

## **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 (IHP) 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 an 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.

## 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,

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**

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)**

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).

**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](http://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](mailto: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](http://www.HIP.in.gov).