Indiana Family and Social Services Administration

Healthy Indiana Plan (HIP) 3.0 Section 1115 Waiver Application

August 5, 2026

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Section 1: Executive Summary

The Healthy Indiana Plan (HIP) has always been built on a simple idea: healthcare coverage for able-bodied adults should be accompanied by personal responsibility. Since its creation in 2008, HIP has demonstrated that Medicaid can be structured to encourage consumer engagement, promote preventive care, and empower individuals to take an active role in managing their health. Unlike traditional Medicaid programs, which were designed primarily to serve the aged, blind, disabled, and other vulnerable populations, HIP was deliberately designed to help the working poor while reinforcing the connection between individual choices, personal accountability, and better health outcomes.

Indiana's commitment to this approach has been unwavering. The Indiana General Assembly made clear that HIP was not intended to operate as an open-ended entitlement program. Rather, it was established as a Section 1115 demonstration designed to test whether a more consumer-driven model could produce better outcomes and greater value for taxpayers. HIP was created to give low-income Hoosiers a healthcare experience that more closely resembles private insurance, incorporating expectations, incentives, and shared responsibility rather than relying solely on traditional Medicaid structures.

Over time, however, a series of legal decisions and federal policy changes undermined key features that made HIP unique. Federal restrictions curtailed Indiana's ability to implement work and community engagement expectations, while litigation gradually stripped away important elements of the original design. As a result, the program drifted closer to a standard Medicaid expansion model and farther from the Hoosier principles on which it was founded.

The Working Families Tax Credit Act of 2025 created an opportunity to restore the principles that originally made HIP successful. Congress appropriately recognized that public assistance should serve as a pathway to independence, not a destination. For able-bodied adults, healthcare coverage should be accompanied by reasonable expectations to work, engage in their communities, and take responsibility for their own well-being. Indiana's proposal seeks to restore HIP as a true demonstration program and reestablish the common-sense expectations that were gradually stripped away through years of federal policy changes and litigation. A program that asks nothing of those who are capable of contributing ultimately does little to promote independence and the upward mobility of its participants.

HIP 3.0 is designed to reaffirm the principle that beneficiaries should have both the opportunity and the responsibility to participate in their own healthcare decisions. The proposal includes point-of-service copayments because healthcare is more likely to be used responsibly when consumers have a direct stake in the decisions they make. When services appear "free," there is little incentive to consider whether a visit is necessary, whether a lower-cost setting is appropriate, or whether preventive steps could have avoided the need for care altogether. HIP 3.0 recognizes that even modest personal financial responsibility can encourage more thoughtful healthcare utilization while preserving access to necessary services.

Just as importantly, HIP 3.0 strengthens incentives for prevention and wellness by rewarding members who complete recommended preventive services and engage in healthy behaviors. Individuals who take steps to improve and maintain their health should see tangible benefits through reduced cost-sharing obligations. The objective is straightforward – to align incentives so that both members and the program benefit when healthcare is used wisely and proactively.

Indiana seeks authority to begin implementing HIP 3.0 on October 1, 2027, so that the full program is operational for the 2028 plan year. The sole exception is the implementation of copayments, which Indiana seeks to adopt as soon as practicable in accordance with state law.

While Indiana is committed to helping vulnerable residents access healthcare, it also has a responsibility to the taxpayers who finance the program. Medicaid expansion was never intended to become an

unlimited financial commitment disconnected from the State's ability to pay. Every dollar spent on unsustainable program growth is a dollar unavailable for education, public safety, infrastructure, and services for Hoosiers with the greatest needs. Fiscal discipline is not simply an administrative concern; it is a prerequisite for preserving the program's long-term viability. If funding mechanisms change or available resources become constrained, Indiana must retain the flexibility necessary to manage enrollment and expenditures responsibly rather than allowing costs to grow without regard to sustainability.

Recent federal changes affecting provider assessment financing create new uncertainty regarding the long-term funding structure that supports HIP. Indiana must therefore retain the tools necessary to manage the program responsibly. This waiver request would provide the State with the flexibility to operate HIP solely under Section 1115 demonstration authority and, if circumstances require, implement reasonable enrollment controls to align participation with available funding. Such authority is not about limiting access, but rather it is about ensuring that promises made today can be honored tomorrow. A program that grows beyond its financial capacity ultimately fails the very people it is intended to serve.

HIP has always been strongest when it combines compassion with expectations, access with accountability, and innovation with fiscal discipline. Through this waiver request, Indiana seeks to preserve that legacy while advancing the next evolution of the program through HIP 3.0. The State is requesting a new five-year demonstration that will restore HIP's original consumer-driven principles, strengthen incentives for health and independence, promote responsible use of healthcare services, and ensure that the program remains financially sustainable for both Indiana taxpayers and future generations of Hoosiers.

Section 2: Historical Narrative and Program Description

2.1 Historical Narrative

HIP first passed the Indiana General Assembly in 2007 with bipartisan support. Indiana pioneered the concept of medical savings accounts in the commercial market and became the first state to apply the consumer-driven model to a Medicaid population. HIP was built on the premise of enfranchising the individual rather than the institution. Instead of relying solely on institution-centered financing, Indiana used cigarette tax revenue and hospital DSH allocations to fund healthcare coverage directly for eligible individuals. This approach gave low-income Hoosiers greater ability to participate in their own healthcare decisions, strengthening choice, encouraging competition among providers, and supporting improved quality. Provided by private health insurance carriers, HIP offered its members a high-deductible health plan paired with the POWER account, which operated similarly to a health savings account. Importantly, this original HIP 1.0 version was not an entitlement program, as enrollment was explicitly capped based on the availability of state budget resources, ensuring the program operated within fiscal constraints.

In 2011, with the passage of the Patient Protection and Affordable Care Act (ACA), the Indiana General Assembly reinforced its support for the program by calling for HIP to be the coverage vehicle for Medicaid expansion in the State. The legislature codified this requirement in Indiana Code §12-15-44.2 and made several conforming changes to the HIP program related to the ACA. In 2014, following a historic agreement with Indiana hospitals that secured funding for the costs of expansion beyond the existing cigarette tax revenue, the State submitted a fiscally sustainable waiver to expand its existing HIP demonstration waiver to cover expansion adults under the ACA, creating HIP 2.0.

Even when seeking to expand Medicaid, Indiana continued to reject an open-ended entitlement model, as the program remained tied to available, dedicated financing rather than an unlimited claim on state resources. From the outset, HIP was designed to operate within defined fiscal limits rather than as an

open-ended entitlement. HIP 1.0 reflected that principle most directly, as enrollment was explicitly capped based on the availability of state budget resources, allowing Indiana to offer defined coverage while maintaining fiscal discipline. As Indiana later prepared to use HIP 2.0 as the vehicle for Medicaid expansion, that same principle was carried forward. In its original waiver expansion application, the State made clear that expansion coverage depended on the continued availability of enhanced federal matching funds and the State's provider assessment on hospitals, stating that "*the waiver submission is conditioned on the availability of enhanced federal matching rate and the continuation of the State's provider assessment on hospitals. If either funding source is reduced at any point during the five-year waiver period, HIP 2.0 will automatically terminate for the new expansion population*." This condition reflected Indiana's longstanding position that HIP could expand only within a sustainable financing structure and could not become an unlimited claim on State general fund revenue. Ultimately, the State was forced to use an underlying Medicaid state plan amendment paired with an 1115 demonstration waiver to successfully implement HIP 2.0.

Effective February 1, 2015, HIP 2.0 began coverage and built on the early HIP experiences and outcomes to improve the program and strengthen the core values of personal responsibility and consumer driven healthcare. Following its implementation, the Indiana General Assembly formally codified the HIP 2.0 program design at Ind. Code §12-15-44.5, and once again reinforced its support of HIP as an alternative to traditional ACA expansion by expressly prohibiting the continuation of Medicaid expansion in the State except through the HIP program and conditioning continuation of the program on the availability of its funding sources.

From 2020 forward, many of the features that had made HIP distinct from a standard ACA expansion were either suspended, never fully implemented, or later invalidated via court order. During the COVID-19 public health emergency (PHE), Indiana suspended key member-responsibility policies, including POWER Account contributions, tobacco surcharges, and disenrollment consequences tied to nonpayment, consistent with federal requirements at the time. In addition, members were automatically enrolled in HIP Plus, rather than moving between HIP Plus and HIP Basic based on required contributions, eliminating a critical healthy incentive option. Without these key program features, HIP turned into a generic Medicaid expansion program that was no longer capable of testing hypotheses and demonstrating operational outcomes imperative to a Section 1115 demonstration waiver. These policies remained in effect into 2023 and throughout the PHE "unwinding" process.

At the same time, Indiana's community engagement policy was never fully implemented. While community engagement reporting activities were initiated, no disenrollments for non-compliance were ever carried out. CMS conditionally approved the requirement in the October 2020 HIP extension; however, the requirement was placed on hold pending federal litigation in other states. Eventually, CMS withdrew conditional approval in June 2021.

The *Rose v. Becerra* litigation marked a decisive break from HIP's demonstration design and substantially dismantled the program as Indiana had structured it. In June 2024, the U.S. District Court for the District of Columbia held that HHS's 2020 approval of Indiana's ten-year HIP extension was arbitrary and capricious because the agency had not adequately considered whether HIP's core consumer-driven features would help furnish medical assistance to eligible individuals. The court's analysis effectively subordinated HIP's broader policy objectives, elevating a narrow coverage-access inquiry over the demonstration's central purpose: testing whether personal responsibility, value-conscious utilization, and member engagement could improve the Medicaid experience for able-bodied expansion adults. The court ultimately vacated the approval and remanded the matter to HHS, placing at risk the very features that distinguished HIP from a traditional Medicaid expansion, including POWER account contributions, the absence of retroactive coverage, and the exclusion of non-emergency medical transportation. Following

the remand, HIP has been permitted to continue only in a diminished form, without POWER account premiums or coverage consequences for nonpayment. As a result, the practical effect was to strip HIP of the defining policy architecture that Indiana designed to test. What had been a limited, consumer-driven Section 1115 demonstration was effectively transformed into a standard ACA Medicaid expansion operating largely without the personal responsibility and incentive structures that characterized the program.

By the time the PHE-era suspensions and the District Court decision had taken effect, HIP no longer operated as the limited, incentive-based alternative to traditional Medicaid expansion contemplated by Indiana legislators and policymakers. The program's defining tools for member engagement, fiscal discipline, and demonstration testing had been substantially disabled, creating the need for a statutory and programmatic reset. In response, the Indiana General Assembly has taken decisive action to restore HIP closer to its original intent. Most notably, Senate Enrolled Act 2 (SEA 2), enacted in 2025, reaffirms that HIP is not an entitlement program and must operate only through a Section 1115 demonstration waiver rather than the Medicaid state plan. SEA 2 also restores fiscal-responsibility guardrails by limiting HIP enrollment based on state appropriations. In addition, in 2026, the General Assembly codified many of the operational requirements of the WFTCA through Senate Enrolled Act 1 (SEA 1) and placed enhanced compliance standards on individuals eligible for HIP. Importantly, SEA 1, which became effective July 1, 2026, establishes additional cost sharing for HIP, aligned with the WFTCA, and directs the Secretary of FSSA to impose new cost sharing requirements on participants while maintaining the federally mandated out-of-pocket maximum of 5% of family income.

Taken together, these legislative changes seek to restore HIP's original framework by reinforcing fiscal sustainability, preserving its status as a limited demonstration rather than an open-ended entitlement, and strengthening eligibility integrity so that enrollment is limited to individuals who meet program requirements.

2.2 Program Authority

Indiana is committed to continuing to serve the adult expansion population through the HIP program; however, we must do so in a fiscally responsible manner. The recent changes in federal law affecting healthcare provider taxes will have a significant impact on the state's ability to fund the HIP program long-term in its current state. To ensure that HIP will be operated in a manner consistent with its original intent and that it not become an open ended entitlement program, the Indiana General Assembly mandated that FSSA seek waiver authority to (i) expressly authorize HIP only through Section 1115 waiver authority, and (ii) operate it in a manner that does not exceed the level of state appropriations or other funding for the plan.

By allowing HIP to be operated as a waiver and in a manner that does not threaten the viability of Medicaid for more vulnerable populations that have traditionally been the focus of the program, including the elderly, disabled, pregnant women, and children, this waiver will support the long-term viability of the Medicaid program as a whole. Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to likely assist in promoting the objectives of the Medicaid program. The purpose of this demonstration is to test and evaluate state-specific policy approaches for covering expansion adults as an optional Medicaid population, consistent with the United States Supreme Court's recognition that states may choose whether and how to cover that population. Therefore, Indiana respectfully requests CMS expressly affirm the optional nature of the adult expansion population described in Section 1902(a)(10)(A)(i)(VIII) by granting authority solely through Section 1115 waiver authority and allowing the State to operate HIP within available state appropriations, consistent with its original intended design.

2.2.1 Waiver Authority

As noted above, the Indiana General Assembly strengthened the Indiana statute requiring HIP to be operated exclusively as a waiver program. Specifically, Indiana Code §12-15-44.5-4 now requires that the plan:

> *(1) is not an entitlement program;*
>
> *(2) serves as an alternative to health care coverage under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.);*
>
> *(3) except as provided in section 4.2(a) of this chapter, must not grant eligibility under the state Medicaid plan for medical assistance under 42 U.S.C. 1396a; and*
>
> *(4) must grant eligibility for the plan through an approved demonstration project under 42 U.S.C. 1315.* [1]

Indiana Code §12-15-44.5-4.2 further requires the Secretary of Family and Social Services Administration to "*amend the Medicaid state plan to not include individuals described in 42 CFR 435.119*," allowing a delay of such action until "*the completion of negotiations with the United States Department of Health and Human Services for a 3.0 plan waiver and an approved implementation of the waiver*." [2]

Accordingly, through this waiver request, Indiana seeks authority to remove HIP expansion coverage from the Medicaid state plan and to cover the adult expansion population solely through a Section 1115 demonstration. Upon CMS approval of this demonstration and completion of the approved implementation process, Indiana will submit any necessary conforming state plan action, including rescission of the existing state plan authority for the adult expansion group, so that HIP eligibility for this population is no longer authorized through the Medicaid state plan. Section 1115 provides the Secretary authority both to waive compliance with certain requirements in Section 1902 and to authorize federal matching funds for expenditures that would not otherwise be matchable under the state plan where the demonstration is likely to assist in promoting Medicaid's objectives.

Here, the relevant state plan eligibility category is the adult expansion group described in Section 1902(a)(10)(A)(i)(VIII) of the Act. Although that population is typically covered through the Medicaid state plan, nothing in Section 1115 prevents the Secretary from authorizing coverage of that same population through demonstration expenditure authority when doing so would further the objectives of Title XIX. Indiana therefore requests expenditure authority under Section 1115(a)(2), together with any related waiver authority under Section 1115(a)(1) necessary to effectuate this approach, so that the State may cover the expansion population through HIP 3.0 as a demonstration-only program.

Specifically, FSSA is requesting a waiver of eligibility requirements to allow for Section 1902(a)(10)(A)(i)(VIII) eligible individuals to be eligible via this Section 1115 demonstration waiver rather than through the State Plan. Essentially, FSSA is seeking to implement HIP 3.0 and corresponding Medicaid eligibility for individuals ages 19 through 64 who would become eligible for coverage under the Medicaid demonstration pursuant to Section 1115(a)(2) of the Act, but whom the state could instead have covered under its Medicaid state plan, while still receiving the enhanced federal medical assistance percentages (FMAP) of 90% for the expansion population.

Section 1115(a)(1) gives the Secretary the authority to waive Section 1902 requirements and continue to pay the state enhanced federal Medicaid matching funds.[3] The Secretary is statutorily authorized to waive any of the requirements in Section 1902 in connection with a demonstration project that the Secretary has

[1] IC 12-15-44.5
[2] IC 12-15-44.5
[3] See HHS Advisory Opinion 24-01 on Medicaid Section 1115 Demonstrations Imposing Work Requirements. December 11, 2024. https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/advisory-opinion-24-01.pdf.

determined will be likely to assist in promoting the objectives of Title XIX. And the core objective of Title XIX is furnishing health coverage to those in need. Therefore, if the Secretary of HHS were to approve a Section 1115 demonstration waiver that allowed Indiana to operationalize expansion to Group VIII individuals through a waiver alone, rather than through the State Plan, while still receiving 90% enhanced FMAP for the expansion population, Indiana's demonstration would successfully fulfill the goal of furnishing health coverage to those in need while still operating within the confines of the Indiana Code established by the Indiana General Assembly. Alternatively, if the Secretary of HHS does not allow Indiana to operationalize expansion to Group VIII individuals through a waiver alone, rather than through the State Plan, while still receiving 90% enhanced FMAP for the expansion population, Indiana will be statutorily required to end the HIP program pursuant to state statute which requires HIP to be terminated if federal funding is reduced below the 90% enhanced FMAP threshold or if there is a reduction in available funding from the Hospital Assessment Fee.[4]

Approval of this request not only promotes Medicaid's coverage objectives by preserving coverage for the expansion population, but it also reinforces the legal structure of the Medicaid expansion population. As the Supreme Court recognized, coverage of the adult expansion group is optional for states. Indiana seeks to continue covering that optional population, but to do so through a Section 1115 demonstration as required by state statute. CMS therefore has a sound legal and policy basis to approve this request, allowing Indiana to continue furnishing medical assistance to the adult expansion population while preserving the fiscal and programmatic structure the General Assembly has determined is necessary for HIP's long-term sustainability.

2.2.2 Budget Constraints

HIP has consistently been structured with strong fiscal safeguards to ensure responsible stewardship of taxpayer resources. The original HIP program included a hard enrollment cap tied to projected per-capita costs, reflecting a deliberate approach to maintaining budget discipline. Similarly, when authorizing HIP 2.0, the Indiana General Assembly made clear that the program would move forward only if federal financial participation for the expansion population remained at or above 90 percent and sufficient revenue from the Hospital Assessment Fee was available to cover the state share of costs. This framework was designed to ensure that HIP would operate within sustainable funding parameters rather than as an open-ended entitlement.

Specifically, Indiana Code § 12-15-44.5-4(b) requires termination of HIP if federal financial participation for the expansion population fell below the ACA's 90/10 match rate and the resulting shortfall could not be fully offset through the hospital assessment fee, or if changes to the assessment structure reduced the funding available to support the program. HIP continues to operate subject to these fiscal constraints and termination triggers. However, the Indiana General Assembly further reinforced this framework through the addition of Indiana Code § 12-15-44.5-10(b) in 2025, which imposed an enrollment limit tied to available funding:

> *(b) The secretary shall limit enrollment in the plan to the number of individuals that ensures that financial participation does not exceed the level of state appropriations or other funding for the plan.*[5]

Since its inception, HIP has utilized a variety of funding sources, including a portion of the Indiana cigarette tax, the Hospital Assessment Fee, and federal funding, for its operational budget. These funding sources have allowed Indiana to expand Medicaid and offer healthcare coverage to the nearly 600,000 Hoosiers currently enrolled in HIP. Costs associated with HIP continue to increase. Both the state and

[4] IC 12-15-44.5-4
[5] IC 12-15-44.5-10

hospitals have continued to work together to keep the HIP program viable for the Hoosiers that it serves every day. Unfortunately, several factors have created new pressures on HIP funding which may jeopardize the future of HIP.

First, cigarette tax revenue, which has funded the HIP program in part since 2008, has declined by an average of 2.7% per year as less Hoosiers continue to smoke.[6] Declining smoking rates represent a positive public health outcome through reduced tobacco-related illness and mortality; however, it also results in lower tobacco tax revenues to fund HIP. This decrease in tax revenue has meant that the Hospital Assessment Fee has had to increase to cover the ever-increasing cost of the HIP program. Unfortunately, that will no longer be possible due to changes in federal law regarding provider taxes as part of the WFTCA.

Second, the WFTCA prohibits states from raising additional state revenues through new provider taxes or from increases to existing provider taxes after July 4, 2025. Correspondingly, if HIP costs continue to increase, the gap between available funding from the hospital assessment fee and program costs will begin to widen and Indiana may no longer be able to operate a HIP program in compliance with state law, as projected costs may soon outpace available program funding.

To address this potential funding shortfall while meeting its legal obligations, Indiana seeks federal recognition that HIP may operate only so long as sufficient state appropriations or other funding are available to support the program. Indiana is not requesting approval of a fixed enrollment cap or a pre-determined numerical limit. Rather, the State seeks explicit confirmation from CMS that, if available funding is no longer sufficient to support HIP consistent with state law and current enrollment, Indiana may either terminate the demonstration authority for the adult expansion population and end HIP expansion coverage or otherwise seek an amendment of the demonstration authority to limit enrollment in HIP (depending on available funding constraints at the time) rather than operate the program beyond appropriated resources.

The goal of Medicaid is to furnish health coverage to those in need, but Indiana law does not permit HIP to spend beyond appropriated funds, requiring termination of the program if reductions in provider assessment fees are below levels needed to fund the program.[7] This request to provide Indiana the flexibility to adjust the program, either through termination or an amendment, reflects the structure of Indiana law, which directs the Secretary to limit enrollment to the number of individuals that ensures financial participation does not exceed available state appropriations or other funding. Because the statute is tied to the availability of funding rather than a specific enrollment number, Indiana seeks flexibility to respond if funding is insufficient to sustain the program. If available funding can no longer support HIP, the State must be able to limit or terminate the waiver authority for the adult expansion population rather than allow entitlement expenditures to exceed available state funds.

Indiana therefore seeks CMS approval of demonstration terms that recognize this fiscally prudent state-law requirement by acknowledging that the state may seek a future amendment to limit enrollment or to terminate Medicaid expansion altogether if the State determines that appropriations or other funding are no longer sufficient to support the program. This authority would support predictable spending, reduce budget risk, and help Indiana meet its constitutional balanced budget requirement while preserving resources for other Medicaid populations and core state priorities.[8]

[6] https://www.protectingtaxpayers.org/analysis/tobacco-vaping-101-indiana-2/
[7] IC 12-15-44.5-4 requires HIP to be terminated if federal funding is reduced below the 90% FMAP threshold or if there is a reduction in available funding from the Hospital Assessment Fee.
[8] Indiana Constitution. Article 10, Section 5.
https://iga.in.gov/publications/indiana_constitution/Constitution%20(as%20amended%202024).pdf

2.3 Program Design

HIP was originally structured as a consumer-driven health plan built around a high-deductible benefit design paired with a Personal Wellness and Responsibility (POWER) account. The POWER account was intended to create “skin in the game,” encourage value-conscious utilization, and reward preventive care through rollover incentives. HIP also incorporated several commercial-market features, including monthly contributions tied to coverage status and multiple benefit package options. This program design was intended to directly combat the standard design under the ACA which treated non-disabled working age adults under the Medicaid expansion the same as traditional more vulnerable Medicaid populations, including the elderly and disabled.

However, the Working Families Tax Credit Act significantly changed the framework for Medicaid expansion in the United States. As a result, expansion coverage now inherently includes greater expectations around personal responsibility and cost sharing. In light of these changes, Indiana will modernize and streamline HIP’s design to align more closely with a standard Medicaid expansion structure as reimagined by the WFTCA which will reduce administrative complexity and lower program administrative costs, all while preserving the program’s core goal of encouraging appropriate utilization, preventive care, and personal responsibility.

Under HIP 3.0, Indiana will move away from the high-deductible/premium-style structure and will discontinue certain elements that are no longer necessary to achieve HIP’s objectives under the WFTCA framework, including the POWER account construct and related HIP Plus/ HIP Basic benefit package design. In their place, Indiana will implement a simpler, more transparent approach centered on copayments at the time of service. Point-of-service copayments are intended to encourage members to make informed choices about where and when to seek care and to support appropriate utilization, while maintaining access to medically necessary services.

To retain HIP’s emphasis on prevention and healthy behaviors, HIP 3.0 will include a clear healthy-incentives feature: members who obtain recommended preventive care will receive a 50% reduction in applicable copayments. This approach preserves a tangible and timely reward for prevention while reducing administrative burden compared to account-based incentives and roll-over features that separate the reward from the action by up to a year.

Indiana will also use this transition to consolidate and simplify benefit design features where appropriate to improve member understanding, easing administration for plans and providers, and supporting long-term program sustainability.

2.3.1 Eligibility

Individuals eligible for Medicaid under 1902(a)(10)(A)(i)(VII) (Group VIII) will be eligibility under this demonstration. Group VIII individuals consist of non-disabled adults between the ages of 19-64 with a household income up to 138% of the Federal Poverty Level (133% with 5% disregard) who are not otherwise eligible for Medicaid. Coverage for this group is subject to all applicable Medicaid laws and regulations, except as expressly waived in this demonstration.

Description	FPL	Demonstration Eligibly Group
Adults ages 19-64 who are not otherwise eligible for comprehensive Medicaid benefits or Medicare	Income under 138% FPL per the Modified Adjusted Gross Income (MAGI) guidelines with 5% income disregard	Adults (as described at 42 CFR 435.119)

Indiana state law prohibits HIP members from state plan eligibility and requires HIP to be operated through a Section 1115 demonstration waiver.[9] While the state does not think it will be necessary to implement, as detailed in *Section 2.2* above, we are seeking the authority to impose a flexible enrollment cap based on biennial appropriations from the state general fund for this population. If the state's financial situation requires a cap on enrollment, an operational protocol would be submitted to CMS for approval at least six months prior to any implementation.

2.3.2 Impacted Populations

Expansion adults otherwise included in the existing HIP 2.0 waiver will be moved into this new 1115 demonstration waiver known as "HIP 3.0". Except for the former foster care youth population that aged out of foster care in another state (as described in more detail below), all other non -expansion adults previously included in the HIP 2.0 waiver will retain their state plan eligibility and be moved into the Hoosier Healthwise program. See *Table 1* below for a full description of each impacted Medicaid eligibility group.

Former foster care youth population that aged out of foster care in another state. As requested as part of the December 20, 2024 HIP 2.0 extension request, Indiana sought new authority to align eligibility rules for youth formerly in foster care who turned 18 before January 1, 2023 (Former Foster Youth) with those who turned 18 on or after January 1, 2023 who are eligible for state plan eligibility pursuant to Section 1002(a) of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act which created a new Former Foster Care Children (FFCC) Medicaid state plan eligibility group. The State seeks to retain authority for that population within the HIP 2.0 waiver.

Table 1: Impacted Medicaid Eligibility Groups

Medicaid Eligibility Group	Description	New Coverage
Adult Transitional Medical Assistance beneficiaries under section 1902(a)(52) and 1925 of the Act	Former Parent & Caretaker relatives eligible for a minimum of 6 and a maximum of 12 months of continued coverage under Transitional Medical Assistance.	State Plan Authority Hoosier HealthWise Coverage
Parents & caretaker relatives eligible under 42 CFR 435.110	Parents and caretakers with income under the State's AFDC payment standard in effect as of July 16, 1996 (section 1931 parents and caretaker relatives), converted to a MAGI-equivalent amount by household size.	State Plan Authority Hoosier HealthWise Coverage
Pregnant women, age 19 and older, eligible under 42 CFR 435.116	Pregnant women with incomes up to 133% of FPL who are enrolled in HIP at the time they become pregnant or are determined eligible for HIP after applying for benefits.	State Plan Authority Hoosier HealthWise Coverage
Former Foster Care Children who aged out of foster care in another state	Individuals formerly in foster care who turned 18 before January 1, 2023 and aged out of foster care in another state, for whom Indiana seeks continued demonstration authority to align	1115 Waiver Authority (HIP 2.0) Hoosier HealthWise Coverage

[9] IC 12-15-44.5-4 and IC 12-15-44.5-4.2

	eligibility with the Former Foster Care Children state plan group established under the SUPPORT Act.	
Adult Expansion (described at section 1902(a)(10)(A)(i)(VIII) of the Act	Adults aged 19-64 with income up to 133% of FPL with a 5% disregard	1115 Waiver Authority (HIP 3.0) HIP Coverage

2.3.3 Delivery System and Benefits

All HIP members will be enrolled in managed care. Members will select their managed care plan at the time of application. The managed care plan selection will remain active for the entire benefit period (January-December each calendar year), even in the event the member experiences a gap in coverage during the benefit period. Each fall an open enrollment period will allow members to select their managed care plan for the following benefit period.

All HIP members will receive a comprehensive benefit package, as detailed in the Alternative Benefit Plan (ABP). The ABP is compliant with all mandated essential health benefits as required by the ACA. The benefit package will provide coverage for all Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits that are available under the State Plan for individuals up to age 21. Individuals who have been determined to be medically frail will receive the same benefits as on the Medicaid State Plan.

2.3.4 Cost-Sharing

All members, unless otherwise excluded, will be subject to cost sharing through copayments. Established copayments will be in compliance with the WFTCA and will be applied to all HIP members, subject to federal regulations. Consistent with federal requirements, the program ensures that no member pays more than five percent (5%) of their income on a quarterly basis.

Because the copayment requirements established in SEA 1 went into effect July 1, 2026, Indiana seeks authorization to begin implementing copayments as soon as possible, either through this demonstration waiver or through a state plan amendment. FSSA will engage with CMS to determine the most efficient and appropriate path for authorization of the “full copayment” structure detailed in the table below as soon as practicable.

As detailed in *Section 2.3.5* below, the HIP 3.0 waiver will also seek to incentivize members to participate in healthy behaviors, such as preventive care, by offering a reduction in the standard HIP copayment amounts.

Category of Service	Full Copayment	Reduced Copayment*
Outpatient Services	$15	$5
Pharmacy	$4 for preferred drugs $8 for non-preferred drugs	$2 for preferred drugs $4 for non-preferred drugs
Dental	$15	$5
Vision	Exam $15 Glasses $15	Exam $5 Glasses $5
Physical, Occupational, & Speech Therapy	$15	$5
Specialist Visit	$20	$5
Rehabilitation Services	$20	$5
DME	Lesser of $25 or cost of item	Lesser of $10 or cost of item
Home Health	$20	$5
Urgent Care	$25	$10
Non-Emergency Use of the ER	$35	$35

**Detailed in section 2.3.5 below*

Note, consistent with federal law, services delivered by a Federally Qualified Health Center (FQHC), Comprehensive Community Behavioral Health Clinic (CCBHC) or Rural Health Center (RHC) are not subject to copayment.

2.3.5 Healthy Incentive Initiative

Individuals eligible for and enrolled in HIP are required to pay copayments for certain health care services as detailed in the WFTCA. Under the demonstration, Indiana will use healthy behavior incentives to improve the health of Medicaid members and promote more responsible health and health care decision-making. Reducing cost-sharing for members who engage in healthy behaviors is expected to encourage preventive care, support better management of chronic conditions, and reinforce prudent use of health care services. These incentives will help strengthen member engagement in their own health and advance the overall objectives of the Medicaid program by supporting healthier outcomes and more efficient use of services.

As detailed above in *Section 2.3.4*, all cost sharing will be in compliance with Medicaid requirements that are set forth in federal statute, regulation, the state plan, and policies, except as necessary to allow HIP to offer cost sharing reductions as an incentive for healthy behaviors. Specifically, members will be eligible to receive reductions in their copayment liability if certain healthy behaviors are maintained or attained during each benefit period.

The healthy behaviors program will incentivize members to engage in certain healthy behaviors and to increase their personal responsibility for their own health. Members who complete at least three healthy behaviors for preventive care services or chronic disease management (or a combination thereof) will receive the incentive of reduced copayments for the remainder of the benefit period and for the following benefit period. Members will be eligible for a reduction in their copayment liability once the minimum threshold has been verified via claims submissions.

For preventive services, members will be able to choose from the following acceptable activities as long as they are appropriate for their age, gender, and risk:

- Health Needs Assessment (if applicable)
- Annual wellness exam/physical
- Lab testing, including cholesterol exam, Hepatitis C, Basic Metabolic Panel, Complete Blood Count, HbA1C
- Cancer screenings, such as breast cancer, cervical cancer, colon cancer, lung cancer, or prostate cancer
- Vaccines such as flu, hepatitis A and B, pneumonia, shingles, Tdap, or respiratory syncytial virus (RSV)
- Dental exam
- Mental health screening under CPT 96127 (depression screenings (PHQ-9), Anxiety screenings (GAD-7), alcohol misuse screenings (AUDIT), or substance use screenings (DAST))

Healthy Behavior	18-20 years old	21-24 years old	25-34 years old	35-39 years old	40-44 years old	45-49 years old	50-64 years old
Health Needs Assessment	X	X	X	X	X	X	X

Annual Wellness Exam/Physical (HEDIS AAP)	X	X	X	X	X	X	X
Labs (must complete at least one – physician ordered based on age & risk)	X	X	X	X	X	X	X
Cervical Cancer Screening (Female) (HEDIS CCS)		X	X	X	X	X	X
Breast Cancer Screening (HEDIS BCS)					X	X	X
Colorectal Cancer Screening (every 5-10 years) (HEDIS COL)						X	X
Lung Cancer Screening (20 pack year smoking history) (TBD)							X
Dental Exam (HEDIS OED)	X	X	X	X	X	X	X
Vaccines (must complete at least one – physician ordered based on age & risk)	X	X	X	X	X	X	X
Mental Health Screening	X	X	X	X	X	X	X

While the majority of the eligible preventive services are available each benefit period, others may have time restrictions based on medical standards, for example, certain cancer screenings are only recommended once every 3 years and therefore would not be available each benefit period.

For chronic disease management, members will be able to choose from acceptable activities, based on their associated chronic condition, such as:

- HbA1c and foot exam for individuals with diabetes
- Eye exam for individuals with diabetes
- Blood pressure and cholesterol tests for individuals with cardiovascular disease
- Lung function/screening for individuals with COPD
- Smoking cessation program participation

These activities are all available within the annual benefit period and should be completed at least annually for the associated underlying chronic conditions.

Rewards will align with the members' annual benefit periods. Members that complete the minimum number of healthy behaviors, verified by claims data, will automatically receive the incentive for the remainder of the current benefit period and the entirety of the following benefit period, assuming the member is still eligible and enrolled. During the following benefit period, the member would then need to complete the minimum number of healthy behaviors again to maintain the incentive into the subsequent benefit period. If a member loses eligibility and then regains eligibility within the incentive period, the member will continue to receive the incentive for the remainder of that benefit period as if they never lost eligibility.

2.3.6 Other Coverage Impacts of the Waiver

HIP and Maternity Coverage

HIP members who become pregnant will transfer to the Hoosier Healthwise program, Indiana's traditional Medicaid managed care program for children and pregnant women. This transfer will take place as soon

as practicable once the state learns about the pregnancy, and the woman will remain in Hoosier Healthwise throughout the 12-month postpartum coverage period. In addition, individuals who apply for Medicaid coverage while pregnant are automatically enrolled in Hoosier Healthwise and then transition to HIP following the postpartum coverage period if their income is equal to or less than 138% FPL.

Presumptive Eligibility

Consistent with state law and current practice, Indiana seeks continued authority to include Federally Qualified Health Centers, Rural Health Centers, Community Mental Health Centers, and Health Department sites as "qualified entities" in an expanded presumptive eligibility program. All provisions of 42 CFR 435.1103 and 435.1110 are applicable to these entities in determining presumptive eligibility. Additionally, state requirements for provider performance standards[10] will be applied to all entities making presumptive eligibility determinations in the state of Indiana.

An individual provided with presumptive eligibility must complete an Indiana Application for Health Coverage during the presumptive eligibility period to gain continued coverage. If individuals do not complete this application, they will lose coverage after the presumptive eligibility period ends. An individual is allowed only one presumptive eligibility coverage period per rolling 12-month period or per pregnancy.

The presumptive eligibility coverage period ends when one of the following circumstances occurs:

- The presumptive eligibility member does not submit an Indiana Application for Health Coverage within the allotted time frame. A completed Indiana Application for Health Coverage must be pending with the Family and Social Services Administration (FSSA) by the end of the month following the month in which presumptive eligibility coverage began.
- The FSSA officially determines the presumptive eligibility member to be ineligible for coverage under an Indiana Health Coverage Program. Eligibility for presumptive eligibility ends on the day after denial of eligibility.
- The FSSA officially determines the presumptive eligibility member to be eligible for coverage. Presumptive eligibility coverage will end prior to the Indiana Health Coverage Program start date with no gap in coverage.

Section 3: Program Goals

The state is committed to the HIP program continuing to improve the health and well-being of participants while maintaining fiscal responsibility through the following goals:

1. Promote value-based decision-making, personal health responsibility and disease prevention to achieve better health outcomes.
2. Improve health care access, appropriate utilization, and health outcomes among HIP members.
3. Assure State fiscal responsibility and efficient management of the program.
4. Program policies will encourage providers to collect copayments and continue providing high quality care to Medicaid members.

Section 4: Evaluation Plan

Under 42 CFR § 431.412, a demonstration application must include "the research hypotheses that are related to the demonstration's proposed changes, goals, and objectives, a plan for testing the hypotheses in the context of an evaluation, and, if a quantitative design is feasible, the identification of appropriate

[10] IC 12-15-4-1.5

evaluation indicators." The state will use both qualitative and quantitative research analysis methods, as appropriate to evaluate the demonstration. Once the demonstration is approved, FSSA will work with CMS to finalize an evaluation design that will guide evaluation activities.

Research Hypothesis and Evaluation Indicators

Goal 1: Encourage HIP members to make value-based decisions, take responsibility for their personal health and disease prevention to achieve better health outcomes			
Research Question	**Outcome Measure**	**Data Sources**	**Analytical Approach**
Hypothesis 1.1: HIP members eligible for reduced copayments will increase utilization of primary care and disease management services during the demonstration period.			
Do copayment reduction incentives result in increased preventive care and disease management behaviors?	Among HIP members eligible for reduced copayments • Annual wellness exam • Cancer screening rates • Blood pressure control • Diabetes HbA1c control	Administrative claims data	Descriptive quantitative analysis

Goal 2: Improve health care access, appropriate utilization, and health outcomes among HIP members.			
Research Question	**Outcome Measure**	**Data Sources**	**Analytical Approach**
Hypothesis 2.1: Member use of preventive care, primary care, prescription drugs, chronic disease management care, and urgent care will be stable during the demonstration period.			
How has the following changed over time for HIP members? · Preventive, primary, urgent and specialty care · Prescription drug use · Chronic care management	Among all HIP members • Ambulatory • Annual wellness exam • Cancer screening rates • Blood pressure control • Diabetes HbA1c control • Proportion of members receiving qualifying preventive care services • Proportion of members using primary care • Proportion of members using specialty care • Enrollment in disease management programs by MCE	Administrative Claims Data MCE reporting	Descriptive quantitative analysis

	• Adherence to prescription drugs • Proportion of members with urgent care visits • Proportion of members with ED visit		
Hypothesis 2.2: Unnecessary ED services will not rise over time for HIP members.			
How have avoidable ED visits among HIP members changed over time?	Proportion of members with preventable or avoidable ED visits (based on NYU Billings ED Visit Algorithm)	Administrative claims data	Descriptive quantitative analysis
Hypothesis 2.3: HIP members will report positive health outcomes.			
How has reported health status for HIP members changed over time?	Proportion of members reporting Excellent/ very good, good, or fair/ poor health	Longitudinal Member Survey (CAHPS)	Descriptive quantitative analysis
Hypothesis 2.4: HIP members will report satisfaction with health care access.			
What percentage of HIP members report getting health care as soon as needed?	Proportion of members reporting that they access care as soon as needed	Member Survey	Descriptive quantitative analysis

Goal 3: Assure State fiscal responsibility and efficient management of the program			
Research Question	**Outcome Measure**	**Data Sources**	**Analytical Approach**
Hypothesis 3.1: HIP will remain budget-neutral for both the federal and state governments.			
3.1.A: Does HIP meet budget neutrality requirements?	• Total annual expenditures for the demonstration population • Documentation of all state and federal costs	Internal financial data Budget neutrality estimates and reports	Descriptive analysis
3.1.B: What are the administrative costs incurred by the State to implement and operate the HIP demonstration?	• Annual administrative costs to implement and operate the demonstration • Contracts or contract amendments to implement, monitor, and evaluate demonstration policies • Annual staff time equivalents needed to implement, administer, and communicate with members about demonstration policies	State administrative records	Descriptive analysis of administrative costs

	• Annual Medicaid agency staff time for those hired to support the demonstration, and time redirected from other Medicaid operations • Identified costs or cost savings accruing to other state agencies that partner with Medicaid (i.e., increased state spending for job readiness programs		
What are the short- and long-term effects of eligibility and coverage policies on Medicaid health care expenditures?	• Total annual health service expenditures for demonstration population • Change in annual PMPM health service expenditures	Medicaid funded-health care expenditures (in total and PMPM) New adult group enrollment from the Medicaid Budget and Expenditure System (MBES) and expenditures from Transformed Medicaid Statistical Information System (T-MSIS) Medicaid Analytic Extracts (MAX) pending CMS approval for research **Indiana and select comparison states*	Difference-in-differences regression models of total service expenditures and PMPM service expenditures
What are the impacts of eligibility and coverage policies on provider uncompensated care costs?	Change in total uncompensated care costs annually	HCRIS data: · Worksheet S-10, line 31 **Indiana and select comparison states*	Difference-in-differences regression model of uncompensated care costs

Goal 4: Program policies will encourage providers to collect copayments and continue providing high quality care to Medicaid members.			
Research Question	**Outcome Measure**	**Data Sources**	**Analytical Approach**
Hypothesis 4.1: Providers will report collecting co-payments for eligible visits.			
Did providers ultimately collect copays for eligible HIP members?	The proportion of providers that reported collecting copays The proportion of providers that reported satisfaction with the	Provider Surveys Provider Focus Group	Descriptive qualitative analysis

	copay collection process		
Hypothesis 4.2: Managed care compliance with primary care appointment availability standards will remain consistent with national trends.			
Are appointment availability standards for HIP members consistent with national trends	MCE compliance with appointment availability standards for HIP members Indiana and comparison states	MCE Reporting	Description quantitative trend analysis
Hypothesis 4.3: Medicaid enrolled primary care and specialty care provider ratios will remain consistent with national trends.			
Do changes in provider enrollment in the Medicaid program remain consistent with national trends?	Ratio of primary care providers to members by MCE Ratio of select specialty care providers to members by MCE Indiana and comparison states	MCE Reporting Provider directories	

Section 5: Demonstration Financing and Budget Neutrality

The budget neutrality requirements for Section 1115 waivers ensure that Medicaid demonstration projections do not increase federal Medicaid spending beyond what it would have been in the absence of the waiver. As a result, states must design their Section 1115 waiver proposals so that projected costs under the waiver are equal to or less than the expected federal costs without the waiver. The budget neutrality formula compares Without Waiver (WOW) expenditures with With Waiver (WW) expenditures, ensuring that WOW costs are greater than or equal to WW costs.

- WOW expenditures, or baseline expenditures, represent the amount the federal government would have spent in the absence of the Demonstration and form the basis for the budget neutrality expenditure limit.
- WW expenditures, or actual expenditures, represent the projected costs under the Demonstration.

The budget neutrality demonstration includes Medicaid Eligibility Groups (MEGs) that are treated as hypothetical for purposes of the budget neutrality test. These populations and/or services could otherwise be covered under existing Medicaid authorities (e.g., the State Plan) and therefore are reflected in both the WW and WOW projections.

Consistent with CMS budget neutrality methodology, expenditures associated with hypothetical MEGs are incorporated symmetrically into both scenarios. As a result, the inclusion of these MEGs does not generate budget neutrality savings and yields equivalent projected expenditures in the WW and WOW baselines for those components.

Additionally, the community engagement requirements reflected in this demonstration are aligned with federal statutory requirements applicable to the expansion population and therefore are assumed to apply

consistently in both the WW and WOW scenarios. Because these requirements are not unique to the demonstration, they do not create a differential fiscal impact between the two projections.

The Demonstration Years (DY) for this waiver are defined as follows:

- DY 1: October 1, 2027 – September 30, 2028
- DY 2: October 1, 2028 – September 30, 2029
- DY 3: October 1, 2029 – September 30, 2030
- DY 4: October 1, 2030 – September 30, 2031
- DY 5: October 1, 2031 – September 30, 2032

Two MEGs are being proposed for this waiver, as follows:

- Expansion MEG: Expansion members who do not meet state's medically frail definition
- Medically Frail MEG: Expansion members that meet state's medically frail definition

The proposed budget neutrality limits below were developed using enrollment and cost projections that account for the community engagement requirements discussed in this Demonstration application. These values are assumed to be the same in the WW and WOW scenarios.

MEG	DY 1	DY 2	DY 3	DY 4	DY 5
Expansion					
Member months	2,912,999	2,602,280	2,615,291	2,628,367	2,641,509
PMPM	$1,000.49	$1,119.62	$1,175.60	$1,234.38	$1,296.10
Expenditures	$ 2,914,426,370	$ 2,913,564,734	$ 3,074,536,100	$ 3,244,403,657	$ 3,423,659,815
Medically Frail					
Member months	1,754,450	1,763,222	1,772,038	1,780,898	1,789,802
PMPM	$1,206.39	$1,266.71	$1,330.05	$1,396.55	$1,466.38
Expenditures	$ 2,116,550,806	$ 2,233,490,940	$ 2,356,899,142	$ 2,487,113,102	$ 2,624,529,857

5.1 Enrollment

The enrollment estimate projects current enrollment levels forward and adjusts for the impact of community engagement requirements.

- *Base data:* The enrollment projection is based on actual enrollment through February 2026.
- *Enrollment trend:* The projection through June 2027 reflects granular enrollment projections developed by the state. Beginning in July 2027, the annual enrollment trend is assumed to be 0.5% for both MEGs.
- *Community engagement requirements:* Under the community engagement provisions of the demonstration, certain non-exempt Expansion MEG enrollees will be required to meet participation criteria to maintain eligibility. It is assumed that approximately 20% of Expansion

MEG enrollment will decline as a result of noncompliance with community engagement requirements. DY 1 is not expected to reflect the full impact of this decrease because disenrollments will occur throughout the year; therefore, a 10% decrease is assumed for DY 1. The Medically Frail MEG is unaffected, as medically frail individuals are exempt from community engagement requirements.

5.2 Per Member Per Month (PMPM) Cost

The accompanying PMPM cost estimates are based on observed CY 2025 costs, adjusted for reimbursement changes assumed to occur before the beginning of the waiver and for the impact of community engagement requirements on population acuity.

- *Base data:* The PMPM cost projection starts with CY 2025 claims and supplemental payment data for the newly eligible adult population (both the Expansion and Medically Frail MEGs).
- *Claims trend:* DY 1 was calculated by adjusting CY 2025 PMPMs to reflect projected changes in categories such as capitation payments, maternity kick payments, state-directed payments, POWER Account payments, and carve-out services, including Mental Health Rehabilitation and High Cost Pharmacy, and by projecting supplemental payments such as General Medical Education reimbursement, FQHC/RHC wraparound payments, and pharmacy rebates forward. For DY 2 through DY 5, the projection assumes an annual PMPM cost trend of 5.0%, before application of the community engagement impacts described below. This trend is a placeholder assumption intended to align with the President's Budget trend and will be updated when a final input is confirmed by CMS.
- *Community engagement requirements:* The Expansion MEG PMPM reflects an adjustment for the anticipated impact of community engagement requirements. It is assumed that approximately 20% of the Expansion MEG population will disenroll as a result of noncompliance with these requirements. Members who disenroll are assumed to have an acuity level equal to 50% of the average acuity of the population prior to disenrollment, reflecting the expectation that noncompliant members are, on average, healthier and lower cost. The net effect of the enrollment reduction and the differential acuity is approximately a 12.5% increase in the effective Expansion MEG PMPM starting in DY 2, with a partial impact in DY 1 as the requirements begin to be implemented. The Medically Frail MEG is unaffected, as medically frail individuals are exempt from community engagement requirements.

5.3 Aggregate Expenditures

Aggregate expenditures for both MEGs are calculated by multiplying the projected member months by the corresponding PMPM cost for each demonstration year.

Section 6: Requested Waivers

The State requests the following waivers::

1. **Comparability** **Section 1902(a)(10)(B) and 1902(a)(17)**
   To the extent necessary to enable the state to vary copayment requirements for individuals based on the completion of desired wellness behaviors

2. **Eligibility** **Section 1902(a)(10)(A)**
   To the extent necessary to enable the state to provide services for the Healthy Indiana Plan 3.0 through a demonstration waiver rather than the State Plan for Medical Assistance

Section 7: Public Notice and Comment

In accordance with 42 CFR 431.408, the State will provide the public and other interested parties with the opportunity to review and provide input on the waiver through a formal, 30-day public notice and comment process which will run from August 5, 2026, to September 4, 2026. During this time, the State will also hold two dedicated public hearings, one of which will be held at a Medicaid Advisory Commission (MAC) meeting.

Public Notice

Electronic copies of all documents, including the proposed Demonstration application and full public notice document (see *Appendix A*), are available for public review on the agency's website at the web address of the HIP program homepage: https://in.gov/fssa/hip/hip-work-requirements/public-notices. All information regarding the submission, including the public notice, the waiver, and other documentation regarding the proposal are available for public review at FSSA, Office of Medicaid Policy and Planning, 402 W. Washington Street, Room W374, Indianapolis, Indiana 46204.

The abbreviated public notice (see *Appendix B*) was formally published in the Indiana Register on August 5, 2026. In addition, the Indiana Family and Social Services Administration sent electronic notification of the demonstration application to the agency's stakeholder distribution list. Interested parties may submit comments to FSSA on the proposed application during the federal 30-day public comment period either electronically or through the mail, as follows:

1. Email: HIP@fssa.IN.gov
2. U.S. Mail:

   Family and Social Services Administration
   Office of Medicaid Policy and Planning
   Attention: Secretary E. Mitchell (Mitch) Roob
   402 West Washington Street, Room W374
   Indianapolis, Indiana 46204

Public Hearings

The State will hold two public hearings for interested parties to learn more about the HIP 3.0 waiver application pursuant to the requirements set forth at 42 CFR 431.408. Public hearings regarding the waiver will be conducted on Friday, August 7, 2026 and Tuesday, August 11, 2026, as described below and as scheduled and publicized in the State's administrative record (the Indiana Register) and the FSSA website.

Public Hearing #1: Friday, August 7, 2026

Indiana Government Center South
Conference Room 2 – Wabash Hall
302 W. Washington Street,
Indianapolis, IN 46204
2:30 – 4:00 pm, EST
Virtual attendees join at this link:
https://www.zoomgov.com/j/1652590855?pwd=G91tZaCmcNJDh0CLLitynFtO9TmCwF.1
Meeting ID: 165 259 0855
Passcode: 252495

Public Hearing #2: Tuesday, August 11, 2026
Medicaid Advisory Committee

Indiana Government Center South
Conference Rooms 1 & 2 – Wabash Hall
302 W. Washington Street,
Indianapolis, IN 46204
10:00 – 11:00 am, EST
Virtual attendees join at this link:
https://www.zoomgov.com/j/1657447049?pwd=nGWFcdZJhmAzbh3R1Qnuvfb4zPHP9R.1
Meeting ID: 165 744 7049
Passcode: 955767
Virtual attendees will be able to submit comments in writing at HIP@fssa.IN.gov, but there will be no audio capabilities for verbal testimony.

Tribal Notice

In addition, the State provided notice of the HIP waiver application and its contents to Indiana's federally recognized Indian tribe, the Pokagon Band of Potawatomi Indians, on July 23, 2026. The notice and opportunity for consultation was provided in accordance with 42 CFR 431.408(b).

Section 8: Demonstration Administration

The State's point of contact for the HIP 3.0 §1115 demonstration is:

Name and Title: Mitch Roob, Secretary
Organization: Indiana Family and Social Services Administration
Telephone Number: 317-233-7447
Email Address: HIP@fssa.IN.gov

APPENDIX A

OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

ADMINISTRATION

Notice of Public Comment Period for Healthy Indiana Plan (HIP) 3.0

August 5, 2026

Pursuant to 42 CFR § 431.408, notice is hereby given that the Indiana Family and Social Services Administration (FSSA) will provide the public with the opportunity to review and provide input on a new Section 1115 demonstration waiver. This notice provides details about the waiver submission and serves to open the 30-day public comment period, which will open on August 5, 2026, and close on September 4, 2026.

In addition to the 30-day public comment period in which the public will be able to provide written comments to FSSA via US postal service or email, FSSA will host two hearings in which the public may provide verbal comments. Hearings will be held at the following dates, times, and locations:

Public Hearing #1: Friday, August 7, 2026

Indiana Government Center South
Conference Room 2 – Wabash Hall
302 W. Washington Street,
Indianapolis, IN 46204
2:30 – 4:00 pm, EST
Virtual attendees join at this link:
https://www.zoomgov.com/j/1652590855?pwd=G91tZaCmcNJDh0CLLitynFtO9TmCwF.1
Meeting ID: 165 259 0855
Passcode: 252495

Public Hearing #2: Tuesday, August 11, 2026
Medicaid Advisory Committee

Indiana Government Center South
Conference Rooms 1 & 2 – Wabash Hall
302 W. Washington Street,
Indianapolis, IN 46204
10:00 – 11:00 am, EST
Virtual attendees join at this link:
https://www.zoomgov.com/j/1657447049?pwd=nGWFcdZJhmAzbh3R1Qnuvfb4zPHP9R.1
Meeting ID: 165 744 7049
Passcode: 955767
Virtual attendees will be able to submit comments in writing at HIP@fssa.IN.gov, but there will be no audio capabilities for verbal testimony.

Prior to finalizing the proposed waiver, FSSA will consider all written and verbal public comments received. The comments will be summarized and addressed in the final draft of the waiver to be submitted to the Centers for Medicare and Medicaid Services (CMS).

1115 Demonstration Summary

FSSA is seeking federal approval of a new five-year Section 1115 demonstration waiver, known as Healthy Indiana Plan (HIP) 3.0, to continue covering adults eligible under the Medicaid expansion population through a demonstration-based program rather than the Medicaid State Plan. The proposed waiver would transition coverage for the expansion population to a standalone Section 1115 demonstration, implement member cost-sharing through copayments consistent with state and federal requirements, and establish incentives that reduce copayments for members who complete preventive care and other healthy activities. The demonstration is intended to promote preventive care, encourage

member engagement in healthcare decision-making, support appropriate utilization of healthcare services, and maintain the long-term fiscal sustainability of the program. Indiana also seeks recognition that the demonstration will operate subject to available state funding and requests flexibility to seek future program modifications or termination if funding conditions change, in accordance with state law.

Demonstration Goals

The state is committed to furthering the HIP program's objective to improve the health and well-being of participants while maintaining fiscal responsibility through the following goals:

1. Promote value-based decision-making, personal health responsibility, and disease prevention to achieve better health outcomes.
2. Improve health care access, appropriate utilization, and health outcomes among HIP members.
3. Assure State fiscal responsibility and efficient management of the program.
4. Develop program policies to encourage providers to collect copayments and continue providing high-quality care to Medicaid members.

Eligible Populations

Individuals eligible for Medicaid under 1902(a)(10)(A)(i)(VII) (Group VIII) will be eligible under this demonstration. Group VIII individuals consist of non-disabled adults between the ages of 19-64 with a household income up to 138% of the Federal Poverty Level (133% with 5% disregard) who are not otherwise eligible for Medicaid. Coverage for this group is subject to all applicable Medicaid laws and regulations, except as expressly waived in this demonstration.

Description	FPL	Demonstration Eligibly Group
Adults ages 19-64 who are not otherwise eligible for comprehensive Medicaid benefits or Medicare	Income under 138% FPL per the Modified Adjusted Gross Income (MAGI) guidelines with 5% income disregard	Adults (as described at 42 CFR 435.119)

Impacted Populations

Except for the former foster care youth population that aged out of foster care in another state, all other non-expansion adults previously included in the HIP 2.0 waiver will retain their state plan eligibility and be moved into the Hoosier Healthwise program. See eligibility table below for a description of each impacted eligibility group currently covered under the existing HIP 2.0 waiver.

Medicaid Eligibility Group	Description	New Coverage
Adult Transitional Medical Assistance beneficiaries under section 1902(a)(52) and 1925 of the Act	Former Parent & Caretaker relatives eligible for a minimum of 6 and a maximum of 12 months of continued coverage under Transitional Medical Assistance.	State Plan Authority Hoosier HealthWise Coverage
Pregnant women, age 19 and older, eligible under 42 CFR 435.116	Pregnant women with incomes up to 133% of FPL who are enrolled in HIP at the time they become pregnant or are determined eligible for HIP after applying for benefits.	State Plan Authority Hoosier HealthWise Coverage
Parents & caretaker relatives eligible under 42 CFR 435.110	Parents and caretakers with income under the State's AFDC	State Plan Authority Hoosier HealthWise Coverage

	payment standard in effect as of July 16, 1996 (section 1931 parents and caretaker relatives), converted to a MAGI-equivalent amount by household size.	
Former Foster Care Children who aged out of foster care in another state	Individuals formerly in foster care who turned 18 before January 1, 2023 and aged out of foster care in another state, for whom Indiana seeks continued demonstration authority to align eligibility with the Former Foster Care Children state plan group established under the SUPPORT Act.	1115 Waiver Authority (HIP 2.0) Hoosier HealthWise Coverage
Adult Expansion (described at section 1902(a)(10)(A)(i)(VIII) of the Act	Adults aged 19-64 with income up to 133% of FPL with a 5% disregard	1115 Waiver Authority (HIP 3.0) HIP Coverage

Delivery System and Benefits

All HIP 3.0 members will be enrolled in managed care. Members will select their managed care plan at the time of application. The managed care plan selection will remain active for the entire benefit period (January-December each calendar year), even in the event that the member experiences a gap in coverage during the benefit period. Each fall an open enrollment period will allow members to select their managed care plan for the following benefit period.

All HIP 3.0 members will receive a comprehensive benefit package, as detailed in the Alternative Benefit Plan (ABP). The ABP is compliant with all mandated essential health benefits as required by the ACA. The benefit package will provide coverage for all Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits that are available under the State Plan for individuals up to age 21. Individuals who have been determined to be medically frail will receive the same benefits as on the Medicaid State Plan.

Presumptive Eligibility

Pursuant to state law, Indiana seeks to continue to allow an expanded set of providers to make presumptive eligibility determinations.

Cost Sharing & Healthy Incentives

All HIP 3.0 members, unless otherwise excluded, will be subject to cost sharing through copayments. Established copayments will be in compliance with the WFTCA and will be applied to all HIP members, subject to federal regulations. Consistent with federal requirements, the program ensures that no member pays more than five percent (5%) of their income on a quarterly basis. Services delivered by a Federally Qualified Health Center (FQHC), Comprehensive Community Behavioral Health Clinic (CCBHC) or Rural Health Center (RHC) are not subject to copayment. During the demonstration, members may earn a reduced copayment amount by participating in healthy behaviors.

Category of Service	Full Copayment	Reduced Copayment
Outpatient Services	$15	$5
Pharmacy	$4 for preferred drugs $8 for non-preferred drugs	$2 for preferred drugs $4 for non-preferred drugs
Dental	$15	$5

Vision	Exam $15 Glasses $15	Exam $5 Glasses $5
Physical, Occupational, & Speech Therapy	$15	$5
Specialist Visit	$20	$5
Rehabilitation Services	$20	$5
DME	Lesser of $25 or cost of item	Lesser of $10 or cost of item
Home Health	$20	$5
Urgent Care	$25	$10
Non-Emergency Use of the ER	$35	$35

The reduction in copayments is intended to incentivize members to engage in healthy behaviors and to increase their personal responsibility for their own health. Members who complete at least three healthy behaviors for preventive care services or chronic disease management (or a combination thereof) will receive the incentive of reduced copayments for the remainder of the benefit period and for the following benefit period. Members will be eligible for a reduction in their copayment liability once the minimum threshold has been verified via claims submissions. For preventive services, members will be able to choose from the following acceptable activities as long as they are appropriate for their age, gender, and risk:

- Health Needs Assessment (if applicable)
- Annual wellness exam/physical
- Lab testing, including cholesterol exam, Hepatitis C, Basic Metabolic Panel, Complete Blood Count, HbA1C
- Cancer screenings, such as breast cancer, cervical cancer, colon cancer, lung cancer, or prostate cancer
- Vaccines such as flu, hepatitis A and B, pneumonia, shingles, Tdap, or respiratory syncytial virus (RSV)
- Dental exam
- Mental health screening under CPT 96127 (depression screenings (PHQ-9), Anxiety screenings (GAD-7), alcohol misuse screenings (AUDIT), or substance use screenings (DAST))

Enrollment and Expenditures Projections

The budget neutrality requirements for Section 1115 waivers ensure that Medicaid demonstration projections do not increase federal Medicaid spending beyond what it would have been in the absence of the waiver. The budget neutrality demonstration includes Medicaid Eligibility Groups (MEGs) that are treated as hypothetical for purposes of the budget neutrality test, as they are populations and/or services could otherwise be covered under existing Medicaid authorities (e.g., the State Plan). As a result, the demonstration does not generate budget neutrality savings and yields equivalent projected expenditures in both the 'with waiver' and 'without waiver' baseline for the budget neutrality test.

The table below details the projected enrollment and expenditures for the five-year demonstration period.

MEG	DY 1	DY 2	DY 3	DY 4	DY 5
Expansion					
Member months	2,912,999	2,602,280	2,615,291	2,628,367	2,641,509
PMPM	$1,000.49	$1,119.62	$1,175.60	$1,234.38	$1,296.10

Expenditures	$ 2,914,426,370	$ 2,913,564,734	$ 3,074,536,100	$ 3,244,403,657	$ 3,423,659,815
Medically Frail					
Member months	1,754,450	1,763,222	1,772,038	1,780,898	1,789,802
PMPM	$1,206.39	$1,266.71	$1,330.05	$1,396.55	$1,466.38
Expenditures	$ 2,116,550,806	$ 2,233,490,940	$ 2,356,899,142	$ 2,487,113,102	$ 2,624,529,857

Evaluation and Hypothesis

The State will use both qualitative and quantitative research analysis methods, as appropriate to evaluate the demonstration. Once the demonstration is approved, FSSA will work with CMS to finalize an evaluation design that will guide evaluation activities based on the draft evaluation parameters below.

Goal 1: Promote value-based decision-making, personal health responsibility and disease prevention to achieve better health outcomes			
Research Question	**Outcome Measure**	**Data Sources**	**Analytical Approach**
Hypothesis 1.1: HIP members eligible for reduced copayments will increase utilization of primary care and disease management services during the demonstration period.			
Do copayment reduction incentives result in increased preventive care and disease management behaviors?	Among HIP members eligible for reduced copayments • Annual wellness exam • Cancer screening rates • Blood pressure control • Diabetes HbA1c control	Administrative claims data	Descriptive quantitative analysis

Goal 2: Improve health care access, appropriate utilization, and health outcomes among HIP members.			
Research Question	**Outcome Measure**	**Data Sources**	**Analytical Approach**
Hypothesis 2.1: Member use of preventive care, primary care, prescription drugs, chronic disease management care, and urgent care will be stable during the demonstration period.			
How has the following changed over time for HIP members? · Preventive, primary, urgent and specialty care · Prescription drug use · Chronic care management	Among all HIP members • Ambulatory • Annual wellness exam • Cancer screening rates • Blood pressure control • Diabetes HbA1c control	Administrative Claims Data MCE reporting	Descriptive quantitative analysis

	• Proportion of members receiving qualifying preventive care services • Proportion of members using primary care • Proportion of members using specialty care • Enrollment in disease management programs by MCE • Adherence to prescription drugs • Proportion of members with urgent care visits • Proportion of members with ED visit		
Hypothesis 2.2: Unnecessary ED services will not rise over time for HIP members.			
How have avoidable ED visits among HIP members changed over time?	Proportion of members with preventable or avoidable ED visits (based on NYU Billings ED Visit Algorithm)	Administrative claims data	Descriptive quantitative analysis
Hypothesis 2.3: HIP members will report positive health outcomes.			
How has reported health status for HIP members changed over time?	Proportion of members reporting Excellent/ very good, good, or fair/ poor health	Longitudinal Member Survey (CAHPS)	Descriptive quantitative analysis
Hypothesis 2.4: HIP members will report satisfaction with health care access.			
What percentage of HIP members report getting health care as soon as needed?	Proportion of members reporting that they access care as soon as needed	Member Survey	Descriptive quantitative analysis

Goal 3: Assure State fiscal responsibility and efficient management of the program			
Research Question	**Outcome Measure**	**Data Sources**	**Analytical Approach**
Hypothesis 3.1: HIP will remain budget-neutral for both the federal and state governments.			
3.1.A: Does HIP meet budget neutrality requirements?	• Total annual expenditures for the demonstration population • Documentation of all state and federal costs	Internal financial data Budget neutrality estimates and reports	Descriptive analysis
3.1.B: What are the administrative costs incurred by the State to implement and operate the HIP demonstration?	• Annual administrative costs to implement and operate the demonstration • Contracts or contract amendments to	State administrative records	Descriptive analysis of administrative costs

	implement, monitor, and evaluate demonstration policies • Annual staff time equivalents needed to implement, administer, and communicate with members about demonstration policies • Annual Medicaid agency staff time for those hired to support the demonstration, and time redirected from other Medicaid operations • Identified costs or cost savings accruing to other state agencies that partner with Medicaid (i.e., increased state spending for job readiness programs		
What are the short- and long-term effects of eligibility and coverage policies on Medicaid health care expenditures?	• Total annual health service expenditures for demonstration population • Change in annual PMPM health service expenditures	Medicaid funded-health care expenditures (in total and PMPM) New adult group enrollment from the Medicaid Budget and Expenditure System (MBES) and expenditures from Transformed Medicaid Statistical Information System (T-MSIS) Medicaid Analytic Extracts (MAX) pending CMS approval for research **Indiana and select comparison states*	Difference-in-differences regression models of total service expenditures and PMPM service expenditures
What are the impacts of eligibility and coverage policies on provider uncompensated care costs?	Change in total uncompensated care costs annually	HCRIS data: Worksheet S-10, line 31 **Indiana and select comparison states*	Difference-in-differences regression model of uncompensated care costs

Goal 4: Program policies will encourage providers to collect copayments and continue providing high quality care to Medicaid members.			
Research Question	**Outcome Measure**	**Data Sources**	**Analytical Approach**
Hypothesis 4.1: Providers will report collecting co-payments for eligible visits.			
Did providers ultimately collect copays for eligible HIP members?	The proportion of providers that reported collecting copays The proportion of providers that reported satisfaction with the copay collection process	Provider Surveys Provider Focus Group	Descriptive qualitative analysis
Hypothesis 4.2: Managed care compliance with primary care appointment availability standards will remain consistent with national trends.			
Are appointment availability standards for HIP members consistent with national trends	MCE compliance with appointment availability standards for HIP members Indiana and comparison states	MCE Reporting	Description of quantitative trend analysis
Hypothesis 4.3: Medicaid enrolled primary care and specialty care provider ratios will remain consistent with national trends.			
Do changes in provider enrollment in the Medicaid program remain consistent with national trends?	Ratio of primary care providers to members by MCE Ratio of select specialty care providers to members by MCE Indiana and comparison states	MCE Reporting Provider directories	

Waiver and Expenditure Authorities

The State requests a renewal of all currently approved waivers, and only requests the following revisions and additions to the existing HIP waivers:

3. **Comparability** **Section 1902(a)(10)(B) and 1902(a)(17)**
   To the extent necessary to enable the state to vary copayment requirements for individuals based on the completion of desired wellness behaviors

4. **Eligibility** **Section 1902(a)(10)(A)**
   To the extent necessary to enable the state to provide services for the Healthy Indiana Plan 3.0 through a demonstration waiver rather than the State Plan for Medical Assistance

Review of Documents and Submission of Comments

All information regarding the submission, including the public notice, the waiver, and other documentation regarding the proposal are available for public review at FSSA, Office of Medicaid Policy and Planning,

402 W. Washington Street, Room W374, Indianapolis, Indiana 46204. These documents are also available to be viewed online at https://in.gov/fssa/hip/hip-work-requirements/public-notices.

Written comments regarding the waiver will be accepted through September 4, 2026, and may be emailed to: Secretary Mitch Roob at HIP@fssa.IN.gov or sent to the FSSA via mail at:

Family and Social Services Administration
Office of Medicaid Policy and Planning
Attention: Secretary E. Mitchell (Mitch) Roob
402 West Washington Street, Room W374
Indianapolis, Indiana 46204

APPENDIX B

Indiana Family and Social Services Administration (FSSA)

Healthy Indiana Plan (HIP) 3.0 Notice of Public Hearing

1115 Demonstration Summary

FSSA is seeking federal authority to implement HIP 3.0 through this new demonstration waiver. Under HIP 3.0, the state would remove HIP expansion coverage from the Medicaid state plan and instead cover the adult expansion population through this Section 1115 demonstration. The demonstration would include copayments that align with new federal requirements and allow individuals to earn reduced copayment amounts through a healthy behavior incentive program. Indiana is also seeking authority to implement enrollment caps to manage program growth based on available state funding and to support the program's long-term viability. The purpose of this demonstration is to test and evaluate state-specific policy approaches for covering expansion adults as an optional Medicaid population, consistent with the United States Supreme Court's recognition that states may choose whether and how to cover that population. In addition to the HIP 3.0 demonstration, Indiana seeks to continue to allow an expanded set of providers to make presumptive eligibility determinations for children, pregnant women, and adults while adding a requirement to verify citizenship prior to granting presumptive eligibility.

Non-expansion adults previously included in the HIP 2.0 waiver will retain their state plan eligibility and be moved into the Hoosier Healthwise program. Expansion adults will be moved into this new 1115 demonstration waiver known as HIP 3.0.

Public Comment and Hearing Information

This notice provides details about the waiver submission and serves to open the 30-day public comment period that will open on August 5, 2026 and close on September 4, 2026.

In addition to the 30-day public comment period in which the public will be able to provide written comments to the FSSA via US postal service or email, the FSSA will host two hearings in which the public may provide verbal comments. Hearings will be held at the following dates, times, and locations:

Public Hearing #1: Friday, August 7, 2026

Indiana Government Center South
Conference Room 2 – Wabash Hall
302 W. Washington Street,
Indianapolis, IN 46204
2:30 – 4:00 pm, EST
Virtual attendees join at this link:
https://www.zoomgov.com/j/1652590855?pwd=G91tZaCmcNJDh0CLLitynFtO9TmCwF.1
Meeting ID: 165 259 0855
Passcode: 252495

Public Hearing #2: Tuesday, August 11, 2026

Medicaid Advisory Committee
Indiana Government Center South
Conference Rooms 1 & 2 – Wabash Hall

302 W. Washington Street,
Indianapolis, IN 46204
10:00 – 11:00 am, EST
Virtual attendees join at this link:
https://www.zoomgov.com/j/1657447049?pwd=nGWFcdZJhmAzbh3R1Qnuvfb4zPHP9R.1
Meeting ID: 165 744 7049
Passcode: 955767
Virtual attendees will be able to submit comments in writing at HIP@fssa.IN.gov, but there will be no audio capabilities for verbal testimony.

All information regarding the submission, including the public notice, the waiver, and other documentation regarding the proposal are available for public review at the FSSA, Office of Medicaid Policy and Planning, 402 W. Washington Street, Room W374, Indianapolis, Indiana 46204. These documents are also available to be viewed online at https://in.gov/fssa/hip/hip-work-requirements/public-notices.

Written comments regarding the waiver amendment will be accepted through September 4, 2026 and may be emailed to: Secretary Mitch Roob at HIP@fssa.IN.gov or sent to the FSSA via mail at:

Family and Social Services Administration
Office of Medicaid Policy and Planning
Attention: Secretary E. Mitchell (Mitch) Roob
402 West Washington Street, Room W374
Indianapolis, Indiana 46204