial participation using state and local dollars to support the non-federal match.

Home and Community-based Waiver Services

In the area of home and community-based waiver services, Indiana has increased its program from a single waiver in the 1980s to seven (7) waivers currently. With the addition of the waiver for children with mental Illness, who but for such services would require psychiatric institutionalization (currently awaiting CMS action) and the potential for a waiver for individuals 0-3 years of age, who have or are at risk of developmental delay, Indiana would have been able to create a waiver for disabled, mentally retarded, mentally ill individuals and elderly individuals at risk of institutionalization. These waivers have allowed Indiana to serve more people by leveraging previously unleveraged state general fund dollars for these populations. Of greater significance, is the fact that these waivers have allowed the state to keep people at home or in the community, instead of in an institutional setting at higher cost per person for the state. Most of the significant changes have been in the area of developmental disabilities services. In the area of elderly services, though funding has been available for community services, it has not been as significant as it has been for developmental disability services. Furthermore, the state lacks the provider capacity to supply those services.

Community Mental Health Services

The MRO, also previously unmatched with federal dollars, is the single expanding pool of funding and services for persons of all ages with mental illness and chronic addictions. This program provides critical case management and outpatient mental health services on an ongoing basis, which assists in preventing or reducing the risk of more costly institutional care. While it does not alleviate the need for mental health services for individuals who are not Medicaid eligible and who have no mental health coverage, MRO has become a critical funding pool for the mental health safety net providers with respect to their Medicaid patients, and especially children who are on Medicaid and need mental health services. The MRO program also takes advantage of local tax dollars to support the non-federal share of the service expenditures using the county property tax dollars that CMHCs receive.

Indiana was able to implement an administrative claiming program to leverage federal dollars to support outreach, enrollment, and coordination efforts conducted by community mental health provides. The non-federal match is also supported by county property tax dollars that CMHCs receive.

Health Care for the Indigent

The Health Care for the Indigent program has also been in effect for more than a decade and was designed as a means to leverage federal dollars to fund health services for the indigent. Like MRO, this program takes advantage of county property taxes to support the non-federal share of Medicaid add-on payments to hospitals.

Disproportionate Share Hospital Program

The Disproportionate Share Hospital program supports financing for services provided to indigent individuals. A significant aspect of this program is to leverage the Health and Hospital tax levy to support indigent care.

Upper Payment Limit Financing Mechanisms

Over the past biennium, there has been significant effort in Indiana to find financing opportunities to help maintain services, provide services to individuals who might not be eligible under current programs, and to minimize potential reductions in reimbursement that would have been necessary to meet the budget shortfall. The UPL financing is one example. Through this federal financing mechanism and using a combination of IGTs and non-federal match certifications, the Medicaid program is able to make additional payments to nursing facilities and in return draw down more federal financing. Indiana's Medicaid program was already taking advantage of this financing mechanism to make additional payments to hospitals.

Provider Taxes

Indiana imposes a provider tax on Intermediate Care Facilities for Mentally Retarded individuals (ICFs/MR). Because these providers are solely Medicaid funded, their assessment costs are permissible costs used in setting their rates annually. Therefore, all of the assessment has been used to fund the annual aggregate rate increase for this group of providers.

In 2003, the Indiana General Assembly authorized a nursing facility provider assessment which is estimated to bring in significant additional federal dollars. This assessment was authorized for only one year, and 80 percent of the new federal dollars that are brought into the state is earmarked for nursing facility payments and 20 percent is to be used by the state to enhance community-based long-term care programs.

Hoosier Rx

Indiana's pharmacy benefit program is currently solely funded with dollars appropriated from the Tobacco Master Settlement fund. The state has applied for an 1115 demonstration waiver which, if approved, would permit the state to drawdown Medicaid federal dollars.

Children with Special Health Care Needs Program

This program administered by the Indiana State Department of Health is one of a handful of programs that provide direct health services. Through coordination of services, as well as the lowering of the income eligibility standard for Medicaid children as a result of CHIP, many children who were served with 100 percent state dollars under this program are now served through the Medicaid program, thereby allowing the state to access federal dollars. This has allowed funding under this program to be used for children who are not Medicaid eligible.

Newborn Screening Program

In the public health sector, the ISDH will be implementing a rate increase for newborn testing that will be cost neutral to the Medicaid program. Indiana's Newborn Screening Program is a legislatively mandated screening (under Indiana Code 16-41-17). It requires that the ISDH maintain a centralized program that provides screening for more than 30 conditions, follow-up, management, family counseling and support, including equipment, supplies, formula, and other materials for all infants identified through the screening as having certain specified conditions.

The Newborn Screening law includes a surcharge fee and creation of a dedicated fund to finance the Newborn Screening program. The screening is funded from the collection of a **$7 surcharge fee** for each infant screened in Indiana. This fee, together with the **central laboratory charge for the**

screening test ($39.50), is paid through individual patient fees, collected by hospitals/birthing institutions from third party billing including public programs. Fifty-three percent of all screenings are for Medicaid-eligible infants. These fees are maintained in the Indiana Newborn Screening Fund, from which monies are appropriated to operate the program. The budget may vary based on the number of infants born annually. For SFY2004-2005, the Indiana General Assembly appropriated **$1.2 million annually** (HEA 1001 Budget Bill) for the Newborn Screening Fund.

To ensure follow-up and treatment, the program provides funding for the Statewide Program of Detection and Management of Inborn Errors of Metabolism at Riley Children's Hospital for the management and treatment of individuals diagnosed with metabolic disorders. The state Children's Special Health Care Services fund provides funding for six sickle cell education and follow-up programs and two hemophilia programs. In SFY2004-2005 appropriations for Sickle Cell Education is **$232,500 annually** (HEA 1001 Budget Bill). This is funded by the Tobacco Master Settlement Agreement Fund.

The program is costly and fees collected have historically not been sufficient to support the battery of screening required by law. In 2003/2004, the ISDH worked with the Indiana Hospital Association to **increase the $7 fee to $30 per child screened**. This increase became effective in January 2004. The ISDH, under an agreement with the OMPP, will transfer a portion of the fee to the Medicaid program to help support the resulting increased state match for infants who are Medicaid eligible. As such, the increase will be cost-neutral to Medicaid. A summary of the program history, protocol and funding is provided in Appendix L.

School-based Administrative Claiming

Schools are prime settings for primary and preventive care for keeping children healthy and ready learn. As such, schools provide (and often share) a nurse managed in a number of schools across the state. Schools, especially those in cities with a significantly poor population, spend time providing assistance with Medicaid enrollment activities and coordination of services, in addition to transportation services. Many of these activities may be eligible for administrative claiming under the Medicaid program. A model program is being developed in Marion County schools through a collaborative arrangement between Marion County school corporations and health services providers in the area, in cooperation with the OMPP. Federal funding that is generated from this program will be utilized to expand school-based clinics in Marion County.

2. Opportunities for Indiana

The following provide opportunities for Indiana for expanding coverage. It should be noted, however, that few of these options are entirely cost neutral.

Furthermore, many involve cost-shifting to other funding streams. As such, they are, for the most part, longer-term solutions for the state.

State Tax Incentives

Fifteen states provide tax relief, either through tax deductions or credits, to an employer or individual who purchases health insurance for themselves, their family, or their employees.

A tax incentive operates as a credit or deduction that reduces the cost of purchasing health insurance through a reduction in an individual's or employer's tax burden. Tax credits are amounts subtracted from the income tax liability itself, unlike deductions, thereby reducing adjusted gross income or taxable income. Tax credits may be refundable or non-refundable. Most tax credits are non-refundable, meaning that if a taxpayer's credit exceeds his/her income tax liability, the taxpayer does not receive the difference as a refund. However, with a refundable tax credit, taxpayers whose credits exceed their income tax liabilities receive the difference in the form of a tax refund. www.statecoverage.net/tax.

Currently, 15 states offer individuals, self-employed individuals or small employers a deduction or credit of a portion or all of their health insurance premiums. Twelve states offer a deduction or credit of 100 percent of the health insurance premium expenditures. Only North Carolina and Kansas offer a refundable credit.

1115 Waiver for High Risk Pools

A waiver similar to Maine's HIV/AIDS waiver and Illinois's HIFA waiver could be utilized to move individuals with HIV/AIDS or hemophilia from ICHIA. Premiums and co-payments may be applied. The funding currently used to support these individuals on ICHIA can be used as the state match. The costs for serving these individuals would be supported in part with federal Medicaid dollars, thereby increasing the number of individuals served. One caution is the impact that drug costs for these populations would have on the Medicaid program to the extent that ICHIA funds are insufficient to cover the full state portion of such costs.

Disabled High Risk Transfer to Medicaid Buy-in

Certain individuals currently on ICHIA may be medically disabled (as defined by the Medicaid program) and may be eligible for MED Works with or without a premium. The state has already undertaken to screen ICHIA members for Medicaid eligibility. Again, drug costs to the Medicaid program should be carefully reviewed as this option does not include any sharing of costs by ICHIA since, theoretically, these would be individuals who are eligible but have not applied for Medicaid, for whatever reason. In SFY2003, it was estimated

that about 2,000 ICHIA members may be Medicaid eligible through the Medicaid buy-in program.

HMO Provider Tax

Healthcare taxes can only be imposed on specific provider classes listed in federal regulations. One of the classes specified in the Social Security Act section 1903(w)(7)(A)(viii) include "services of Medicaid Managed Care Organizations." This suggests that not all HMOs would need to be taxed to meet the broad-based requirements for provider taxes.

Purchasing Pools

The concept of insurance purchasing pools or cooperatives has been presented to the HIIF Subcommittee on Health Insurance Purchasing Cooperatives. The proposal was that the State would support the development of a collective purchasing arrangement that would contract with health plans to provide coverage to eligible individuals. The cooperative would negotiate with private health plans on behalf of participating individuals. Individual participation would be voluntary.

The intended beneficiaries of this model would be unemployed, self-employed, high-risk, and uninsured individuals who would otherwise be unable to afford health coverage in the individual market.

Enhanced Community Health Center Funding

The Community Health Center (CHC) Program provides funds under Section 330 of the Public Health Service Act to provide for primary and preventive healthcare services in medically-underserved areas. The FFY2002 appropriation for this program was $1.3 billion. Opportunities for maximizing CHC funding in Indiana is being considered in further detail by the *Other Public Programs Subcommittee* of HIIF, including potential for using tobacco funds and other ISDH grant funds. These options are also explored in further detail in the report, *Assessment of State Options for Expanding Health Coverage*.

Premium Assistance Programs and Employer-Sponsored Plans

These options are cost-effective alternatives to covering the costs of healthcare expenditures for individuals who need coverage but cannot afford private insurance premiums. These can be accomplished through a state-only coverage program (i.e., with no federal participation) or through a HIFA waiver which provides federal support.

Katie Becket Option

The Katie Beckett option is a special eligibility option for state Medicaid programs that allows certain children with long-term disabilities or complex

medical needs, living at home with their families to receive Medicaid. Because of the expansion of Medicaid income standard for children, this option is likely to impact only a small segment of the population: those in families with income higher than current Medicaid standards, who have a long-term disability or complex Medicaid need, and who are not currently served on a waiver due to waitlists.

Children, who are otherwise not eligible for other Medicaid programs because the income or assets of their parents are too high, may be eligible for Medicaid under this optional eligibility group if they meet the following eligibility criteria:

- The child is under 19 years of age and determined to be disabled by standards in the Social Security Act;
- Requires a level of care at home that is typically provided in a hospital or nursing facility;
- Can be provided safe and appropriate care in the family home;
- Does not have income or assets in his or her name in excess of the current standards for a child living in an institution; and
- Does not incur a cost at home to the Medicaid Program that exceeds the cost Medicaid would pay if the child were in an institution.

There are some differences between the Katie Becket Option and Indiana's disregard of parental income in waiver programs. First, waiver programs are limited by the number of individuals whom the state can serve in a particular year under the approved waiver. Thus, once the state reaches the cap, no more children can be served, even if eligible, resulting in a waiting list which can be lengthy. Until recently, Indiana's definition of disability for the Medicaid program has been more restrictive that the SSI disability definition. Following a number of lawsuits and changes in legislation, this distinction is for the most part non-existent; however, for purposes of financial eligibility, unless the child is eligible for a waiver and the state has not exceeded its cap, their financial eligibility will include parental income. Even though they may be medically eligible, they may not be financially eligible.

Adopting the Katie Beckett options will apply the parental disregard protection to all disabled children who apply for the Medicaid program. The costs are unknown at this time. Children in high risk groups could benefit from an expansion such as children with hemophilia or HIV/AIDS who would be medically eligible but whose family incomes are too high for current Medicaid coverage.

V. CONCLUSION

Indiana is able to fund healthcare services for individuals who are uninsured or underinsured through a variety of publicly funded programs with the Medicaid program being the largest both in dollars and beneficiaries. While the Medicaid rolls continues to increase, and while Indiana has a rich benefit package (in terms of coverage), in

comparison to other states, it is one of the worst in the nation in covering working-poor adults and families.

Indiana has been able to significantly enhance funding by taking advantage of a variety of federally-permissible financing mechanisms, as well as by leveraging federal dollars to support many programs and services that were 100 percent state funded. All of these leveraging opportunities have been achieved through the Medicaid program. However, because of budgetary pressures and increased enrollment in the program (even under current eligibility standards) Indiana has been reluctant to make any Medicaid program expansions that will place additional pressures on the Medicaid state budget.

Although there are still opportunities for expansion, such as 1115 demonstration waivers, provider taxes, Indiana can no longer only look to its Medicaid program to solve the needs of the uninsured. Greater focus and attention needs to be placed on public/private partnerships, such as the creation of purchasing pools and tax incentives for small employers, as some of the solutions for insuring working poor adults in our communities.

Listing of Appendices