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:

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

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