

Indiana Family and Social Services Administration

Healthy Indiana Plan 1115 Waiver Extension Application



HEALTHY INDIANA PLANSM
Health Coverage = Peace of Mind

Submitted
6/30/2014

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Section 1: Executive Summary

The Healthy Indiana Plan (HIP), which passed the Indiana General Assembly in 2007 with bipartisan support, builds upon the state's long and successful history with consumer-driven health plans. Indiana pioneered the concept of medical savings accounts in the commercial market and is the first and only State to apply the consumer-driven model to a Medicaid population. Provided by private health insurance carriers, HIP offers its members a High Deductible Health Plan (HDHP) paired with the Personal Wellness and Responsibility (POWER) account, which operates similarly to a Health Savings Account (HSA).

The private health insurance experience provides an alternative to traditional Medicaid and promotes consumerism by requiring members to make contributions into their account. This gives members "skin in the game," which empowers them to demand price and quality transparency as they make cost-conscious health care decisions and take responsibility for their health. In addition, the infusion of market principles works to educate members and prepare them to participate in the private market when they are able to transition off the program.

This waiver application is submitted concurrently with a separate 1115 Demonstration waiver (HIP 2.0 Waiver). The HIP 2.0 Waiver seeks to expand HIP to all non-disabled adult Hoosiers below 138% of the federal poverty level (FPL), as well as to implement key enhancements based on the first six years of HIP program experience. If approved, the HIP 2.0 Waiver will eliminate the coverage gap created by the Patient Protection and Affordable Care Act (ACA), providing an affordable health insurance product to all low-income individuals who would otherwise be ineligible for both Medicaid and the premium tax credits available through the Marketplace. If the Centers for Medicare and Medicaid (CMS) does not approve the HIP 2.0 Waiver request, the State submits this request as an alternative application to preserve the current HIP program for the current enrollees who rely on the program.

Through this waiver request, the State aims to at least continue the HIP program for the maximum waiver renewal period of three years in its current form, with no new changes.

Section 2: Program Description

Traditional Medicaid programs offer coverage to vulnerable individuals, but numerous studies indicate poor health outcomes in spite of high spending. A University of Virginia study found that Medicaid patients are almost twice as likely to die after an inpatient surgery, stay in the hospital forty-two percent (42%) longer, and cost twenty-six percent (26%) more than individuals with private health insurance.¹ A study conducted by Johns Hopkins similarly found higher mortality rates among Medicaid patients, indicating they are twenty-nine percent (29%) more likely to die within three years following receipt of a lung transplant.²

The HIP model was developed as an alternative to traditional Medicaid in order to harness the success of the private health insurance market to lower costs and improve health outcomes for Hoosiers. The program utilizes an account similar to an HSA that empowers enrollees to become

¹Avik, Roy. (2012). The Medicaid Mess: How Obamacare Makes It Worse. Retrieved from http://www.manhattan-institute.org/html/ir_8.htm.

² *Id.*

active consumers of health care services and to evaluate cost and quality of services. Six years later, HIP has demonstrated significant success in achieving this goal.

HIP’s consumer-driven design creates incentives for members to exercise personal responsibility and live healthy lifestyles. This design encourages members to take control of their health care spending and to be active purchasers of health care services. While other efforts aimed at bending the health care cost curve are aimed at providers and insurers, HIP brings the member directly into the equation, aligning incentives across all parties and uniquely empowering the individual to demand cost and quality transparency. Through the introduction of these market forces, HIP is able to yield superior results compared to traditional Medicaid.

2.1 Eligibility

HIP targets non-disabled adults between the ages of 19 and 64 with a household income less than 100% FPL who are not otherwise eligible for Medicaid. Currently, Section 1931 parents and caretaker relatives are not eligible for HIP. This population is instead placed in the Hoosier Healthwise (HHW) program - Indiana’s full benefit Medicaid program for children, parents, pregnant women, and certain caretaker relatives. While HIP does not limit enrollment for parents and caretaker relatives with income below 100% FPL, the State does impose a firm enrollment cap of 36,500 on the number of non-caretakers allowed to participate in HIP.

2.1.1 Populations Ineligible HIP

Individuals eligible for services under traditional Medicaid are described below in [Table 2.1.1 \(A\)](#).

Table 2.1.1 (A): Current Medicaid Populations Ineligible for HIP

1. Mandatory categorically needy low-income families and children eligible under section 1925 for Transitional Medical Assistance.
2. Mandatory categorically needy poverty level infants eligible under 1902(a)(10)(A)(i)(IV).
3. Mandatory categorically needy poverty level children aged 1 up to age 6 eligible under 1902(a)(10)(A)(i)(VI).
4. Mandatory categorically needy poverty level children aged 6 up to age 19 eligible under 1902(a)(10)(A)(i)(VII).
5. Optional categorically needy poverty level pregnant women eligible under 1902(a)(10)(A)(ii)(IX).
6. Optional categorically needy poverty level infants eligible under 1902(a)(10)(A)(ii)(IX).
7. Optional categorically needy AFDC-related families and children eligible under 1902(a)(10)(A)(ii)(I).
8. Mandatory categorically needy low-income parents eligible under 1931 of the Act.
9. Mandatory categorically needy pregnant women eligible under 1902(a)(10)(A)(i)(IV) or another section under 1902(a)(10)(A)(i).
10. Individuals qualifying for Medicaid on the basis of blindness.
11. Individuals qualifying for Medicaid on the basis of disability.
12. Institutionalized individuals assessed a patient contribution toward the cost of care under 1902(f).
13. Individuals dually eligible for Medicare and Medicaid (42 CFR §440.315).
14. Children receiving foster care or adoption assistance under title IV-E of the Act.
15. Women needing treatment for breast or cervical cancer who are eligible under 1902(a)(10)(A)(ii)(XVIII).

16. Illegal or otherwise ineligible aliens who are only covered for emergency medical services under section 1903(v).

The current HIP program also excludes the following individuals from HIP coverage.

Table 2.1.1 (B): Individuals Currently Ineligible for HIP (2014)

1. Those eligible for Medicaid under the state plan with the exception of the family planning option, as described in Table 2.1.1.1(A) above.
2. Those eligible for Medicare.
3. Pregnant women for the purpose of pregnancy-related services.
4. Those otherwise eligible for medical assistance.
5. Those with income in excess of 100% FPL.
6. Those who fail to pay a POWER account contribution within 60 days (not inclusive of the first POWER account contribution) are excluded from HIP eligibility for 12 months if they fail to pay.

2.1.2 Populations Eligible for HIP

Individuals eligible for services under traditional Medicaid are described below in Table 2.1.2.

Table 2.1.2: Current Populations Eligible for HIP

Description	FPL and/or other qualifying criteria	Demonstration Eligibility Group(s)	Consistent with below group(s) prior to January 1, 2014
Adults age 19 to 64 who are not otherwise eligible for comprehensive Medicaid benefits or Medicare.	Income under 100% FPL per the Modified Adjusted Gross Income (MAGI) guidelines with 5% disregard, payment of POWER account contribution, no resource limit.	Adults (As described in the final rule at 42 CFR 435.119. “The adult group” of Section 1931 parents and caretaker relatives will not be in HIP, but will be eligible for HHW coverage.)	Parents and Caretakers, Non-Caretaker Adults

2.1.3 Enrollment Limit

The Indiana Code makes clear that HIP is not an entitlement program, and that the State may not enroll new participants if revenues from the cigarette tax cannot support additional clients. The waiver addresses sustainability by (i) eliminating the income disregard for HIP caretakers and (ii) placing an enrollment cap on HIP non-caretaker adults. The cap on non-caretaker adults is

reinforced by CMS as part of the federal budget neutrality agreement. While HIP does not limit enrollment for parents and caretaker relatives with income below 100% FPL, the waiver imposes a firm enrollment cap of 36,500 on the number of non-caretakers allowed to participate in HIP. In accordance with the current Special Terms and Conditions (STCs), the State requests continuation of its authority to modify eligibility criteria for new entrants during the demonstration if the State projects that expenditures for the program will exceed annually authorized and appropriated State funds.

2.2 Benefits

The HIP program provides comprehensive benefits (set forth in [Table 2.2](#) below) including physician, inpatient, outpatient, mental health services, pharmaceuticals, laboratory services, and other therapies through a Secretary-approved plan. The plan does not cover non-emergency transportation, dental, or vision services for adults. Pregnancy-related services are also excluded, as pregnant HIP members are transferred to the HHW program for the duration of the pregnancy. Preventive services, such as annual examinations, smoking cessation programs, and mammograms are covered without charge to the member up to \$500, and are not included in the deductible amount. After the deductible is met through the POWER account funds, the HIP program includes a comprehensive benefit package, covering up to \$300,000 in services annually and a lifetime benefit limit of \$1 million.

Table 2.2: HIP Benefits

Benefit	Limits/Inclusions (as applicable)
Inpatient Facility	
Medical/Surgical	
Mental Health/Substance Abuse	Covered same as any other service.
Skilled Nursing Facilities	Subject to a 60-day maximum.
Outpatient Facility	
Surgery	
Emergency Department	For HIP Caretakers: \$3 Co-payment for services determined to be non-emergency. For HIP Adults: \$25 Co-payment for services determined to be non-emergency.
Urgent Care	
Physical/Occupational/Speech Therapy	25-visit annual maximum for each type of therapy.
Radiology/Pathology	
Pharmacy and Blood	Generic preference; but brands allowed when no generic is available.
Professional Services	
Inpatient/Outpatient Surgery	
Inpatient/Outpatient ER Visits	
Office Visits/Consults	
Preventive Services	At least \$500 annual first dollar coverage.
Physical/Occupational/Speech Therapy	25-visit annual maximum for each type of therapy.
Radiology/Pathology	

Outpatient Mental Health/ Substance Abuse	Covered the same as any other illness.
Ancillary Services	
Prescription Drug	Brand name drugs are not covered where a generic substitute is available.
Home Health	Excludes long term care.
Hospice	
Emergency Transportation	
Durable Medical Equipment/Supplies/Prosthetics	
Family Planning Services	Excludes abortion or abortifacients. Includes contraceptives and sexually transmitted disease testing as described in Medicaid law (42 USC 1396).
Lead Screening Services	Under 21 Years of Age.
Hearing Aids	
Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services	Subject to the HIP benefit coverage limits.
Disease Management Services	

In August 2010, Milliman certified that the current HIP benefits do not meet the benchmark equivalent standard based on the ACA coverage requirements, and as such, HIP would be considered Secretary approved coverage.³ The State seeks approval for the current HIP benefit package described above to continue to be designated Secretary-approved coverage; and requests an ongoing waiver for the requirement to provide non-emergency transportation coverage. Current HIP benefits will continue to be subject to the \$300,000 annual and \$1 million lifetime limits.

2.3 Cost-Sharing

Currently, HIP utilizes two forms of cost-sharing. First, HIP requires individuals to contribute to their POWER account. Second, HIP requires individuals pay co-payments for non-emergency usage of hospital emergency departments (ED). The State sets POWER account contribution rates on a sliding fee scale, reflecting approximately 2% of the participant's household income. Consistent with the CMS standard, members do not pay more than 5% of their annual income in combined cost-sharing (POWER account contributions and ED co-payments). Non-caretaker adults in the current HIP program pay a flat \$25 co-payment for all non-emergency ED visits.

Per CMS rules for HIP parents and caretaker relatives, the total aggregate amount of (1) POWER account contributions, (2) HIP co-payments, (3) Medicaid cost-sharing requirements, and (4) CHIP cost-sharing requirements may not exceed 5% of family income. If a member approaches the cost-sharing limit, the health plan verifies the member's cost-sharing documentation and notifies the HIP program manager that the member (1) has reached the 5% maximum contribution amount and (2) the date 5% limit is reached. The member is not required to pay any

³ Analysis of the Healthy Indiana Plan benefits in comparison to Indiana's Essential Health Benefits and the Medicaid State Plan has also been completed. These additional analyses are available upon request.

further POWER account contributions or ED co-payments for the rest of the 12-month benefit period.

2.3.1 Co-Payments

Consistent with the 2014 STCs, HIP members may be charged co-payments for non-emergency use of a hospital ED in accordance with the table below.

Table 2.3.1: HIP Non-Urgent Use of ED Co-Payment Schedule

POPULATION	CO-PAYMENT AMOUNT
HIP Caretakers with Incomes Above the AFDC Income Limit as Indicated in the State Plan through 100% FPL	\$3.00 per visit
HIP Non-Custodial Parents and Childless Adults	\$25.00 per visit

Other than ED co-payments, the only other cost-sharing to which HIP members will be subject is the monthly POWER account contribution set forth in [Section 2.3.2](#).

2.3.2 POWER Accounts

Modeled in the spirit of an HSA, HIP provides each member a POWER account valued at \$1,100 per member. This account is comprised of individual and State contributions and is used to pay the member's deductible expenses - also \$1,100. Instead of traditional cost-sharing of premiums and co-payments, HIP members must make monthly contributions to their POWER account, with the contribution no more than 2% of income. The State contributes the remainder of the POWER account funding up to the deductible amount. In order to ensure the POWER account is fully funded on the first day of service, the State pre-funds the account. The health plans are required to pay claims for all service costs after the deductible is met. [Table 2.3.2](#) indicates the individual POWER account contribution amounts.

Table 2.3.2: POWER Account Contributions

Annual Household Income	Maximum POWER Account Contribution	Estimated maximum annual/monthly contribution Individual	Estimated maximum annual /monthly contribution Family of 4
All enrollees less than 25% FPL	Not more than 2% of income	\$54.46 / \$4.54	\$111.76 / \$9.31
All enrollees between 25% and 50% FPL	Not more than 2% of income	\$108.90 / \$9.08	\$223.50 / \$18.63
All enrollees between 50% and 75% FPL	Not more than 2% of income	\$163.36 / \$13.61	\$335.26 / \$27.94
All enrollees between 75% and 100% percent FPL	Not more than 2% of income	\$217.80 / \$18.15	\$447.00 / \$37.25

HIP members may also receive contribution assistance from their employers and not-for-profit organizations. Employers are permitted to pay up to 50% of their employee's required POWER

account contribution; and not-for-profit organizations are permitted to contribute up to 75% of the individual's required POWER account contribution.

After completing an application and meeting the financial and other eligibility criteria, members are "conditionally eligible" for the HIP program. They do not become fully eligible until they make their first POWER account contribution. Once fully enrolled, members must continue to make monthly contributions to maintain their HIP eligibility. If they fail to make this contribution within a sixty (60) day grace period, they are dis-enrolled from HIP and must wait twelve (12) months to re-apply.

Unlike traditional premiums or co-payments, HIP members own their contributions and are entitled to any unused contributions if they leave the program. Additionally, HIP members who receive required preventive services are rewarded by allowing any remaining balance (including the State's contribution) in their POWER account to roll over and offset required contributions in the next year. If individuals do not complete the required preventive services, only the pro-rated balance of the member's contribution rolls over; and the State share of the contribution will return to the State. Any rollover amount can reduce required contributions in the following year. The incentive is designed to increase the use of preventive care as well as to encourage prudent use of account dollars. In the long term, the regular use of preventive services under the HIP program should reduce costs and improve the health of the individual members and the total HIP population.

Section 3: Historical Narrative

Indiana has a long and rich history with consumer-driven healthcare programs. In 1992, Indiana-based Golden Rule Insurance Company executive, J. Patrick Rooney, pioneered the concept of medical savings accounts with his own employees. Based on its success encouraging his employees to make more cost-conscious health care decisions, Rooney began selling medical savings account plans in 1996 and played an integral role in securing Congressional authorization for tax advantaged HSAs in 2003.

Since then, Indiana employers have increasingly adopted HSAs for employee health plans. In 2006, the State of Indiana introduced consumer-driven health plan options to its nearly 30,000 employees and their dependents. By 2010, eighty-five percent (85%) of state employees elected to enroll in a HDHP plan option attached to an HSA. In 2013, ninety-six percent (96%) of state employees chose a consumer-driven health plan option.

The number of consumer-driven plans in the Indiana commercial health insurance market has also continued to increase. As of January 2013, 420,643 Hoosiers were covered by HDHPs/HSAs, representing nine percent (9%) of commercial market enrollment (greater than the U.S. average of seven percent (7%)). Among all states, Indiana ranked seventh in the percentage of HDHP/HSA enrollees under age 65 with private health insurance.

Given Indiana's rich history and proven track record of success with consumer-driven health care, the State turned to these principles to develop a plan to address its uninsured residents and their health needs. Prior to HIP, the Indiana Medicaid program had one of the lowest eligibility thresholds in the nation. There was little support to expand the State's traditional Medicaid

program as an open-ended entitlement that would strain the State's budget in future years. Additionally, a traditional Medicaid plan appeared unlikely to significantly improve participant health status given its lack of incentives for appropriate healthcare utilization.

Following input from numerous stakeholder meetings and bipartisan collaboration, the State of Indiana, under the leadership of Governor Mitch Daniels, designed the Healthy Indiana Plan (HIP) to introduce healthcare consumerism and private market principles to the Medicaid program. As the program was funded largely by an increase in the cigarette tax, it was designed to maintain limited enrollment in order to ensure a balanced State budget. During the 2007 legislative session, Rep. Charlie Brown authored and Sen. Patricia Miller sponsored a bipartisan bill enabling HIP. After the bill was passed with wide bipartisan support in April 2007, the Indiana Family and Social Services Administration (FSSA) immediately moved to develop an implementation plan and began negotiations with CMS to obtain federal waiver approval. On January 1, 2008, HIP began enrolling working-age, uninsured adults in coverage.

In 2011, following the passage of the ACA, the Indiana General Assembly reinforced its support for HIP by calling for HIP to be the coverage vehicle for a Medicaid expansion. The legislature passed Senate Enrolled Act 461 (codified at Indiana Code §12-15-44.2), which made several conforming changes related to the ACA, including revising program eligibility thresholds to align with the Marketplace coverage options available to individuals beginning in 2014. In addition, the legislation included a provision authorizing the Secretary of the Family and Social Services Administration to "amend [HIP] in a manner that would allow Indiana to use the plan to cover individuals eligible for Medicaid resulting from the passage of the [ACA]."

The State has repeatedly sought approval to expand and extend HIP coverage. In December 2011, after four successful years of administering HIP and entering the fifth and final year of its original demonstration period, the State submitted a three year waiver extension request. Although CMS did not accept all of the requested legislative modifications to the program, in September 2012, CMS granted a one year extension. In April 2013, the State requested an additional three year extension. This request was again approved in September 2013 for another one year term to run through December 31, 2014.

In the most recent waiver request, CMS granted the State several modifications to HIP eligibility. The waiver contained specific language that allows the State to adjust eligibility levels to control enrollment. Beginning in 2014, HIP eligibility was reduced to cover individuals with household income up to 100% FPL, recognizing that individuals above 100% FPL who were previously eligible for HIP would have new coverage options and access to premium tax credits and cost-sharing reductions via the federal Marketplace. Further, consistent with the changes in the HIP legislation, requirements that an individual be uninsured for at least six months and lack access to employer-sponsored insurance were removed from the HIP eligibility criteria effective January 1, 2014.

The more recent series of one-year, temporary extensions of the HIP program have resulted in a substantial amount of uncertainty for current enrollees lacking alternative coverage options. During this time, the State has consistently sought guidance from CMS regarding the long-term

future of HIP and its potential expansion. The State remains committed to the promise of the HIP coverage model improving cost and quality of healthcare services.

Concurrent with this waiver, the State is submitting the HIP 2.0 Waiver proposal. While the State prefers to move forward with the program enhancements detailed in the HIP 2.0 Waiver, the State seeks to extend the current HIP program as it is currently structured if CMS does not approve the HIP 2.0 proposal. As detailed in Sections 3 and 4 of this waiver proposal, the HIP demonstration project has conformed to its applicable STCs, and has effectively adapted to a changing healthcare market and regulatory landscape while achieving its foundational goals and objectives. Therefore, the State seeks, at minimum, a three year waiver renewal of the existing HIP program without modification. Approval would ensure ongoing coverage and provide certainty and continuity of care for the thousands of Hoosiers currently utilizing HIP's affordable coverage option.

3.1 HIP Operations & Managed Care Entities

The HIP program has evolved over the course of the demonstration, with several key changes. At the beginning of the program, HIP contracted with two managed care entities (MCEs) - Anthem and MDwise - and had a third Enhanced Services Plan (ESP) that was operated by the State's high risk pool, the Indiana Comprehensive Health Insurance Association (ICHIA), to provide coordinated coverage for HIP members with high risk conditions. The ESP plan is discussed in more detail in [Section 3.2](#) below. During the initial contracting period in 2007, the State selected two managed care plans Anthem and MDwise in collaboration with AmeriChoice, which leveraged commercial experience and HSA experience. However, since then, MDwise has changed billing and claims subcontractors. During the first three and a half years of the program, the contracts governing the State's relationship with Anthem and MDwise were modified to contain costs, improve member service, streamline ESP, and ensure that the MCEs remained financially stable.

In 2008, both Anthem and MDwise ended the year with losses as the capitation rates did not reflect the pent-up demand for services and high disease burden of a previously uninsured population. Actuarial analysis conducted on the first year of program claims encouraged the State to make significant contract modifications. The claims experience showed that parents and caretaker relatives had a twenty-five percent (25%) higher risk-adjusted relative morbidity than the commercially-insured population; and non-caretaker adults had an even higher morbidity - calculated to be sixty-five percent (65%) greater than a comparable commercially-insured population. HIP members also used services at a much higher rate when compared to a commercially-insured population. Parents and caretaker relatives initially had 38% more inpatient hospital days and 181% more ED visits; and non-caretakers had 155% more inpatient hospital days and 269% more ED visits than their commercially-insured counterparts. Over the course of the first year of enrollment, HIP members increased their use of pharmacy services and decreased their use of all other services, with the decline in utilization beginning in approximately the third month of enrollment.⁴

⁴ Damler, R. (2009). Experience under the Healthy Indiana Plan: The short-term cost challenges of expanding coverage to the uninsured.

The pent-up demand for services has been challenging for health plans to manage. However, over the life of the program, costs have decreased as the health plans have seen high inpatient costs replaced with more outpatient visits and use of prescription drugs. The State amended the risk-sharing arrangements in their 2009 HIP contracts. The amended contracts included higher monthly capitated rates for parents and caretaker relatives and a stop-loss provision for non-caretaker adults (effective retroactively to January 2009), and new selection criteria for the high risk pool. CMS approved the amended contracts in mid-December 2009.

The 2010, HIP contracts included a carve-out for most pharmacy services so the State could take advantage of pharmacy rebates - a funding source that would not be available if the services were included in the managed care contracts. The ACA has since allowed states to claim rebates even for pharmacy services provided through managed care plans. The carve-out for pharmacy costs helped the State meet and exceed budget neutrality requirements. The State consolidated all pharmacy purchasing for Medicaid programs into one contract. This consolidation maximized rebate savings available to the State and achieved administrative simplifications, subsequently increasing savings on prescribing, dispensing, claims submission, program analytics, and prior authorization for pharmaceuticals.

The negotiations for the 2011 health plan contracts addressed the costs of care. Both Anthem and MDwise reported declines in utilization and more predictable costs due to sustained member access to routine and preventive health care services. The 2011 contracts represented the first time the State combined HIP and HHW (which serves the State's non-waiver Medicaid managed care populations) into one contract. The State's intent was to integrate contracts to gain some program efficiencies and to make the programs seamless for families who have some members in HHW and others in HIP. In this way, the programs become more family-friendly, as family members have the ability to access care within the same provider network, even though individual family members may be covered by different programs. The new contract effectively integrates coverage; and the plans maintain a single call center for both HIP and HHW members -- a way of offering 'one stop shopping' to families. Unifying the programs has also simplified program administration for providers, as the new contract aligned all policies and procedures for the two programs (although provider reimbursement remains based on Medicare rates in HIP).

Also in 2011, the State selected a third MCE to serve HIP members. Anthem and MDwise continue to serve HIP; and the State added Managed Health Services (MHS), which has traditionally served Indiana's Medicaid HHW population. In an additional effort to improve the consumer experience, the plans were required to implement a debit swipe card for HIP members to use at the point-of-service to verify eligibility, service coverage, and provider participation in HIP. The card linked to member POWER accounts, and members could compare the estimated cost of service to the estimated balance in the POWER account. Debit cards were designed to provide the full \$1,100.00 upon determination of eligibility, regardless of the amount paid by the member at that point. The debit card is intended to enhance the member experience, using the POWER account and promoting consumer-driven health care. MHS operationalized the card on January 1, 2011 and the other MCEs followed later in the year. Both Anthem and MDwise currently issue a single swipe card that functions as both member identification card and debit card, while MHS issues separate member identification and debit cards.

No substantial changes have occurred with the contracts since 2011; with recent contract negotiations focused primarily on rates, particularly as impacted by the ESP changes detailed below. HIP performance metrics and measures have not changed over these contracting periods.

3.2 Enhanced Services Plan (ESP)

The ESP was designed to reduce health plan risk and lower capitation rates. Initially, ESP participants were expected to represent the top 1% of risk in the HIP population. Through modifications to the ESP program, this population currently represents the top 3% to 5% of risk in the HIP population. While this high risk group received all the same HIP services and benefits as other members, the State's high risk plan, ICHIA, managed this population on an Administrative Services Only basis. In 2014, ACA provisions reduced the need for a state high risk plan, and ICHIA dissolved. The MCEs now manage both the high risk pool ESP members and regular HIP members; and the capitation rate has been adjusted to accommodate the higher cost of the ESP individuals.

HIP's higher-than-expected initial cost of care resulting from pent-up demand and higher morbidity and co-morbidities of a previously-uninsured population, urged the State to identify ways to reduce the risk to the health plans. First, the State expanded the list of conditions that would qualify an individual to participate in the ESP; and the State simplified referral processes to make ESP determinations timelier. Originally, HIP members waited for a high risk condition to be reported; at which point the condition was verified by a State-contracted vendor that interviewed the patient to determine if the ESP placement was appropriate. To improve access to ESP, the State altered several enrollment policies and expanded the list of qualifying conditions in July 2009. Since mid-2009, when HIP applicants check one of the qualifying conditions on the application, they are automatically enrolled in the ESP and stay enrolled until their eligibility is redetermined. If member claims history at redetermination confirms ESP eligibility, he or she will stay with the ESP. If the member no longer has one or more qualifying condition, he or she will transition to one of the other health plans. In addition, the plans now have more time to refer a member to ESP - six months as opposed to sixty (60) days in 2008. In July 2009, when the new policies took effect, Anthem and MDwise reviewed their claims records, applied Milliman's underwriting guidelines, and scored their members. Those members with an ESP-qualifying condition and a risk score at or above a certain threshold were transferred to the ESP. However, due to the dissolution of ICHIA, starting in 2014, MCEs no longer refer members to a separate plan, but, rather include those members in the general HIP pool and continue to manage their care while receiving a higher capitation rate from the State for doing so.

3.3 Application Processing

The State's vendor struggled to keep up with the flow of applications —receiving more than 120,000 in CY 2008 (yielding more than 35,000 enrollees). High enthusiasm for the program, assertive outreach and advertising, and pent-up demand led to more than 18,000 applications submitted in just the first month of the program. The State's vendor adjusted staffing to accommodate the initial surge of applications, but the queue lengthened again the second half of 2008. An initiative to upgrade enrollment and eligibility business processes impacted HIP application processing the first year and affected all other public assistance programs operated by FSSA. To address the issue, the vendor hired additional eligibility staff January 2009. The application processing delays seen in the first demonstration year did not substantially slow

enrollment. For example, by March 2009 HIP was approaching the enrollment cap (34,000) for non-caretaker adults - a level the State had not expected to reach until the third or fourth year of the demonstration. To manage enrollment levels and ensure the State could maintain budget neutrality, the State closed enrollment for non-caretakers in March 2009.

In 2009, the State made significant progress with the HIP application backlog. HIP operations staff resolved issues and identified possible solutions. In January 2010, 18 additional state eligibility consultants (SECs) joined the State staff to assist with application processing, increasing timely application processing from seventy-one percent (71%) in May 2009 to almost ninety-one percent (91%) as of September 2012. The State also developed a revised enrollment dashboard in 2009, including more information on HIP application processing and showcasing different aspects of the HIP program. This dashboard still helps the State manage application processing; however, HIP application processing has operated smoothly since the changes made in 2010. In 2013, eighty-nine percent (89%) of the total 73,171 applications were processed in a timely manner.

3.4 Non-caretaker Waitlist

The original HIP waiver agreement imposed a cap on the number of non-caretaker adults who could enroll in the program. On March 12, 2009, HIP closed enrollment to non-caretaker adults. At that time, the number of non-caretaker members had reached 32,000, just below the 34,000 cap established in the STCs. Enrollment for non-caretakers was closed before the cap was reached to ensure applicants (1) pending eligibility determination, (2) appealing denied applications or (3) losing HHW coverage after giving birth could be enrolled in HIP without exceeding the cap. Although enrollment closed, all new non-caretaker applications were reviewed for eligibility and placed on a waiting list if determined eligible. In the fall of 2009, CMS agreed to raise the cap by 2,500 individuals for an overall limit of 36,500 non-caretakers; and the State opened 5,000 non-caretaker slots and sent letters to the first 5,000 applicants on the waitlist. The invited applicants reapplied for HIP to verify program eligibility.

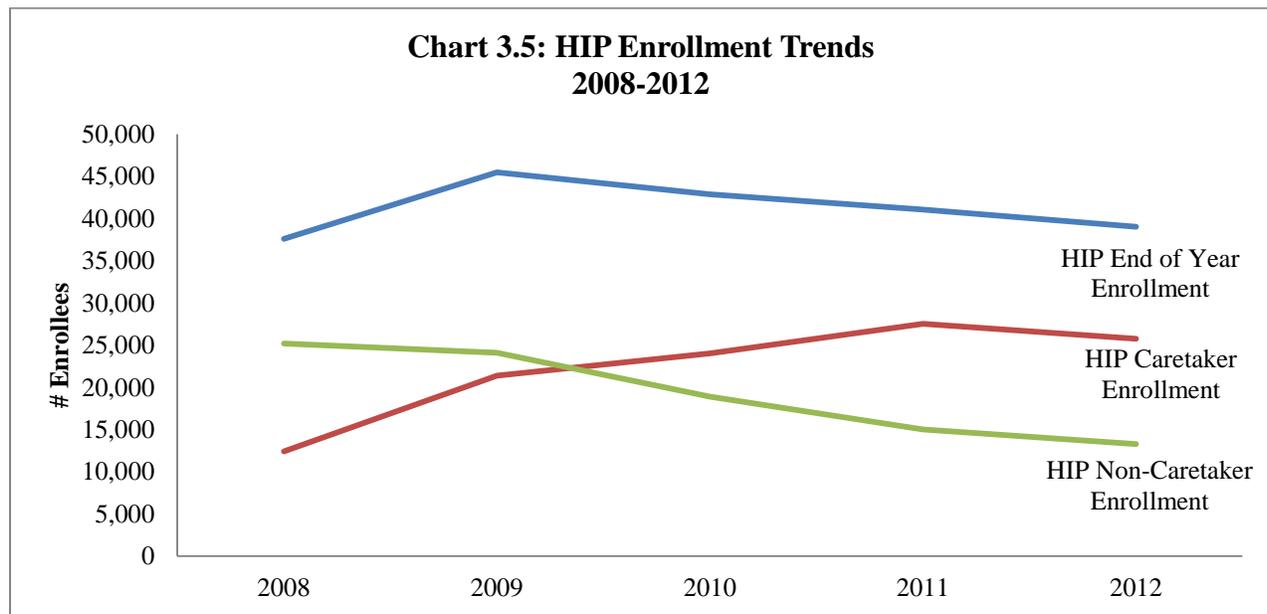
When the ACA passed in March 2010, HIP enrollment of non-caretaker adults remained closed due to legislative Maintenance of Effort (MOE) provisions and a concern that, since the program could not be closed to caretakers, the State could be forced to cover costs beyond the funds available from the cigarette tax fund. When non-caretaker enrollment declined, in August 2011, the State opened 8,000 more slots to individuals on the waitlist. During the first quarter of 2012, 18,800 letters invited non-caretakers on the waitlist to reapply for the program. Only 1,587 individuals responded and enrolled (generating an 8.4 percent response rate). Most of the letters generated no response, suggesting possible changes in applicant financial or living situations, including a possible change in address. In April 2012, after the push for new enrollment, the waitlist closed and no additional individuals were added between April and December. At the end of 2012, the waitlist consisted of 46,388 non-caretaker adults.

In 2013, HIP eligibility guidelines changed to align with the federal Marketplace. Starting in 2014, individuals above 100% FPL received State and MCE assistance to find coverage through the federal Marketplace, and nearly 50,000 individuals on the waitlist were invited to re-apply to HIP and/or seek coverage on the federal Marketplace, depending on the financial eligibility information on file. HIP members and HIP waitlist members under 100% FPL maintained or

gained coverage on HIP and the waitlist was eliminated. Further, the State does not anticipate reinstating a waitlist for the program in future years.

3.5 Enrollment Trends

From 2008 through December 2013, the State received 483,561⁵ valid applications and 105,135 unique members have been enrolled. In 2008 - the first year of program operations - the State received 120,313 applications. Applications declined in 2009 with only 72,282 submitted; but applications increased again in 2010 with 117,252 submissions. In subsequent years, between 70,000 and 80,000 new applications have been received each year - specifically 78,641 applications in 2011; 75,172 applications in 2012; and 71,993 applications in 2013.



The chart above shows the year-end enrollment trends for the first three years of the HIP program. The image clearly shows the decline in non-caretaker enrollment and the increase in caretaker enrollment. HIP enrollment was 37,568 at the end of 2008, 45,460 at the end of 2009, 42,872 at the end of 2010 and current enrollment at the end of 2012 was 39,005. As the program progressed the percentage of caretakers ever enrolled increased in comparison to non-caretakers. For those ever enrolled in HIP in 2010, fifty-six percent (56%) were caretakers and forty-four percent (44%) were non-caretakers. By comparison, at the end of 2008, sixty-seven percent (67%) of enrollees were non-caretakers and thirty-three percent (33%) of enrollees were caretakers. As of the end of 2013, approximately seventy percent (70%) of enrollees (totaling 24,544) were caretakers and approximately thirty percent (30%) of enrollees (totaling 10,390) were non-caretakers.⁶

⁵ Valid applications exclude duplicate and incomplete applications received. HIP Dashboard, December 2013.

⁶ Annual data from annual HIP reports, and HIP Dashboard December 2013.

Over the course of the HIP program the majority of members have been under 100% FPL. Member distribution by FPL in December 2013 is consistent with the previous trend: seventy-two percent (72%) of HIP enrollees are currently at or below 100% FPL. On average, only ten percent (10%) of HIP enrollees are above 150% FPL. In 2014, the eligibility criteria changed due to the availability of Marketplace plans and premium tax credits for individuals over 100% FPL. Therefore, in 2014, all HIP members are below 100% FPL.

Table 3.5 (A): HIP Enrollee Distribution by FPL⁷

FPL	2008	2009	2010	December 2011	December 2012	December 2013
<100% FPL	26,969 72%	41,795 71%	37,061 62%	27,533 69.0%	27,276 69.9%	25,348 72.6%
101 – 150% FPL	6,955 19%	11,432 19%	13,849 23.1%	8,288 20.7%	7,767 19.9%	6,290 18%
>150% FPL	3,620 10%	6,079 10%	9,015 15%	4,075 10.2%	3,966 10.2%	3,296 9.4%
TOTAL	37,544 100%	59,306 100%	59,945 100%	39,896 100%	39,005 100%	34,934 100%

Following an eligibility determination, HIP members may select Anthem, MDwise or MHS as their plan. Over the first three years of the program (2008 to 2010), approximately seventy percent (70%) of members enrolled in Anthem and approximately thirty percent (30%) enrolled in MDwise. The third demonstration year (2011) was the first year the HIP program offered a third managed care entity option for members to choose. At the end of 2011 approximately five percent (5%) of HIP members selected the MHS plan. Enrollment in MHS has increased over time. As of February 2014, Anthem maintained approximately fifty-nine percent (59%) of HIP enrollments, MDwise had approximately twenty-six percent (26%), and MHS managed fifteen percent (15%) of HIP enrollment.⁸

In spite of some policy and operational changes over time, program enrollee demographics are relatively consistent. Over the course of the HIP program, member distribution by gender has been steady, though women enroll in significantly higher numbers. As of 2013, sixty-eight percent (68%) of enrollees are female and thirty-two percent (32%) are male. Geographically, HIP members are distributed throughout the state, with enrollment mirroring the general population density patterns in the state.⁹ Similarly, member distribution by race has, over the course of the program, closely aligned with the distribution of working age uninsured adults under 200% FPL in Indiana.¹⁰ Over the course of the HIP program, the percentage of enrollees identifying as White averages around eighty-three percent (83%) and the members identifying as Black average ten percent (10%); with Hispanic, Native American, and Other making up the

⁷ Data from HIP Annual Reports 2008-2010. HIP Dashboards December 31, 2011, December 31, 2012, and December 2013.

⁸ HIP Dashboard February 28, 2014.

⁹ HIP Year 3 Annual Report, Pg. 29-30.

¹⁰ HIP Year 1 Annual Report, pg. 20.

remainder. Age distribution has also been relatively steady throughout the course of the program. To date, member age distribution has consistently skewed toward more aged individuals with those under 30 representing the smallest proportion of HIP members.

3.6 Benefit Limit

HIP includes a \$300,000 annual and \$1 million lifetime benefit limit. Over the course of the program, few members have reached or come close to reaching these limits. The HIP program monitors members to ensure that members are able to be transferred to another program if they are close to reaching \$300,000 in annual limits or \$1,000,000 in lifetime limits, ensuring members are not denied necessary services. If a member does reach, or comes close to reaching these limits, the State assesses the member for potential traditional Medicaid eligibility. All members coming within \$100,000 of the \$300,000 annual benefit limit were transferred to ESP, Medicaid, or other programs. The number of members meeting the benefit limits for each demonstration year are displayed below. No members have met the lifetime \$1,000,000 limit.

Table 3.6: HIP Members at Benefit Limit

Year	Members at \$200,000	Members at \$300,000	Members at \$1,000,000	Total
2008	1	0	0	1
2009	17	2	0	19
2010	1	0	0	1
2011	3	0	0	3
2012	0	0	0	0
Total	22	2	0	24

3.7 Disenrollments

Enrollees can disenroll or be terminated from HIP for any of the following reasons: (1) electing to disenroll, (2) failing to pay a POWER account contribution, (3) failing to complete the redetermination process, or (4) no longer meeting eligibility requirements. Between 2008 and 2010, 35,323 members left HIP. Approximately fifty-seven percent (57%) of enrollees left within a month of the annual redetermination process period. Of the remaining disenrollments, eight percent (8%) of members (totaling 6,199) failed to pay a POWER account contribution. In 2011, only 1,843 of disenrollments were due to not making a subsequent POWER account payment. Individuals no longer meeting eligibility requirements comprise the remaining disenrollments, and may include a pregnant woman who transfers to traditional Medicaid for the duration of her pregnancy (and may reenter HIP afterward), a member who becomes eligible for Medicaid disability, a member who passes away or moves out of State.¹¹

HIP has not experienced problems with affordability. The 2013 Mathematica survey of HIP members found that seventy-six percent (76%) of contributors considered the amount of their POWER account contribution to be ‘just right’, while nine percent (9%) indicated they would pay an even greater contribution.¹²

¹¹ Data from DMA Data Request #8790, ran October 18, 2012.

¹² Mathematica. (2014). 2013 Survey of HIP Members.

Further, the program ensures that no member pays more than five percent of his or her income, consistent with CMS rules. In some cases, this results in situations where members are not required to make any monthly contributions and the State funds the entire account. Non-contributing HIP participation may occur in two ways: (i) the family has exceeded its 5% of income limitation due to payment of CHIP premiums; or (ii) the member has no income. For these members, POWER accounts are 100% state-funded. For 2008, approximately thirty-five percent (35%) of HIP enrollees did not contribute to their POWER account. Over the course of the program this percentage has decreased and stabilized, and has consistently been between twenty percent (20%) to twenty-two percent (22%) between 2010 and 2013.

Section 4: Program Evaluation

Over the course of the demonstration, HIP has made substantial progress toward meeting program goals. In accordance with CMS's Special Terms and Conditions (STCs), the State performs an annual evaluation of the HIP program, including claims and administrative data analysis, External Quality Reviews, and survey data collection. In annual reports, the State provides detailed information on program progress and documents the quality and improved access to services under the demonstration.

The HIP program is independently evaluated by Mathematica Policy Research (HIP contracted evaluator), Milliman, Inc. (State actuarial partner), and Burns & Associates (External Quality Review team for both the HIP and HHW programs). The most recent annual report (2012) was submitted to CMS in 2013. Outcome data in the annual report highlights HIP's many successes and lends support to the effectiveness of the program's design. The following section summarizes HIP's key accomplishments in the initial demonstration period and outlines new goals for the future of the program.

4.1 Progress on Program Goals

4.1.1 Reducing the number of low income Hoosiers

Since its inception, HIP has offered an important safety net for its members who would have otherwise been uninsured. As of December 31, 2013, HIP served 116,765 unique Hoosiers over the six years of the program.

4.1.2 Improving access to appropriate, quality-based healthcare services for low income Hoosiers

The HIP program reimburses health care providers at Medicare rates - a key feature designed to increase the number of providers accepting HIP, thus broadening the primary and specialty care networks. As a result of these incentives, HIP meets and exceeds access standards statewide. According to the 2013 Burns & Associates External Quality Review focus study on access to care, the access rate among HIP adults was higher in every region than the corresponding age and region cohort in the HHW program, the Medicaid program covering pregnant women, children, and parents and caretaker relatives eligible for Medicaid.

Two years of Consumer Assessment of Health care Providers and Systems (CAHPS) data indicate a high level of member satisfaction with health plan performance. In 2012, all three managed care entities (MCEs) offering HIP coverage received higher ratings for overall healthcare experience, personal doctor, ability to get needed care, ability to get care quickly, doctor communication, and health education than the benchmarks from the year before. Survey

data supports the CAHPS results and indicates a high level of member satisfaction with the program. According to the 2013 Mathematica survey, approximately ninety-five percent (95%) of members reported they were either somewhat or very satisfied with their overall experience with HIP. Further, ninety-eight percent (98%) of members reported they would choose to re-enroll if they left the program but became eligible again.

Mathematica's 2010 HIP member survey suggests improved access to care following enrollment into HIP. When survey respondents enrolled in HIP one month prior were asked to compare their current access to care to when they were uninsured, they reported being:

- More likely to have a primary medical provider (PMP) and more likely to use a doctor's office or clinic as their usual source of care rather than the hospital emergency department;
- More likely to receive preventive care, acute care, specialty care, and prescription medications; and
- Less likely to have an unmet need for healthcare.

Further, the proportion of members reporting not seeking necessary preventive care, treatment for an acute accident, illness or injury, or specialty care in the previous six months due to cost was drastically lower in established members than new members.

4.1.3 Promoting value-based decisions making and personal health responsibility

HIP has successfully demonstrated that financial incentives encourage members to be thoughtful healthcare purchasers and take personal responsibility for their health care decisions. These incentives begin with enrollment, when most HIP members are required to contribute to their POWER account to fund a portion of their deductible expenses as a condition of ongoing coverage. Each year of the demonstration, the proportion of members making their initial contributions to complete the enrollment process has increased. In 2008 - the first year of the program - about eighty-nine percent (89%) of conditionally eligible members required to make contributions, thus becoming fully enrolled. In 2012, ninety-four percent (94%) of conditionally eligible members completed this requirement. The annual rate of members failing to make subsequent required monthly contributions never exceeded seven percent (7%).

Generally, HIP members indicate a willingness to accept even more responsibility for the cost of their health care and report that the required contributions are affordable. According to the 2013 Mathematica survey, seventy-six percent (76%) of members feel the amount of their monthly POWER account contribution was the right amount and nine percent (9%) felt that is was, in fact, too low. Additionally, about eighty-two percent (82%) of HIP members are willing to pay \$5 more per month to remain enrolled in HIP, and seventy-five percent (75%) are willing to pay \$10 more. Members also prefer the POWER account contribution method over making co-payments. The survey found that eighty-three percent (83%) of members preferred to pay a fixed monthly amount up front with the opportunity to receive unspent funds back over making co-payments each time they visited a health professional, pharmacy, or hospital. The POWER account rollover incentive appears to motivate members to consider the value of the services they seek and spend their funds carefully.

HIP members demonstrate active engagement in managing their health care dollars and understanding the cost of services. According to Mathematica's 2013 survey of HIP participants, thirty percent (30%) of participants indicated they ask their provider about the cost of their care when they seek treatment; more than three quarters (77%) of members had a basic understanding of the POWER account; and nearly sixty percent (60%) reported checking the account balance at least monthly. A 2009 Product Acceptance Research survey of HIP members showed that sixty percent (60%) of respondents think differently about how or where they get health care since enrolling in HIP.

HIP member eligibility is reassessed annually, and enrollees are required to complete a redetermination application and return it in a timely manner to maintain eligibility. Over the first two years of the demonstration, eighty-five percent (85%) of members returned their application packet in a timely manner, and by the end of 2012, the return rate increased to ninety-two percent (92%). Providing redetermination paperwork in a timely manner fosters a higher continuity of care and improved health outcomes.

Claims data shows the effort to prevent non-emergent visits to the emergency department (ED) through co-payments effectively deters inappropriate use. Co-payments (\$25 for non-caretakers and \$3 for caretakers) cannot be made from the POWER account. According to a Milliman analysis, in 2012 only thirty-two percent (32%) of HIP members visited the ED, compared to thirty-eight percent (38%) of comparable traditional Medicaid participants (pregnant women, parents and caretaker relatives eligible for Medicaid).

Notably, non-caretaker member use of the ED has declined steadily over the course of the demonstration. Between 2009 and 2013, there was a seventeen percent (17%) decrease the percentage of non-caretaker HIP members visiting the ED; and the number of non-caretaker ED visits per 1,000 members dropped by thirty-four percent (34%) in the same timeframe. The disease burden is high among non-caretaker members, and the declining ED utilization rates may reflect the required co-payment's effectiveness in deterring inappropriate use and promoting use of services in non-emergent, primary care settings.

Required contributions to the POWER account and having "skin in the game," may also improve ED utilization rates. According to a Milliman analysis, members making POWER account contributions visited the ED at a rate of 556 visits per 1,000 members; while members not required to make POWER account contributions visited the ED at a rate of 869 visits per 1,000 members. Even though co-payments for non-emergent use of the ED cannot be made from the POWER account, those who contribute to the account appear to exhibit more cost-conscious and responsible ED use behaviors.

4.1.4 Promoting primary prevention

HIP rewards preventive care use by allowing the entire POWER account balance (State and individual contributions) to roll over and offset the amount of the required contribution in the next benefit year if the member receives at least one age- and gender-appropriate service. This policy incentivizes members making POWER account contributions to receive preventive care in order to reduce their annual contributions. Additionally, HIP's policy to cover the first \$500 of preventive services without drawing from the POWER account drastically reduces barriers to preventive care access. HIP members receive preventive care at rates similar to a commercially

insured population. Between 2010 and 2012, the percentage of all HIP members receiving preventive services increased from fifty-six percent (56%) to sixty percent (60%). Preventive service utilization rates by age and gender remained constant or rose slightly in all groups except for females ages 19-34. Overall, the utilization rates for at least one preventive service increased with age; and women were far more likely than men to receive preventive care (69% versus 39% in 2012). In 2012, sixty-one percent (61%) of HIP members required to make POWER account contributions received at least one recommended service, while only fifty-three percent (53%) of non-contributors received preventive care. This indicates that member investment and benefits linked to preventive service utilization may both pay a part in reinforcing preventive care use over emergency department use.

4.1.5 Ensuring State fiscal responsibility and efficient management of the program

HIP continues to stay well within its federally-mandated waiver budget neutrality margin, and the enabling state legislation requires costs not exceed the revenue generated by the cigarette tax designated for the program. According to Milliman estimates, the state maintained a waiver margin well above the total CMS-approved limit between 2008 and 2011. These margins were based on per member, per month (PMPM) costs for HHW caretakers, children, and pregnant women that grew at a slower rate than the projected Medicaid spending established in the STCs of the HIP waiver. In 2012, however, increased hospital reimbursement rates under a hospital assessment fee program (established by the State legislature in 2007) effectively raised the PMPM costs for HHW participants and reduced the waiver margin to a negative figure. Cumulatively, however, the waiver margin has been maintained well below the five-year budget neutrality requirement.

Over the first three years of the demonstration, CMS also required the State to implement cost-saving initiatives for the program. These initiatives were in the areas of third-party liability cost recoveries, estate recovery, and collections through identified fraud and abuse. Together, these initiatives generated savings of nearly \$20 million. This level of savings exceeded the requirements set forth in the STCs for the first five years of the demonstration (\$15 million). In 2012, CMS also approved two cost-saving projects related to strategic purchasing agreements for incontinence supplies and hemophilia blood factor products. That same year, the State began to carve out pharmacy benefits, consolidating all state-administered pharmacy services into one contract to achieve additional savings. Because of the pharmacy carve out, the waiver margin increased by \$72 million from 2010 to 2011. Through 2012, the State diverted approximately \$50 million of Disproportionate Hospital Share (DSH) funds to the HIP program annually. In 2013, the cost-saving initiatives generated sufficient savings to make the DSH fund re-allocation unnecessary.

By design, revenue generated from the cigarette tax serves as the major financing mechanism for HIP. In State Fiscal Year 2013, the cigarette tax generated \$430 million, of which \$123 million was allocated to HIP with the remainder allocated to other public health programs. The amount of cigarette tax revenue allocated to HIP has fluctuated annually over course of the demonstration, ranging from \$120 to \$130 million each year.

Section 4.2 Future Goals

If the HIP program is approved in its current form, the State will continue to pursue the goals identified above and will conduct further study of these areas. Additional study and time to

collect data will help the State understand the long-term impact of HIP. The State intends to continue investigating the effects of consumer-directed health plan design on enrollee care-seeking behavior.

Section 4.3 Health Plan Performance-External Quality Review

In 2013, Burns & Associates, Inc. (B&A) conducted an external quality review (EQR) of Anthem, MDwise, and MHS for calendar year 2012. The EQR assessed the performance of the health plans; and the EQR report did not suggest the plans have any systematic issues related to their performance. The recommendations and suggestions made to the plans recognized a level of competency at the plans, citing several items as best practices. In addition to validating (auditing) of performance measures and performance improvement projects for the MCEs, the EQR identified two focus studies completed as part of the review, covering: (1) access to primary care and (2) mental health care utilization and care coordination.

4.3.1 Access to Care

In consultation with the State, B&A constructed a focus study on access to care including both quantitative and qualitative components. The analysis expanded the study population beyond the limits defined by the HEDIS® measures for access to primary care but limited the study to primary care office visits conducted in a physician office, federally qualified health clinic (FQHC), or rural health clinic (RHC). Analyses examined the sample population by age, race/ethnicity and geographical region.

The qualitative component to this focus study included interviews with the MCE Provider Services staff in June to learn more about their approach to conducting outreach. B&A then conducted 59 interviews with provider entities contracted with the MCEs. The interviews spanned ten weeks and included representatives of all provider specialties in each region of the state. In total, B&A conducted interviews at 29 primary medical provider (PMP) offices, 10 FQHC (Federally Qualified Health Centers), 10 RHCs (Rural Health Centers), and 10 community mental health centers (CMHCs).

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

Provider feedback pertaining to HHW, HIP, and MCEs was mixed. B&A analyzed the key factors related to provider satisfaction, including (1) quality of the MCEs provider field staff, (2) quality of assistance and training office staff received from the MCEs, and (3) ease in getting paid by the MCE. The key factor related to dissatisfaction from providers related to inconsistency across MCEs and programs (i.e., prior authorization submission and adjudication, a single Medicaid manual rather than one for fee-for-service (FFS) Medicaid and separate manuals for each MCE, consistent and accurate claims processing, and consistent responses from customer service representatives).

4.3.2 Mental Health Care Utilization and Coordination

B&A developed a focus study for the 2012 EQR continuing the 2011 EQR study. In this year's EQR, B&A conducted a broad review of mental health utilization across all members of HHW and HIP.

Of all HIP members enrolled in CY 2012, 28.9% had a mental health diagnosis reported on an encounter. A greater proportion of Caucasian HIP members were diagnosed with a mental health disorder than other races and ethnicities. According to the study, 31.3% of Caucasian members were diagnosed with mental health diagnosis on an encounter compared to 20.2% of African-American and 16.6% of Hispanics. Among the HIP population, three diagnoses comprised half of all mental health diagnoses—tobacco use disorder (19.6% of total), attention deficit disorder (15.5% of total), and major depressive or bipolar disorder (14.9% of total). Outpatient mental health clinics and CMHCs play an important role in the delivery of these services since more than eighty percent (80%) of all services were billed by these two provider types. Community mental health providers delivered less than ten percent (10%) of the services (except in Anthem HIP).

Section 5: Requested Program Changes

The State is not requesting any revisions to the HIP program in this waiver. All of the requested program changes are set forth in the HIP 2.0 Waiver, which is submitted concurrently, and in the alternative with this waiver extension application. In the event the HIP 2.0 Waiver is not approved by CMS, the State submits this waiver requesting the extension of the 2014 STCs without change.

Section 6: Evaluation Plan

Since the State has not requested any changes to the waiver, the State does not propose any changes to its evaluation plan for the duration of the demonstration extension. Mathematica developed an evaluation plan for HIP during the HIP initial demonstration period. HIP meets its program goals and provides quality care to clients, as described in [Section 3](#). During the extension period, Indiana may seek to make some slight modifications to the evaluation design in order to focus on new areas of study. All evaluation reports will continue to address HIP's progress on program goals in addition to the evaluation questions present in the STCs.

Evaluation reports will include evaluation on the following HIP goals:

- Reduce the number of uninsured low income Hoosiers.
- Reduce barriers and improve statewide access to health care services for low income Hoosiers.
- Promote value-based decision making and personal health responsibility.
- Promote primary prevention.
- Prevent chronic disease progression with secondary prevention.
- Provide appropriate quality-based health care services.
- Assure State fiscal responsibility and efficient management of the program.

During the waiver extension period evaluation reports will continue to include responses to the following STC evaluation questions:

1. How many HIP participants reach their \$300,000 annual benefit limit each year? How do these individuals meet their health care needs after they exhaust the annual benefit limit and before the next coverage term begins?
2. How many HIP participants reach their \$1,000,000 lifetime benefit maximum? How do they meet their health care needs after their HIP benefits are exhausted?
3. What are the consequences of limiting participants' ability to switch plans after they have made an initial POWER Account contribution? What percentage of HIP applicants are auto-assigned to an MCE?
4. What percentage of the potentially eligible population enrolls in HIP? How does the percentage vary by major population subgroups (HIP Caretakers, HIP Non-Caretakers) and income level?
5. What are the consequences of requiring HIP participants with family income less than 100% FPL to pay monthly premiums? How many of these participants fail to make their first POWER Account contribution? How many of these participants are disenrolled for failure to pay their contributions?
6. To what extent has HIP impacted the uninsurance rate in Indiana?
7. To what extent has HIP reduced uncompensated care provided by Indiana's federally-funded health clinics?
8. How many enrollees exhaust their POWER account each year? How many enrollees are able to roll-over a sufficient POWER account balance to reduce their subsequent year's required contribution by at least half? How many enrollees are able to achieve a \$0 contribution by this means?

Section 7: End Stage Renal Disease Enrollees

To be eligible for a kidney transplant in Indiana, individuals must have insurance supplemental to their Medicare coverage. Individuals with end stage renal disease (ESRD) are not eligible for Medigap or Medicare Advantage. Additionally, due to their Medicare eligibility they are ineligible to receive a tax credit to purchase insurance on the federal Marketplace. Medicaid coverage, therefore, is the only supplemental coverage option available to ensure continued placement on a kidney transplant list. In May 2014, Indiana amended the HIP waiver to provide continued Medicaid eligibility to individuals with ESRD who had been on spend-down prior to the State's transition to 1634 status.

Indiana is in the process of developing a 1915(i) state plan program for individuals with ESRD who meet the needs-based and target criteria outlined in the state plan and have income up to 300% of the federal poverty level (FPL). The 1915(i) program will provide coverage to the

majority of individuals who were originally authorized for continued Medicaid eligibility through the May 2014 1115 waiver amendment. The State proposes to provide continued Medicaid coverage through the Healthy Indiana Plan (HIP) Section 1115 waiver for a subset of individuals with ESRD who meet the eligibility criteria described below.

7.1 Eligibility Criteria

The State intends to provide coverage to Medicare eligible individuals who have income over 300% FPL, with a diagnosis of ESRD, who were eligible under the Section 1115 waiver as of December 31, 2014. These individuals may not reside in a long-term care facility or receive services through a HCBS waiver. Individuals must have countable resources below \$1,500 (single recipients) or \$2,250 (married recipients) and be otherwise eligible for Medicaid.

7.2 Delivery System

Individuals in this population will be served under the fee-for-service delivery system and will not be considered Healthy Indiana Plan (HIP) or Hoosier Healthwise (HHW) enrollees. They will be a group separate and distinct from the HIP and HHW populations.

7.3 Cost-Sharing Requirements

This population will not be subject to the HIP POWER account requirements. Individuals in this group will have an ESRD liability. The liability will be calculated using spend-down methodology based on incurred medical costs. Individuals that incur medical expenses that bring their income to the Supplemental Security Income (SSI) federal benefit rate (FBR) will have no further incurred costs subject to the ESRD liability. Other cost sharing requirements for these enrollees are stipulated in the Medicaid state plan.

7.4 Covered Benefits

Individuals in this population will be eligible for full Medicaid state plan benefits afforded to categorically needy eligibility groups as outlined in Indiana's state plan.

Section 8: Public Comment

FSSA held public hearings for this three-year Section 1115 waiver renewal application pursuant to the requirements set forth at 42 CFR 431.408. A copy of the full public notice that announced the two public hearings is included in Appendix A of this waiver application. The notice was posted on the agency's website at the web address of the Section 1115 waiver program's homepage: HIP.in.gov. In addition, notice was also published in the Indiana Register on May 21, 2014. OMPP also published notice in the Indiana Health Care Provider (IHCP) Bulletin, which was sent electronically to all IHCP providers. Electronic copies of all documents related to the HIP waiver renewal application were also available on the HIP website.

On June 4, 2014, FSSA presented this HIP waiver application to the Medicaid Advisory Committee, the State's Medical Care Advisory Committee that operates in accordance with 42 USC §431.12. Also, pursuant to state law, the HIP waiver renewal application was presented to the Indiana Budget Committee on June 20, 2014. During the meeting, legislators active on the Budget Committee were able to review and comment on the waiver.

In accordance with the notice, public hearings were conducted on May 28 and May 29, 2014 as scheduled and publicized, at the Indiana Government Center Conference facilities and the Indiana State House. Two individuals testified at the two public hearings. A court reporter transcribed both hearings. Both hearings were made available to the public via a telephone conference line and a live, free webcast. The notice provided the option for any individual, regardless of whether he/she attended the public hearing, to submit written feedback to the State by email or by USPS mail. A total of eight (8) written comments were received. The below summary combines the ten (10) total comments offered through the public hearings and through writing via mail and email.

8.1 Summary of Public Comments

The majority of commenters offered general support for the HIP renewal waiver application, although, all supporters expressed a preference for the HIP 2.0 waiver application. These commenters encouraged CMS to renew the State's existing HIP waiver as set forth in this HIP waiver renewal application only in the event CMS denies or delays the HIP 2.0 waiver application. One commenter reinforced the importance of continuity of care for the tens of thousands of Hoosiers who currently rely on HIP.

Only two (2) commenters were opposed to the design of the current HIP program. One commenter urged revision of the HIP waiver renewal application, stating that the extension of the temporary waiver granted in 2014 was not approvable. Another commenter stated that HIP should not be extended due to the problems affecting the program, including long wait lists and lack of comprehensive coverage.

Another commenter expressed serious concerns regarding low physician reimbursement under the program, warning that an expansion of Medicaid will only lead to more problems with access. He suggests increasing physician reimbursement.

8.2 Summary of State Response

The State appreciates all comments received. The waiver request as written addresses many comments received, and the State has made no changes to this application, at this time, in response to the public comments received during the thirty day public comment period. However, all comments will continue to inform the State in its discussions with CMS and the potential development of the Special Terms and Conditions.

Other than the inclusion of additional waiver related individuals above 300% FPL with End Stage Renal Disease (ESRD) as set forth in Section 7 of this waiver application and a few technical revisions to the requested waivers listed in Section 9, the content of this application is identical to the copy of the HIP waiver renewal application initially posted on the FSSA website on May 15, 2014.

Section 9: Types of waivers being requested

FSSA requests the following waivers:

9.1 Title XIX Waivers

1. Amount, Duration, and Scope and Comparability **Section 1902(a)(10)(B)**

To the extent necessary to enable Indiana to vary the services offered to individuals, within eligibility groups or within the categorical eligible population, based on differing managed care arrangements or on the absence of managed care arrangements. Individuals enrolled in the HHW program receive additional benefits such as case management and health education that may not be available to other Medicaid beneficiaries not enrolled in HHW.

2. Freedom of Choice **Section 1902(a)(23)**

To the extent necessary to enable Indiana to restrict the freedom of choice of providers for the demonstration eligibility groups.

3. Reasonable Promptness **Section 1902(a)(3)/Section 1902(a)(8)**

To the extent necessary to enable Indiana to prohibit reenrollment for 12 months for individuals in Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults) who are disenrolled for failure to make POWER account contributions.

To the extent necessary to enable Indiana to delay provision of medical assistance until the first day of the month following an individual's first contribution to the POWER account.

4. Methods of Administration: Transportation **Section 1902(a)(4)**
insofar as it incorporates 42 CFR 431.53

To the extent necessary to enable Indiana not to assure transportation to and from providers for Demonstration Population 4 (HIP Caretakers) or Demonstration Population 5 (HIP Adults).

5. Eligibility Section **Section 1902(a)(10)(A)**

To the extent necessary to allow Indiana not to provide medical assistance for Demonstration Population 4 (HIP Caretakers) or Demonstration Population 5 (HIP Adults) until the first day of the month following an individual's first contribution to the POWER account.

6. Amount, Duration, and Scope of Services **Section 1902(a)(10)(B)**

To the extent necessary to permit Indiana to offer to Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults), known as "the adult group" in the proposed rule at 435.119, benefits that differ from the benefits offered to the categorically needy group.

To the extent necessary to enable Indiana to vary the amount, duration and scope of services offered to individuals in the Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults) who meet the annual maximum benefit of \$300,000.

7. Retroactive Eligibility **Section 1902(a)(34)**

To the extent necessary to allow Indiana to not provide medical assistance to Demonstration Population 4 (HIP Caretakers) or to Demonstration Population 5 (HIP Adults) for any time prior to the first of the month following an individual's first contribution to the POWER account.

8. Prepayment Review **Section 1902(a)(37)(B)**

To the extent necessary to allow Indiana not to ensure that prepayment review be available for disbursements by members of Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults) to their providers.

9. Cost-Sharing **Section 1902(a)(14);
insofar as it incorporates Section 1916 and 1916A**

To the extent necessary to enable Indiana to charge required POWER account contributions and co-payments up to 5% of family income for Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults).

10. Dental and Vision Coverage **Section 1902(a)(43)**

To the extent necessary to enable Indiana not to cover certain vision and dental services described in sections 1905(r)(2) and 1905(r)(3) of the Act to 19 and 20 year-old members of Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults).

11. Income and Resource Test **Section 1902(a)(10)(c)**

To the extent necessary to enable Indiana to exclude funds in the POWER account from the income and resource test established under state and federal law for purposes of determining Medicaid eligible for Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults).

12. Statewideness/Uniformity **Section 1902(a)(1)**

To the extent necessary to enable Indiana to operate the Demonstration and provide managed care plans or certain types of managed care plans, including provider-sponsored networks, only in certain geographical areas.

9.2 Costs Not Otherwise Matchable

FSSA requests that the following expenditures be regarded as expenditures under the State's Medicaid Title XIX state plan.

1. Costs of ESRD Eligibility Group

Costs associated with providing coverage to Medicare eligible individuals who have income over 300% FPL, with a diagnosis of ESRD, who were eligible under the Section 1115 waiver as of December 31, 2014. These individuals may not reside in a long-term care facility or receive services through a HCBS waiver. Individuals must have countable resources below \$1,500 (single recipients) or \$2,250 (married recipients) and be otherwise eligible for Medicaid.

2. Expenditures Related to MCO Enrollment and Disenrollment

Expenditures made under contracts that do not meet the requirements in Section 1903(m) of the Act, as specified below. Indiana managed care plans which serve HIP members will be required to meet all requirements of section 1903(m) of the Act except the following:

Section 1903(m)(2)(A)(vi) and (xi) insofar as they incorporate federal regulations at 42 CFR 438.56, to the extent that the rules in section 1932(a)(4) of the Act are inconsistent with the HIP disenrollment rules (as contained in paragraph 26 of the demonstration's 2014 Special Terms and Conditions), such as restricting an enrollee's right to disenroll within 90 days of enrollment in a new managed care organization (MCO). Enrollees may change MCOs without cause within 60 days of enrollment in an MCO or before they make their first POWER account contribution, whichever occurs first. Enrollees may disenroll from an MCO with cause at any time.

Section 10: Financing Reports

Please see attached financing report prepared by Milliman Inc.

Appendix A: 2014 Notice of Public Hearing

Indiana Family and Social Services Administration

Notice of Public Hearing and Public Comment Period

Pursuant to 42 CFR Part 431.408, notice is hereby given that: **(1) on May 28, 2014, at 9:00 a.m., at the Indiana Government Center South, Conference Center Room B, 402 West Washington Street, Indianapolis, Indiana 46204-2744; and (2) on May 29, 2014, at 1:00 p.m., at the Indiana State House, Room 156-B, 200 West Washington Street, Indianapolis, Indiana 46204-2786,** the Indiana Family and Social Services Administration (“FSSA”) will hold public hearings on the extension of the existing Healthy Indiana Plan 1115 waiver request (“HIP Extension Waiver”) that will be submitted to the Centers for Medicare and Medicaid Services (“CMS”) to extend the current Healthy Indiana Plan (“HIP”) for calendar years 2015 through 2017. Both public hearings will be accessible via web conference at <http://www.webinar.in.gov/hip/>. In addition, FSSA will present the HIP Extension Waiver to the Medicaid Advisory Committee on Wednesday, June 4, 2014 at 10:00 a.m. at the Indiana War Memorial, Shoup Hall, 431 North Meridian Street, Indianapolis, IN 46204.

This notice also serves to open the **30-day public comment period, which closes June 21, 2014 at 4:30 pm.**

The Healthy Indiana Plan (“HIP”), which passed the Indiana General Assembly in 2007 with bipartisan support, builds upon the state’s long and successful history with consumer-driven health plans. Individuals eligible for HIP are non-disabled adults between the ages of 19 and 64 with household income below 100% of the federal poverty limit (“FPL”). HIP, via private health insurance carriers, offers its members a High Deductible Health Plan (“HDHP”) paired with a Personal Wellness and Responsibility (“POWER”) account, which operates similarly to a Health Savings Account (“HSA”). This private health insurance experience provides an alternative to traditional Medicaid and promotes consumerism by requiring members to have “skin in the game,” which empowers them to demand price and quality transparency as they make cost-conscious health care decisions and take responsibility for their health. HIP, in its current form, is scheduled to expire on December 31, 2014.

FSSA is submitting the HIP Extension Waiver concurrently with a separate HIP 2.0 1115 waiver (“HIP 2.0 Waiver”) application. The HIP 2.0 Waiver seeks to expand HIP to all non-disabled Hoosiers between the ages of 19 and 64 with household income below 138% of the FPL. FSSA is submitting the HIP Extension Waiver as an alternative to the HIP 2.0 Waiver in order to preserve the current HIP program in the event CMS does not approve the HIP 2.0 Waiver. FSSA is not requesting any changes or modifications in the HIP Extension Waiver.

OBJECTIVES

Seven objectives have driven the implementation of HIP in Indiana: 1) reduce the number of low-income uninsured Hoosiers; 2) improve access to appropriate, quality-based health care to low-income Hoosiers; 3) reduce barriers and improve statewide access to health care services for low income Hoosiers; 4) promote value-based decision-making and personal health responsibility; 5) promote better health outcomes through preventative care; 6) prevent chronic disease progression with secondary prevention; and 7) ensure State fiscal responsibility through efficient management of the program.

BENEFICIARIES, ELIGIBILITY, & FINANCING

HIP offers health care coverage to non-disabled individuals between the ages of 19 and 64, who have household incomes below 100% of the FPL and who are not otherwise eligible for Medicaid or Medicare. Income eligibility for HIP is determined using the modified adjusted gross income (“MAGI”) methodology with a 5% disregard. While HIP does not limit enrollment for parents and caretakers with household income below 100% FPL, it imposes an enrollment cap of 36,500 for non-caretaker individuals.

From 2008 through December 2013, the State received 483,561 valid applications and 105,135 unique members have been enrolled in HIP since the program’s inception. HIP currently covers approximately 41,000 individuals. Due to the elimination of the waitlist, HIP enrollment is expected to reach the enrollment target of 45,000 in 2014,

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comprised of approximately 25,000 caretakers and 20,000 non-caretakers. Enrollment is projected to remain at these levels through the three year renewal period.

The purpose of the HIP Extension Waiver is to continue HIP for three years without change, in the event that the HIP 2.0 waiver is not approved. Over the three-year demonstration period (2015-2017), the extension of the HIP waiver in its current form is expected to cost approximately \$3.6 billion in state funds, and \$10.6 billion in total combined state and federal funds. The table below provides the estimated state and federal costs divided by year.

Estimated State and Federal Program Costs 2015-2017 (in millions)

Calendar Year	Demonstration Year	Expenditures without Waiver	Total Waiver Expenditures	State Share of Expenditures	Waiver Margin	Cumulative Margin
2015	8	\$ 3,153.7	\$ 3,298.9	\$1,104.5	(\$ 145.3)	\$ 907.4
2016	9	\$ 3,385.4	\$ 3,531.4	\$1,182.3	(\$ 146.0)	\$ 761.4
2017	10	\$ 3,634.6	\$ 3,781.0	\$1,265.9	(\$ 146.4)	\$ 615.0

BENEFITS AND HEALTH CARE DELIVERY SYSTEM

HIP offers a comprehensive Secretary-approved benefits plan. Preventive services, such as annual examinations, smoking cessation programs, and mammograms are covered without charge to the member up to \$500 and are not included in the deductible amount. After the \$1,100 deductible is met through the utilization of POWER account funds, the HIP program includes a comprehensive benefit package, covering up to \$300,000 in services annually and a lifetime benefit limit of \$1 million for care services, home health services, physician services, inpatient/outpatient hospital services, maternity services, emergency transportation, prescription drugs, diagnostic services, durable medical equipment and medical supplies, rehabilitative services, home health services, and mental health and substance abuse services. Non-emergency transportation, dental, and vision services are not covered. Pregnancy-related services are also excluded, as pregnant HIP members are transferred to the HHW program for the duration of the pregnancy. FSSA is requesting a waiver of the requirements to offer non-emergency transportation services and Early Periodic Screening, Diagnoses, and Testing (“EPSDT”) services to individuals between the ages of 19 and 21 in order to standardize the benefit package for members.

All HIP medical benefits are currently provided through three managed care entities (“MCE”), Anthem, MDwise, and Managed Health Services. At the time of application, HIP members have access to enrollment brokers, who provide counseling on the full spectrum of available MCE choices, to assist with their MCE selection. Once an MCE has been selected, the member must remain in the MCO for 12 months, with limited exceptions. Members who do not select an MCE will be auto-assigned to an MCE but will have the opportunity to change the assigned MCE before the first POWER account contribution is made.

COST SHARING REQUIREMENTS

HIP utilizes two forms of cost-sharing. First, members must contribute to their POWER account to help fund the \$1,100 deductible. POWER account contribution rates are based on a sliding fee scale, reflecting approximately 2% of the member’s household income. At the end of a 12-month coverage term, any remaining funds in the POWER account may be carried forward to the next coverage term to reduce the member’s required POWER account contribution for that term. Second, members must pay co-payments for non-emergency use of hospital emergency departments (ED). Non-caretaker members are required to pay a \$25 co-payment for non-emergency ED visits. Parent and caretaker members with household incomes above the AFDC limit as set forth in the State Medicaid Plan up to and including 100% of the FPL are charged a \$3 co-payment for non-emergency ED visits. Consistent with the CMS standard, members will not pay more than 5% of their annual income for combined cost-sharing (POWER account contributions and ED co-payments).

HYPOTHESES & EVALUATION

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Since the FSSA will not request any changes in the HIP Extension Waiver, FSSA does not propose any changes to its hypotheses and evaluation plan for the duration of the demonstration extension.

Evaluation reports will include evaluation of the following HIP hypotheses:

- Reduction in the number of uninsured low income Hoosiers.
- Reduction of barriers and improvement in statewide access to health care services for low income Hoosiers.
- Increased value-based decision making and personal health responsibility.
- Promotion of primary prevention.
- Prevention of chronic disease progression with secondary prevention.
- Provision of appropriate quality-based health care services.
- Assurance of State fiscal responsibility and efficient management of the program.

During the waiver extension period evaluation reports will continue to include responses to the following evaluation questions:

1. How many HIP members reach their \$300,000 annual benefit limit each year? How do these individuals meet their health care needs after they exhaust the annual benefit limit and before the next coverage term begins?
2. How many HIP members reach their \$1,000,000 lifetime benefit maximum? How do they meet their health care needs after their HIP benefits are exhausted?
3. What are the consequences of limiting members' ability to switch plans after they have made an initial POWER Account contribution? What percentage of HIP applicants are auto-assigned to an MCE?
4. What percentage of the potentially eligible population enrolls in HIP? How does the percentage vary by major population subgroups (HIP Caretakers, HIP Non-caretakers) and income level?
5. What are the consequences of requiring HIP members with household income less than 100% of the FPL to pay monthly premiums? How many of these members fail to make their first POWER Account contribution? How many of these members are disenrolled for failure to pay their contributions?
6. To what extent has HIP impacted the uninsurance rate in Indiana?
7. To what extent has HIP reduced uncompensated care provided by Indiana's federally-funded health clinics?
8. How many members exhaust their POWER account each year? How many members are able to roll-over a sufficient POWER account balance to reduce their subsequent year's required contribution by at least half? How many members are able to achieve a \$0 contribution by this means?

WAIVER & EXPENDITURE AUTHORITIES

The following includes a list of waiver and expenditure authorities for the HIP Extension Waiver:

1. **Amount, Duration, and Scope and Comparability** **Section 1902(a)(10)(B)**
To the extent necessary to enable Indiana to vary the services offered to individuals, within eligibility groups or within the categorical eligible population, based on differing managed care arrangements or on the absence of managed care arrangements. Individuals enrolled in the HHW program receive additional benefits such as case management and health education that may not be available to other Medicaid beneficiaries not enrolled in HHW.
2. **Freedom of Choice** **Section 1902(a)(23)**

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To the extent necessary to enable Indiana to restrict the freedom of choice of providers for the demonstration eligibility groups.

3. **Reasonable Promptness** **Section 1902(a)(3)/Section 1902(a)(8)**

To the extent necessary to enable Indiana to prohibit reenrollment for 12 months for individuals in Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults) who are disenrolled for failure to make POWER account contributions.

To the extent necessary to enable Indiana to delay provision of medical assistance until the first day of the month following an individual's first contribution to the POWER account.

4. **Methods of Administration: Transportation** **Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53**

To the extent necessary to enable Indiana not to ensure transportation to and from providers for Demonstration Population 4 (HIP Caretakers) or Demonstration Population 5 (HIP Adults).

5. **Eligibility Section** **Section 1902(a)(10)(A)**

To the extent necessary to allow Indiana not to provide medical assistance for Demonstration Population 4 (HIP Caretakers) or Demonstration Population 5 (HIP Adults) until the first day of the month following an individual's first contribution to the POWER account.

6. **Amount, Duration, and Scope of Services** **Section 1902(a)(10)(B)**

To the extent necessary to permit Indiana to offer to Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults), known as "the adult group" at 42 CFR 435.119, benefits that differ from the benefits offered to the categorically needy group.

To the extent necessary to enable Indiana to vary the amount, duration and scope of services offered to individuals in the Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults) who meet the annual maximum benefit of \$300,000.

7. **Retroactive Eligibility** **Section 1902(a)(34)**

To the extent necessary to allow Indiana to not provide medical assistance to Demonstration Population 4 (HIP Caretakers) or to Demonstration Population 5 (HIP Adults) for any time prior to the first of the month following an individual's first contribution to the POWER account.

8. **Prepayment Review** **Section 1902(a)(37)(B)**

To the extent necessary to allow Indiana not to ensure that prepayment review be available for disbursements by members of Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults) to their providers.

9. **Cost-Sharing** **Section 1916A; Section 1902(a)(14) insofar as it incorporates Section 1916(a)(1)**

To the extent necessary to enable Indiana to charge required POWER account contributions and co-payments up to 5% of family income for Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults).

10. **Dental and Vision Coverage** **Section 1902(a)(43)**

To the extent necessary to enable Indiana not to cover certain vision and dental services described in sections 1905(r)(2) and 1905(r)(3) of the Act to 19 and 20 year-old members of Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults).

11. **Income and Resource Test** **Section 1902(a)(10)(c)**

To the extent necessary to enable Indiana to exclude funds in the POWER account from the income and resource test established under state and federal law for purposes of determining Medicaid eligible for Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults).

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12. **Statewideness/Uniformity**

Section 1902(a)(1)

To the extent necessary to enable Indiana to operate the Demonstration and provide managed care plans or certain types of managed care plans, including provider-sponsored networks, only in certain geographical areas.

REVIEW OF DOCUMENTS AND SUBMISSION OF COMMENTS

The proposed HIP Extension Waiver documents are available for public review at the FSSA, Office of General Counsel, 402 W. Washington Street, Room W451, Indianapolis, Indiana 46204. The documents may also be viewed online at www.HIP.in.gov.

Written comments regarding the HIP 2.0 Waiver may be sent to the FSSA via mail at 402 West Washington Street, Room W374, Indianapolis, Indiana 46204, Attention: Steve Holt or via electronic mail at HIP.Renewal@fssa.in.gov **through June 21, 2014**.

FSSA will publish a summary of the written comments, once compiled, for public review at www.HIP.in.gov.