

Exhibit 11

Indiana Family and Social Services Administration

Healthy Indiana Plan 1115 Waiver Extension Application



HEALTHY INDIANA PLANSM
Health Coverage = Peace of Mind

Submitted
4/12/2013

2013 HIP 1115 WAIVER RENEWAL APPLICATION

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Section 1: Introduction

Indiana seeks federal approval to continue and expand its successful waiver program, the Healthy Indiana Plan (HIP). HIP's innovation has proven that redesigning Medicaid to empower and engage participants to be consumers of health care can have a dramatic impact on utilization and outcomes. In 2010, and prior to the Supreme Court of the United States ruling which makes Medicaid expansion optional under the Patient Protection and Affordable Care Act (PPACA), the Indiana Legislature passed Senate Enrolled Act 461 (Indiana Code 12-14-44.2), calling for HIP to be the coverage vehicle for the newly eligible Medicaid expansion population under the PPACA. While, the State has not yet committed to a Medicaid expansion, we seek approval to use HIP as the coverage vehicle should the state move forward with expansion.

In September 2012, CMS granted a one-year extension of the groundbreaking Healthy Indiana Plan 1115 waiver demonstration. The program now expires in December 2013 and, per the Centers for Medicare and Medicaid Services (CMS) guidelines, the State submits this subsequent request to extend the program beyond 2013 for the maximum waiver renewal period of 3 years. The issues presented in this waiver request are not new and Indiana has brought these issues to CMS since 2010. Therefore, we request prompt resolution so policy makers can understand the future of the HIP program. If CMS does not give Indiana permission to continue the program, the State will need at least six months to halt future enrollment and dismantle the current program.

The waiver application is materially identical to our December 2011 submission. It has been updated to reflect the Supreme Court decision which makes Medicaid expansion optional, data updates over the past year have been provided, and a preliminary analysis of the Essential Health Benefit requirements as they relate to Medicaid benchmarks has been included.

Section 2: Background and Program Description

The initial HIP demonstration project was approved in December 2007, and the program began January 1, 2008. Through the current demonstration year, HIP covers caretaker and non-caretaker adults up to 200% of the federal poverty level (FPL).¹ HIP represents one of the first Medicaid demonstration projects that worked towards harnessing the promise of consumerism through member participation to incentivize positive health behaviors and improve health outcomes. The program created Personal Wellness and Responsibility (POWER) accounts modeled after Health Savings Accounts (HSA) to encourage enrollees to be consumers of health care services that evaluate cost and quality. Five years later, HIP has demonstrated significant success in achieving its goals and remains the sole Medicaid demonstration project modeled on the principals of consumer-driven health plans.

In 2010, the Indiana Legislature passed Senate Enrolled Act 461, which became Indiana Code (IC) 12-15-44.2. This legislation adds a requirement for enrollees to make a minimum contribution to their POWER

¹ Caretakers are a categorically eligible Medicaid population; these individuals have a dependent under the age of 19. Non-caretakers are adults without dependents under the age of 19 that the HIP waiver grants the State permission to cover to an enrollment cap of 36,500 individuals, contingent upon the waiver's budget neutrality agreement.

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account of \$160 annually, allows not-for-profits to make up to 75% of the members required contribution to the POWER account, authorizes Managed Care Entities (MCEs) to contribute to the POWER account to incentivize positive health habits, and lowers the FPL allowed for HIP eligibility. The \$160 annual contribution will still be subject to requirements in IC 12-15-44.2 that stipulates that enrollees may not spend more than 5% of their income in contributions and copayments for health care; for individuals who reach the 5% limit contribution requirements will be suspended.

In December 2011, a 3 year extension request was submitted for the HIP program. This request was approved for a one year period in September 2012. CMS has indicated it will not allow the minimum contribution for this one year period in 2013, but we repeat this request in consideration for 2014 and beyond. Our data indicates that making contributions does not deter individuals from needed care, but does lead to more appropriate utilization behavior².

HIP demonstrates that requiring contributions of members results in significant differences in utilization behavior. Within HIP itself, differences in care utilization have been observed between members who contribute to their POWER account and members who do not contribute, suggesting that making a contribution impacts healthcare consumption behavior. Non-contributors overall have a significantly higher use of Emergency Room (ER) services and non-emergency ER visits that could be partially attributed to not having to pay into POWER accounts or make co-payments for non-emergency ER use. Non-contributors have 66.8 non-emergent ER visits per 1,000 members while contributors have 34.7 non-emergent ER visits per 1,000 members.³ The non-contributing population in general suffers from higher morbidity;⁴ however, the POWER account contributions and the influence of consumerism cannot be ruled out as factors contributing to this vast difference in utilization.

Over the first four demonstration years, HIP has realized success. Between January 2008 and December 2011, HIP served 90,034 Hoosiers. In two separate independent evaluations of the program, HIP members have indicated a high level of satisfaction with their coverage and member satisfaction surveys conducted by the contracted health plans also show satisfaction rates consistently greater or comparable to commercial plans. The HIP program has noted differences in care utilization patterns compared with traditional Medicaid programs, including greater use of preventive care, lower ER usage, and increased utilization of generic pharmaceuticals. Eighty-percent of HIP enrollees complete the preventive services required for a POWER account rollover and, on average, over the first 12 months of enrollment HIP member non-emergency utilization of the ER decreases by 14.8%.⁵

HIP policies to promote personal responsibility have also had a positive impact. HIP incents individuals to obtain preventative health care by allowing the entire balance (State and individual contribution) of their POWER Account to rollover to the next benefit period, reducing their required contribution for the

² Mathematica 2010 Survey of HIP Members

³ Data from Mathematica Data Enclosure, December 2010.

⁴ *ibid.*

⁵ Data from Mathematica Data Enclosure, December 2010.

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following year. To this end, members have engaged in positive health behaviors including seeking preventive services at rates higher than comparable Medicaid populations, decreasing their non-emergency use of the ER, and increasing their utilization of services offered by primary care physicians. HIP members are actively aware of their POWER account balance and are supportive of the program: 94% are satisfied or highly satisfied with their coverage, and 99% of HIP enrollees would choose to reenroll in the program.⁶ Survey data collected by Mathematica in 2010 suggests that the majority of respondents knew key features of the program. For example, most HIP members were aware of their POWER account, believed that they had been given adequate information about the account, and knew where to look for more information if they needed it.

Personal responsibility is the keystone of the HIP program. HIP policy requires that individuals make their monthly contributions within 60 days or face expulsion from the program for 12 months. Members must also return their redetermination packets on time, or face dismissal from the program. The vast majority of members pay their POWER account contribution on time, and during the first two years of the program only 3% of enrollees were disenrolled for failing to pay their POWER account contributions after enrollment. While this number grew to 8% of enrollees in 2010 and 9% of enrollees in 2011⁷, it has remained steady at 9% of the total terminations from HIP through October 2012. In addition to POWER account payments, enrollees are required to complete a redetermination packet and return it in a timely manner. A Mathematica analysis for the first two years of the program showed that 85% of HIP enrollees submitted redetermination packets on time. For the third year of the demonstration, 2010, 96% of enrollees submitted their redetermination packet on time. This trend continues and at least 91% submitted timely in 2011 and 92% submitted timely in 2012. These results suggest that HIP's policies encourage members to engage in their health care and that the members value the program.

Eligibility and budget neutrality requirements would remain the same in 2014, but the State requests that, as granted in the 1 year 2013 extension, disproportionate share hospital payments (DSH) not be diverted, since the State can achieve budget neutrality without these funds. With the expected changes in Medicaid eligibility in 2014, the caretaker and non-caretaker categories under HIP become the 'adult group';⁸ and this waiver renewal application reflects the changes in the Final Rule on Medicaid program changes published in the Federal Register March 23, 2012.

HIP provides an alternative to traditional Medicaid and is the nation's first consumer-driven coverage program for low-income adults. HIP features a comprehensive high deductible health plan and a modified Health Savings Account (HSA) called the POWER account, which invites members to be thoughtful and engaged health care consumers. Contingent on payment of a monthly contribution to their POWER account, the current waiver provides HIP eligibility to Hoosiers between the ages of 19 and

⁶ Product Acceptance Research Telephone Survey of HIP members, 2009.

⁷ In 2011 9% represented 1,843 individuals terminated for not paying a contribution after enrollment.

⁸ As described by the *Medicaid Program: Eligibility Changes under the Affordable Care Act* final rule at 435.119.

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64, earning below 200% FPL, who have not had access to employer sponsored insurance for at least six months.

As covering deductible costs is a known challenge for low income populations, HIP modifies the traditional HSA model to make it compatible with low income needs and limitations. First, the State subsidizes the POWER account to ensure the account is fully funded, up to the amount of the deductible. It requires health plans to provide payment to providers for deductible costs, even though the account may not contain the individual's full annual contribution. The State also ensures that the deductible is not a barrier to recipients receiving preventive services as the first \$500 in preventive services are provided outside the deductible. While HIP contributions are not tax deductible, historically most participants are below federal poverty level and would not avail income tax benefits from tax deductible contributions.

After a \$1,100 deductible is met through POWER Account funds, the HIP program includes comprehensive health plan benefits up to \$300,000 annually and \$1,000,000 lifetime which are waived from certain benchmark requirements.⁹ Instead of traditional cost-sharing of premiums and copayments, HIP participants make upfront contributions for their health care through required POWER account contributions. The funds contributed to the POWER account are used to pay for deductible expenses. Contributions are based on a sliding scale so that individuals can afford to make the monthly payments but still have "skin in the game." The program ensures that no participant pays more than 5% of their income, consistent with CMS rules. Employers are also currently allowed to contribute up to 50% of the member's required contribution. Additionally, the renewal for 2013 allows not-for-profits to contribute up to 75% of the member contribution.

Participants have control over how POWER account dollars are spent and receive monthly statements on POWER account expenditures and account balances. If participants fail to make their contributions within sixty days, they are removed from the program and may not reenroll for twelve months.¹⁰ Unlike traditional premiums or copayments, 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 rollover and offset required contributions in the next year. If individuals do not complete the required preventive services, only the pro-rated balance of their individual contribution rolls over. Any rollover amount can reduce required contributions in the following year. The incentive is designed to increase the use of preventive care. 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 total HIP population.

⁹ HIP is not currently a benchmark plan due to the lack of maternity coverage, and the annual and lifetime coverage limits.

¹⁰ Members are not considered enrolled in HIP until they have made their initial contributions, those that never make an initial contribution are not subject to the 12 month enrollment exclusion.

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HIP provides comprehensive benefits including physician, inpatient, outpatient, mental health services, pharmaceuticals, labs, and other therapies. HIP requires copayments for non-emergency use of the emergency room; these copayments currently vary from \$3 to \$25 dependent on an individual's caretaker status and his or her federal poverty level (FPL) and cannot be paid out of the member's POWER Account. For this extension request copayment amounts are requested to be updated consistent with the January 2013 Cost-sharing NPRM. Different from traditional Medicaid programs, individuals are provided with monthly POWER Account statements and Explanations of Benefits that explain costs of care. These provisions are aimed at increasing member awareness of the cost of care and promoting consumerism and efficient care seeking behavior.

HIP promotes personal responsibility by requiring that members are timely with payments and eligibility paperwork submission; otherwise, enrollees face a twelve month penalty period before they may reenroll in the program. This also ensures that individuals do not enroll only when they are ill and require treatment and then drop coverage when they recover. HIP provides reimbursement to healthcare providers at Medicare rates, which in Indiana are higher than traditional Medicaid, thus encouraging a more robust provider network. These increased rates also improve enrollee access to care. HIP's progress towards meeting its program goals will be discussed later in this document.

Section 3: Historical Narrative

In 2006, Indiana ranked second in the nation for incidence of adult smoking, had poor general health indicators, and a low rate of preventive care utilization. Additionally in 2005, 860,000 individuals¹¹ had been without health insurance in the last year, and 62% of these uninsured were working age adults below 200% FPL.¹² Prior to HIP, the Indiana Medicaid program had one of the lowest eligibility thresholds in the nation and only covered non-disabled caretakers up to 23% of FPL. There was little support to expand the State's traditional Medicaid program as an open-ended entitlement that could strain the State's budget in future years. Additionally, a traditional Medicaid plan had questionable ability to significantly improve the health status of individuals, a lack of incentives for participants to utilize health care appropriately, and the structure did not promote personal responsibility. While consumer driven health plans and HSAs were used in the commercial marketplace, they had not been used for low-income populations. Based on input from numerous stakeholder meetings, Governor Mitch Daniels instructed his staff to design a health care plan that incorporated health care consumerism and private market principles. This ensured the maintenance of a balanced State budget by not creating an open-ended entitlement program, and promoted health for Hoosiers.

Governor Daniels presented the design of the HIP program to the public in November of 2006. Once proposed, Republican State Senator Pat Miller and Democrat State Representative Charlie Brown championed the effort and sponsored House Bill 1678 during the 2007 session of the General Assembly. Through their leadership, the Indiana Check-Up plan, which contained the enabling legislation for HIP,

¹¹ U.S. Census Bureau, Current Population Survey (CPS), 3-year average, 2003-2005.

¹² State Health Access Data Assistance Center (SHADAC), University of Minnesota, *2003 Health Insurance for Indiana's Families Summary* (August 2003).

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passed with bipartisan support with votes of 70-29 in the House of Representatives and 37-12 in the Senate. HIP's enabling legislation only permits the State to enroll as many individuals as its funding can support to ensure long-term budget sustainability. HIP enrollment is constrained by the number of dollars generated through a cigarette tax increase included in the enabling legislation that funds the program. This tax increase simultaneously discourages smoking and youth smoking in the State has declined since the passage of the law.

After the bill was passed in April 2007, the Family and Social Services Administration (FSSA) moved immediately to develop an implementation plan and began negotiations with CMS to obtain federal waiver approval. HIP began enrolling working-age, uninsured adults on January 1, 2008, seven months after passage of the enabling legislation and less than a month after receiving approval for the program from the CMS.

An unforeseen challenge of HIP was the pent-up demand for services in the uninsured population. Initially, the HIP population used services at a greater rate than the traditional Medicaid population, likely due to untreated disease in this previously uninsured population. However, since inception, HIP members have taken advantage of preventive services, lowered their non-emergency ER use, and learned to manage their chronic conditions through the use of prescription medications. Over the course of HIP, the program has met and exceeded the State's performance expectations. The State remains committed to HIP as a program that provides quality care to low income individuals while embracing the principals of consumerism.

In December 2011, after 4 successful years of administering HIP, the State submitted a 3 year waiver extension request. This request included changes to the HIP program including the addition of permitting not-for-profits to contribute to members POWER accounts, request for a minimum contribution, modifications to the budget neutrality agreements, and changes anticipating PPACA requirements beginning in 2014. In September 2012, a one year waiver extension request was granted though the minimum contribution requirements added to the HIP legislation in 2011 were not included in the approval.

3.1 Contract Modifications

HIP has evolved over the course of the demonstration. At the beginning of the program, HIP contracted with two MCEs, Anthem and MDwise, and had a third Enhanced Services Plan (ESP) that is separate but is 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. 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, better serve members, streamline ESP, and ensure that the MCEs remained on stable financial footing.

During the initial contracting period in 2007 the State selected two managed care plans Anthem and MDwise, in collaboration with AmeriChoice, that leveraged commercial experience and HSA experience. However, since then, MDwise has changed billing and claims subcontractors. Acting in some capacity as a third health plan option, ESP is administered on an Administrative Services Only basis through ICHIA. If

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the HIP program continues, the State will consider another contractor for the HIP ESP program, as the ICHIA program will end in 2014 due to PPACA implementations.

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. Non-caretakers in general had higher costs than caretakers. The State amended the risk-sharing arrangements in their 2009 HIP contracts. The amended contracts included higher monthly capitated rates for caretakers and a stop-loss provision for non-caretakers (effective retroactively to January 2009), and new criteria for the high risk pool. CMS approved the amended contracts in mid-December 2009. The losses were due to the high morbidity of a previously uninsured population and pent-up demand of the early entrants, especially amongst the non-caretaker population where no Medicaid coverage existed. Actuarial analysis conducted on the first year of program claims experience showed that caretakers had a 25% higher risk adjusted relative morbidity than the commercial population, and non-caretakers had an even higher morbidity at 65% greater than a comparable commercial population. These populations also initially used services at a much higher rate, compared to a commercial population. Caretakers initially had 38% more inpatient hospital days and 181% more ER visits, and non-caretakers had 155% more inpatient hospital days and 269% more ER visits. 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.¹³ This 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 2010 HIP contracts included a carve-out for most pharmacy services. The carve-out for pharmacy costs helped the State meet and exceed the budget neutrality requirements. The State consolidated into one contract all the pharmacy purchasing for Medicaid programs. This consolidation was done to maximize rebate savings available to the State, as well as to achieve administrative simplifications, and thus savings, on prescribing, dispensing, claims submission, program analytics, and prior authorization for pharmaceuticals. For members, this new arrangement provides access to an expanded list of pharmaceuticals, including brand-name pharmaceuticals. For providers, it streamlines the prescribing system, moving from multiple distinct lists of preferred drugs for different public programs and plans, to one list. This shift utilizes one set of prior authorization requirements, one claims processing methodology, and one help desk. Thus far, both vendors are working closely with the State and the State has established a good working relationship with these vendors.

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 now that the population has access to routine and preventive health care services.

¹³ Damler, R. *Experience Under the Healthy Indiana Plan: The short-term cost challenges of expanding coverage to the uninsured*. Milliman Inc. (August, 2009).

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The 2011 contracts represented the first time the State combined HIP and Hoosier Healthwise (HHW) into one contract. HHW serves the State's non-waiver Medicaid managed care populations. The State's purpose is 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. As a result, the State views both programs as more family friendly. The new contract developed this integration and requires plans to maintain one call center for both programs -- a way of offering 'one stop shopping' to families with members in both the HIP and HHW programs. Unifying the programs also brings administrative simplification for providers, as the new contract aligns all policies and procedures in the two programs (although provider reimbursement remains based on Medicare rates in HIP). The State believes the new contracts will bring a focus on family health to both programs.

During the 2011 process the State selected three plans to serve the HIP population. Anthem and MDwise continue to serve HIP, and the State added Managed Health Services (MHS), which has traditionally served Indiana's Medicaid Hoosier Healthwise population. Under the new contracts, the plans must also implement a debit swipe card for HIP members. The cards are to be used at the point-of-service to verify eligibility, whether the service is covered, and whether the provider is participating in HIP. The card is linked to their POWER accounts, and members should be able to assess at the point of service what their contribution to the costs of the services will be (i.e., what will be deducted from their POWER accounts). All debit cards must make available the full \$1,100.00 on day one of eligibility regardless of the current amount paid in by the member. The debit card is intended to enhance the experience of using the POWER account and promote consumer driven healthcare. MHS operationalized the card as of January 1, 2011 and the other plans followed later in the year. All debit cards were required to have the capability for eligibility determination and cost estimation as of July 1, 2011, with full implementation of the debit card in place by January 1, 2012. Both Anthem and MDwise issue a single swipe card that functions as their ID card and debit card, while MHS issues separate ID and debit cards. In the first two quarters of 2011, the health plans mailed flyers to their members along with the debit cards to educate the members on the benefits of utilizing the card.

No substantial changes occurred during 2012 or 2013 contract negotiations and contract negotiations have focused primarily on rates. 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 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 receiving all the same HIP services and benefits, these high risk individuals are currently managed by the State's high risk plan, ICHIA, which has experience in managing high cost health conditions. The HIP population is separate from the State's high risk pool.

HIP's higher than expected initial cost of care, which partly resulted from pent-up demand and the higher morbidity and co-morbidities of a previously uninsured population, drove the State to identify ways of reducing the risk to the health plans. One means of attaining this goal was to expand the list of

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conditions that would qualify an individual to participate in the ESP and simplify referral processes to make ESP determinations timelier. Originally, ESP was accessed when a high risk condition was reported and verified and the State contracted with a vendor to interview the patient to determine if the ESP placement was appropriate. To make access to ESP more convenient, the State altered several enrollment policies and expanded the list of qualifying conditions in July 2009. When HIP applicants check one of the qualifying conditions on the application, they are now automatically enrolled in the ESP and stay enrolled until their eligibility is redetermined. If their claims history at redetermination confirms the information reported on the application, they will stay with the ESP; otherwise, they will be transitioned to one of the other health plans. In addition, the plans now have six months to refer a member to the ESP, as opposed to 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 found to have an ESP qualifying condition and a risk score at or above a certain threshold were transferred to the ESP at that time. This process is expected to continue for the life of the waiver and no changes are requested. As the State's high risk pool will be eliminated in 2014, the State will identify a new vendor to manage the high risk individuals in the HIP program. Understanding the future of HIP will be critical to initiating this process.

3.3 Application Processing

At two different times during the first year of program operations, the State's vendor struggled to keep up with the flow of applications—more than 120,000 were submitted in CY 2008 (yielding more than 35,000 enrollees). At program initiation, high enthusiasm for the program, assertive outreach and advertising and pent-up demand led to more than 18,000 applications being submitted in just the first month. The State's vendor adjusted staffing to accommodate this initial surge in interest, but the queue again lengthened during the second half of 2008. Part of the challenge in managing applications may have been that HIP's launch coincided with a major initiative to upgrade enrollment and eligibility business processes affecting all public assistance programs operated by FSSA. To address the issue, additional eligibility staff was hired in 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 that the State had not expected to reach until the third or fourth year of the demonstration. To manage enrollment levels, and to ensure the State could maintain budget neutrality, the State closed enrollment for non-caretakers in March 2009.

The State also made significant progress in 2009 with the HIP application backlog. HIP operations staff worked to resolve various issues and have identified approaches to expedite their resolution. In late 2009, the State hired an additional 18 state eligibility consultants (SECs), who were brought on in January 2010. They have increased the percentage of applications processed in a timely manner from 71% in May 2009 to almost 91% as of September 2012. In the second quarter of 2009, the State developed a revised enrollment dashboard to include more information on the HIP application processing and to showcase different aspects of the HIP program. This dashboard continues to be used to manage application processing, however, for the application processing for HIP has operated smoothly since the changes made in 2010.

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3.4 Non-caretaker Waitlist

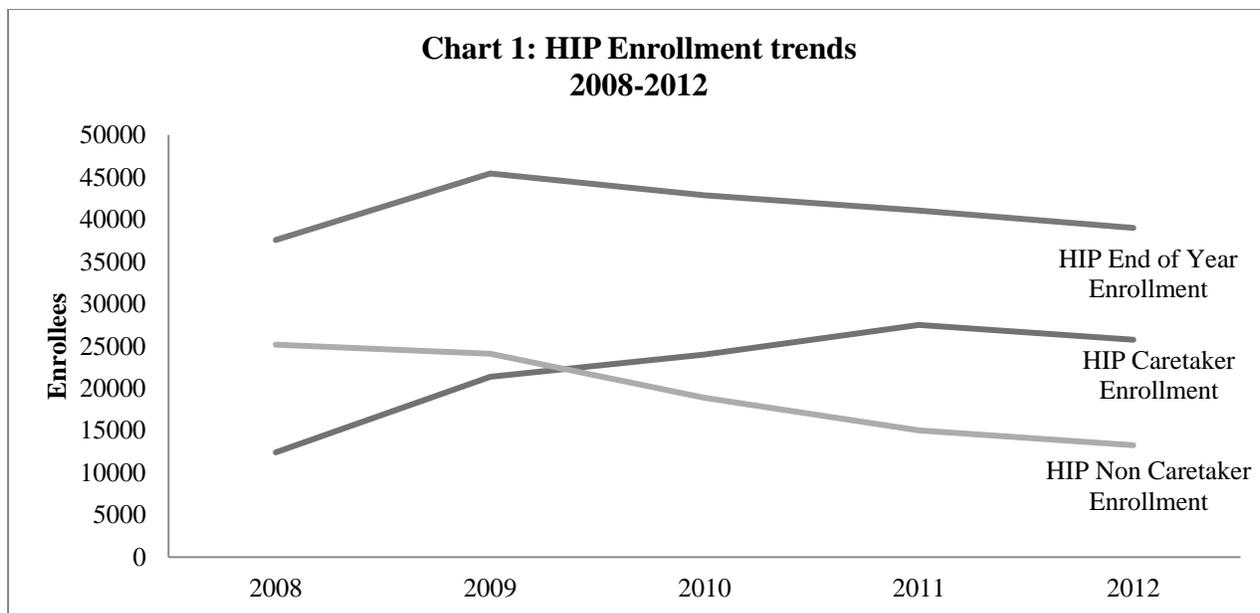
The waiver agreement imposed a cap on the number of non-caretakers who could enroll in the program. On March 12, 2009, HIP closed enrollment to non-caretakers. At that time, the number of non-caretakers members had reached 32,000, just below the 34,000 cap established in the Special Terms and Conditions (STC). Enrollment for non-caretakers was closed before the cap was reached to ensure that applicants in the eligibility determination process or appealing denied applications and any pregnant woman who after delivering lost HHW eligibility could be enrolled in HIP without exceeding the cap. At the same time, all new applications from non-caretakers were reviewed for eligibility and placed on a waiting list if determined eligible. CMS agreed to raise the cap by 2,500 individuals for an overall limit of 36,500 non-caretakers. The State opened 5,000 non-caretaker slots in the fall of 2009 and sent letters to the first 5,000 applicants on the waitlist in November 2009. The invited applicants started the enrollment process by reapplying for HIP and having their eligibility for the program redetermined. With the passage of the Affordable Care Act in March 2010, HIP enrollment of non-caretaker adults remained closed due to the Maintenance of Effort (MOE) provisions contained in this legislation and a concern that, since the program could not be closed to caretakers, the State could be forced to cover costs beyond the funds that were available from the cigarette tax fund. Based on declining enrollment of non-caretakers, the State initiated the opening of an additional 8,000 slots to individuals on the waitlist in August 2011. The waitlist for non-caretakers was 46,388 as of the end 2012.

3.5 Enrollment Trends

From initiation through December 2012, the State received a total of 411,568¹⁴ valid applications and 105,135 unique members had been enrolled. In 2008, the first year of program operations, the State received 120,313 total applications. Submitted applications dropped off in 2009 with 72,282 being submitted but picked back up again in 2010 with 117,252 submissions. The following year, 2011 saw 78,641 applications. The applications received in 2012 were substantially the same as 2011 and totaled 75,172.

¹⁴ Valid applications exclude duplicate and incomplete applications received. HIP Dashboard December 2012.

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The chart above shows the end of year enrollment trends for the first three years of the HIP program. The decline in non-caretaker enrollment and the increase in caretaker enrollment is apparent. 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. The program’s population is divided into caretaker and non-caretaker groups. As the program has progressed the percentage of caretakers ever enrolled has increased in comparison to the non-caretakers enrolled. For those ever enrolled in HIP in 2010 56% were caretakers and 44% were non-caretakers. By comparison, at the end of 2008 67% of enrollees were non-caretakers and 33% of enrollees were caretakers. As of the end of 2012, 66% (25,746) of enrollees were caretakers and 34% (13,255) were non-caretakers.¹⁵

Over the course of the HIP program the majority of members have been under 100% FPL. Member distribution by FPL in December 2012 is consistent with the previous trend: 70% of HIP enrollees are currently at or under 100% FPL. HIP has consistently averaged only 10% of enrollees over 150% FPL.

Table 1: HIP Enrollee Distribution by FPL¹⁶

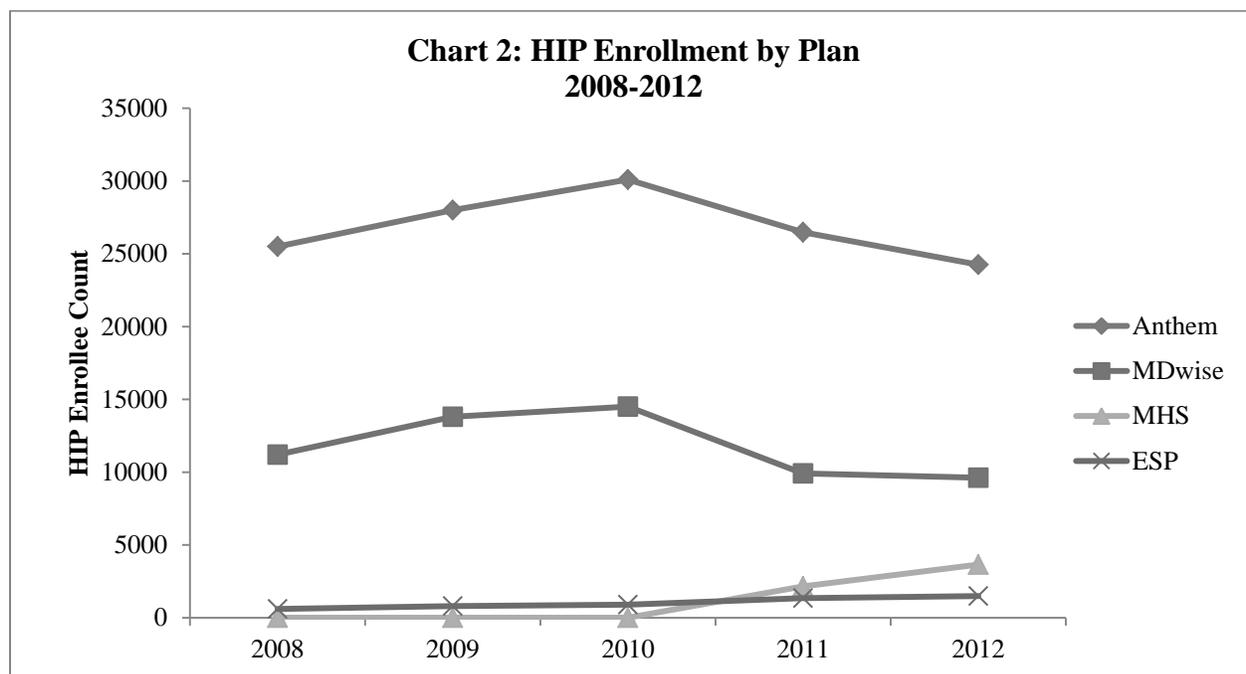
FPL	2008	2009	2010	December 2011	December 2012
<100% FPL	26,969 72%	41,795 71%	37,061 62%	27,533 69.0%	27,276 69.9%
101 – 150% FPL	6,955 19%	11,432 19%	13,849 23.1%	8,288 20.7%	7,767 19.9%
>150% FPL	3,620 10%	6,079 10%	9,015 15%	4,075 10.2%	3,966 10.2%
TOTAL	37,544 100%	59,306 100%	59,945 100%	39,896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

¹⁵ Annual data from annual HIP reports. August data from August HIP Enrollment Summary.

¹⁶ Data from HIP Annual Reports 2008-2010. HIP Dashboards December 31, 2011 and December 31, 2012.

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When found eligible, HIP members are able to select Anthem, MDwise or MHS as their plan, or they are placed into ESP if they identify that they have a high risk condition. Over the first three years of the program (2008 to 2010) between 68% and 70% of members have enrolled in Anthem, and 30% to 32% have enrolled in MDwise. With the changes to the ESP assignment process the percentage of HIP members enrolled in ESP increased from 1% to 3% between 2009 and 2010. This rate has held steady and in December of 2011 3.4% of HIP members were enrolled in ESP. The third demonstration year (2011) was the first year of the HIP program that had a third managed care option for members to choose from. At the end of 2011 approximately 5% of HIP members had selected the MHS and by the end of 2012 this had increased to 9%. In 2012, Anthem maintained 62% of HIP enrollment, the percent of members enrolled in MDwise dropped to 25% and the percent enrolled in ESP increased from 3% to 4%.



Over the course of the HIP program, member distribution by gender has been steady, though one gender has been predominant. At the end of the most current demonstration year (2012) 68% of enrollees are female and 32% of enrollees are male. Geographically, HIP members are distributed throughout the state, with higher concentrations in Indiana's population centers and overall enrollment reflects the population density of the state.¹⁷ 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.¹⁸ Over the course of the HIP program, the percentage of enrollees who identified as white averaged around 83% and the members who identified as black averaged 10% with Hispanic, Native American and others making up the remainder. Age distribution has also been relatively steady throughout the course of the program. To date, member age distribution has consistently skewed

¹⁷ HIP Year 3 Annual Report, Pg. 29-30.

¹⁸ HIP Year 1 Annual Report, pg. 20.

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towards more aged individuals with those under 30 representing the smallest proportion of HIP members.

Table 2: Percentage Member distribution by age

Age	2008	2009	2010	2011	2012
<30	19.3%	20%	15%	12.9%	12.0%
30-39	21.4%	25%	29%	29.9%	29.2%
40-49	26.6%	27%	28%	30.0%	30.0%
50+	32.9%	28%	28%	27.3%	28.8%

*Data from HIP Annual Reports 2008 – 2010 and HIP December 2011/December 2012 dashboards.

3.6 Benefit Limit

HIP includes an annual limit of \$300,000 in benefits and a lifetime benefit maximum of \$1,000,000. 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. This monitoring is to ensure that members are not denied needed services. If a member does reach, or come close to reaching these limits, an attempt is made at determining eligibility for traditional Medicaid. All members who have come within \$100,000 of, or reached, the \$300,000 annual benefit limit were transferred to ESP, Medicaid or other programs. The number of members that met these criteria in each demonstration year are displayed below. No members have met the lifetime \$1,000,000 limit.

Table 3: HIP Members at Benefit Limit

Year	Members at \$200,000	Members at \$300,000	Members at \$1,000,000	Total
2008	1		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 POWER Account Contributions

The POWER account, a unique feature of the HIP program, requires members to make upfront contributions to their health care costs. Based on FPL and caretaker status, contributions range from 2% to 5% of enrollee income and can be reduced by payments from an enrollee’s employer or from a not-for-profit organization. Over the course of HIP, there have been a percentage of individuals who do not contribute to their POWER accounts due to the way income is counted and offset during eligibility

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determination. For these members accounts are 100% state funded. The State did not intend for there to be any members who did not contribute to their POWER account, nor was this part of the original waiver negotiations. For 2008, approximately 35% of HIP enrollees did not contribute to their POWER account. Over the course of the program this percentage has been decreased and stabilized. For example, non-contributors represented in 21% of HIP enrollees in December 2010, 20.1% in December 2011, 20.6% in December 2012. This waiver renewal request includes modifications to the POWER account contributions to address the approximately 20% of members who do not contribute.

3.8 Disenrollments

Enrollees can disenroll from HIP at any time or be terminated from HIP for failing to pay a POWER account contribution, for failing to complete the redetermination process, or if it is found that the individual no longer meets eligibility requirements. Between 2008 and 2010 a total of 35,323 members left HIP. It was most common for enrollees to leave during the redetermination period approximately 12 months after being enrolled; 57% or 20,015 enrollees left the program within a month of the redetermination period. Of the remaining disenrollments, 6,199 (1,835 in 2008 and 2009 and 4,364 in 2010) members were disenrolled because they failed to pay a POWER account contribution. This represents 8% of HIP members ever enrolled in the program between 2008 and 2010. In 2011, only 1,843 of disenrollments were due to not making a subsequent POWER account payment. The remaining disenrollments from HIP would include pregnant women who are transferred to traditional Medicaid for the duration of their pregnancy (and then may reenter HIP afterwards) or member who become eligible for Medicaid disability as well as members who pass away or move out of State.¹⁹

Section 4: Summary of Quality Reports

As required under the STCs, the State has conducted an evaluation of the HIP program and has developed annual reports on the program. Mathematica Policy Research and Milliman have been contracted with to independently evaluate the quality of the HIP program. The 2010 annual report was submitted in June 2011 and discussed in detail the results of Mathematica's monitoring activities. The program shows noteworthy variations in care seeking behavior between contributors and non-contributors and caretakers and non-caretakers. While all of these groups respond to HIP incentives they have different ways of seeking care which the program continually investigates. A summary of these analyses are included in this waiver renewal application. The State continues to perform annual EQR reports.

Improves Access To Care:

- The HIP program appears to be meeting its goal to improve access to care for low-income Hoosiers enrolled in the plan. HIP provider networks are adequate. If there are any shortages with particular types of specialty (such as neurosurgeons), plans allow access to out-of-network providers. Data from Mathematica's 2010 survey of HIP members indicate that access to care improves after enrollment. Members are more likely to receive

¹⁹ Data from DMA Data Request #8790, ran October 18, 2012.

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preventive care and get prescription medications and report fewer unmet health care needs. In addition, the proportion of members reporting the ER as their usual source of care declines dramatically after enrollment in HIP. Mathematica surveyed the use of care in the last six months of new and established HIP members. The table below shows the difference in care utilization between new enrollees and established enrollees. Established enrollees use more primary and preventive services, prescription drugs, are less likely to use the ER and less likely to report the ER as their main source of care.

Table 4: Care Utilization between new enrollees and established enrollees²⁰

Care Utilized	New Enrollees	Established Enrollees
Primary Care	60%	90%
Preventive Care	28%	69%
Prescription drugs	54%	80%
ER	38%	32%
ER as main source of care	30%	9.2%

- Mathematica continues to document that 90 percent of HIP members have a physician visit within 12 months of enrolling.
- A Milliman analysis of HIP enrollee service utilization for the first 18 months of the program compared HIP enrollees to comparable Medicaid and commercial populations. HIP incentives for members to seek preventive care have demonstrated success. Individuals enrolled in HIP had higher preventive care visits than Indiana’s HoosierHealthWise (HHW) Medicaid population. The HIP Caretaker population had 445.4 well-care visits per 1,000 enrollees, and the non-caretaker population had 281.8 well-care visits per 1,000 enrollees compared to HHW adults 195.3 visits per 1,000 enrollees. This analysis indicates that HIP Caretakers seek preventive care more frequently than comparable commercial populations and non-caretakers seek preventive care at rates similar to comparable commercial populations.

Table 5: Preventive Care Utilization (January 2008-June 2009)

Population	Well Care Visit (utilization rate per 1,000)
HHW- Adults	195.2
HIP-Caretakers	445.4
HIP- Non-Caretakers	281.8
Commercial (Adult only) (1)	354.8
Commercial (Adult only) (2)	306.2
Ohio Medicaid Adults	352.7

(1) Age / Gender adjusted to HIP – Caretaker population

(2) Age / Gender adjusted to HIP – Non Caretaker population

²⁰ Healthy Indiana Plan Section 1115 Annual Report: Demonstration Year 3 (2010), pg. 38. Submitted June, 2011.

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- The State monitors member access on a monthly basis including evaluating health plans primary and specialty care networks. Member access is examined on distance from primary and specialty care providers, access to hospital care, and appointment wait times. Mathematica reports that with enrollment in HIP utilization of health care services increased and unmet need declined.

Increases Knowledge of Health Care Spending:

- Data from Mathematica's 2010 survey of HIP members indicate that most survey respondents were aware of their POWER account, believed that they had been given adequate information about the account, and knew where to look for more information if they needed it. Approximately 60% reported knowing the balance of their POWER account and 45% reported checking their account at least monthly, important first steps of cost conscious consumers.²¹
- A 2009 Product Acceptance Research (PAR) telephone survey of HIP members found that six in ten respondents now think differently about how or where they get health care since enrolling in HIP and that one-third have asked the cost of a medical procedure or service before receiving treatment.

POWER Account/Consumer Directed Plan Does not Discourage Participants from Seeking Needed Care:

- Mathematica's analysis of utilization shows that members are accessing services and that the POWER account contributions do not discourage participants from seeking needed healthcare. As individuals remain enrolled in HIP, they move away from seeking routine care in the ER and begin seeking care in physicians' offices. Over 12 months of enrollment, on average HIP enrollees show a 14.8% decline in non-emergent ER use and a 25% increase in physician office visits. No evidence was found suggesting that HIPs consumer based structure discourages enrollees from seeking needed care. Additionally, a Mathematica survey of HIP members found that approximately 70% of enrollees indicated that the monthly contribution was just the right amount and something they could afford. Another 7% thought they could afford a monthly contribution that was a little higher than the current amount. In contrast, approximately 8% thought the monthly contribution was far too high.
- At its conception, the HIP program intended to have all members contribute to their POWER account; however, due to the way income is calculated and the lack of a program requirement for a minimum contribution, since 2010 approximately 20% of enrollees have not been required to contribute to their POWER account. This has led to an opportunity to analyze possible differences in care seeking behavior between contributors and non-contributors. Contributors have lower rates of ER use from the beginning of their

²¹ Healthy Indiana Plan Section 1115 Annual Report: Demonstration Year 3.

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enrollment in HIP. Over 12 months of continuous enrollment 35% of contributors visit the ER with 24% visiting the ER at least once for a non-emergent visit. Non-contributors visit the ER more frequently; 57% visited the ER and 34% of non-contributors enrolled for 12 months continuously had a non-emergency ER visit. Non-contributors also experience fewer gains in than contributors in physician office visits; for contributors physician office visits increase by 26% over 12 months of enrollment and for non-contributors it increases by 22%.²²

Table 6: HIP Members Service Utilization

Over 12 Months of continuous enrollment:	Contributors	Non-Contributors
Any ER Visit	35%	53%
Any Non-Emergency ER Visit	25%	34%
Increase in Physician Office Use	26%	22%

Whether contributing to a POWER account has a direct effect on care seeking behavior remains under investigation. Non-contributors have unique care seeking behavior and are overall more likely to visit an ER than contributors. This may be influenced by their contributor status, however, for all enrollees, the HIP program works over the course of enrollment to decrease non-emergency ER use and increase physician office use.²³

- A Milliman analysis of the first year of Anthem’s experience with HIP showed that after adjusting for morbidity differences non-contributors have higher expenditures than contributors. The non-contributor caretaker population had 3.5% increased expenditures over the contributor caretaker population and the non-contributor non-caretaker population had expenditures 13% higher than the non-contributor non-caretaker population.²⁴

Currently, HIP is a fully functioning program achieving several of its goals including: improving access to care for low-income Hoosiers; promoting preventive care among most HIP members; providing quality of care; achieving high levels of member satisfaction; and maintaining the program’s fiscal soundness. Enrollment patterns continue to indicate that upon entry to the HIP program, most members remained enrolled for a full year or more. Steady enrollment provides opportunities for HIP and the health plans to (1) give members guidance on how to use health care services appropriately and (2) reap the benefits of initiatives that promote the use of preventive care, disease management programs, and case management services. It also means that members have an opportunity to benefit from responding to program incentives.

²² Mathematica Data Preview, December 2nd, 2010.

²³ Data in this paragraph: Mathematica data supplement for the HIP Year 3 Annual Report: December 2, 2010.

²⁴ Milliman report to HIP Taskforce: August 7th, 2009.

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4.1 Progress on Program Goals

Goal 1: Reducing the number of uninsured low-income Hoosiers

- HIP seeks to reduce the number of uninsured low-income Hoosiers. HIP has been providing an important safety net for its members who would have been uninsured otherwise. Given the expected limited revenue from the State cigarette tax, HIP was not intended to cover all Hoosiers below 200% of FPL. As of December 31, 2012, HIP has served 105,135 Hoosiers.
- Although the overall uninsured rate among low-income working-age Hoosiers did not change between 2008 and 2009, data suggest that uninsured rates among caretakers declined by 4%. At the same time, Medicaid coverage rates among low-income caretakers increased by 7.1%. Those with income below 150% of the FPL experienced declines in their uninsured rates. For example, working-age adults with income between 101% and 150% of FPL saw their uninsured rate decline by 2.6% between 2008 and 2009 while their Medicaid coverage rate increased by 4.3%. The increase in Medicaid coverage rates among low-income adults who are typically not eligible for Medicaid unless they have a disability, suggest that during the economic downturn, Medicaid, including the HIP program, was moderating any increase in uninsured rates.
- Between 2009 and 2011 Indiana's uninsurance rate for individual between 18 and 65 is estimated to have declined slightly. In 2009 aggregate data indicates approximately 734,000 adults were uninsured (18.8% of population over 18 and under 65) and in 2011 this estimate had decreased to 671,000 (17.3% of the population over 18 and under 65). No direct analysis has been conducted to indicate HIP directly impacted this decline in the number of uninsured working age adults in Indiana, however, HIP coverage may have been a factor in this decrease.²⁵

Goal 2: Reduce barriers and improve statewide access to health care services for low-income Hoosiers

- Plans report that all HIP members, in all health plans, have access to a primary medical provider (PMP) within 30 miles of their homes.
- All plans continue to work on their specialty networks; deficiencies are few, and plan administrators think problems with certain specialties are due to general medical shortage areas, or inadequate numbers of providers for the population as a whole in some regions of Indiana.
- A 2010 Mathematica survey of HIP members suggests that access to care improves after enrollment into HIP. Using respondents who had only enrolled in HIP in the previous month and their access to care while uninsured as the control against which the success of HIP is judged, the survey data indicate that HIP members are:
 - More likely to have a PMP and more likely to use a doctor's office or clinic as their usual source of care rather than the ER,
 - More likely to receive preventive care, acute care, specialty care, and prescription medications, and
 - Less likely to have an unmet need for care.
- All plans are required to submit access reporting annually along with a geo-access map of provider locations. If a plan does not have the necessary access as outlined in the scope of work,

²⁵ Data based on 2012 Census Bureau release.

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the plan must submit the reporting on a monthly basis and outline efforts to increase access. At this time, all plans are meeting the access requirements.

Goal 3: Promote value-based decisions making and personal health responsibility

- HIP uses several financial incentives to encourage members to become thoughtful health care purchasers and active participants in maintaining or improving their health. These incentives begin upon enrollment, when most HIP members are required to contribute to the cost of their care by making monthly payments to their POWER accounts. Findings to date suggest that:
 - As of the end of 2012, nearly four of every five HIP members made a contribution to their POWER account.
 - Utilization differences have been noted between contributors and non-contributors. Non-contributors have 66.8 non-emergent ER visits per 1,000 members while contributors have 34.7 non-emergent ER visits per 1,000 members. The non-contributing population in general suffers from higher morbidity, however, the POWER account contributions and the influence of consumerism cannot be ruled out as factors contributing to this vast difference in utilization.²⁶
 - Survey data collected by Mathematica in 2010 suggest that the majority of respondents knew key features of the program. For example, 81% of established HIP members were aware of their POWER account, 71% of these believed that they had been given adequate information about the accounts, and 95% knew their monthly contribution amount.
 - Over the first two years of the HIP program only 3% of enrollees were disenrolled for failing to pay their POWER account contribution. The disenrollment rate increased over the third year with 4,364 individuals being disenrolled in year three. This was more than twice the number of individuals disenrolled for failure to pay a POWER account contribution for the first two years of the program. The number of individuals disenrolled for failure to pay a POWER account contribution in 2011 was more consistent with the first two years of the program with 1,843 individuals not making a subsequent POWER account contribution. Over the first four years of the program 9% of total enrollees have been disenrolled for failure to pay a POWER Account contribution. Over half of total disenrollments occurred in 2010 which appears to be an outlier. It is expected with further years' data on disenrollments due to failure to pay a POWER account contribution that the percentage for the life of the program will decline.
 - HIP member eligibility is redetermined annually. Enrollees are required to complete a redetermination packet and return it in a timely manner. A Mathematica analysis for the first two years of the program showed that 85% of HIP enrollees returned redetermination packets on time. This percentage has increased through the life of the program and the most recent year of the demonstration, 2012, at least 92.33% of enrollees submitted their redetermination packet on time.

²⁶ Data from Mathematica Data Enclosure, December 2010.

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Goal 4: Promote primary prevention

- A large proportion of HIP members obtain primary care services. Given that most HIP members stay enrolled in the program, and only some are cycling on and off, HIP and its health plans should see benefits in promoting the receipt of appropriate preventive care. HIP encourages the use of preventive services by providing first dollar coverage for preventive services. Preventive services up to \$500 are not subject to the deductible and members do not have to draw on their POWER account funds. HIP also ties POWER account rollovers, and reductions in future monthly contributions, to the completion of required preventive care.
 - Roughly 90% of HIP members who started eligibility periods in 2008 and 2009 and stayed continuously enrolled for 12 or more months had a physician office visit of any type.²⁷
 - Service records for the seven different preventive services the Office of Medicaid Policy and Planning (OMPP) required for full rollovers consistently indicate that the majority of HIP members received some type of preventive care during their first year of enrollment.
 - Analysis of the first 18 months of HIP shows that members have greater rates of preventive care use than the HHW Medicaid population. Over this period, for every 1,000 enrollees HIP had 445.4 caretaker preventive visits and 281.8 non caretaker preventive visits while the HHW population had 195.2 preventive visits per 1,000 enrollees. HIP preventive use in caretakers is greater than similar commercially insured populations and the use in non-caretakers is comparable to a similar commercially insured population.²⁸
 - Considering only services obtained in the first six months after enrollment in the HIP program, encounter claims records indicate that 2009 members obtained preventive care more quickly. For example, within the first six months of enrollment, 41% of young (ages 19-34) female 2008 members had received at least one recommended preventive service. Among 2009 members, 46% of females met this criterion within the first six months of enrollment.²⁹
 - To promote preventive care, the health plans are pursuing a number of different strategies, including member mailings, newsletters, telephone outreach, and support. The ESP administrator implemented a new care coordination program in 2010.

Goal 5: Prevent chronic disease progression with secondary prevention

- By lowering cost and access barriers to care and activating members to be more engaged patients, HIP aims to slow disease progression among members with chronic conditions. Analyses to date indicate that:

²⁷ HIP Year 3 Annual Report, (June 2, 2011).

²⁸ Milliman Data, Presentation to Governor March 23, 2010.

²⁹ HIP DY 3 (2011) Annual Report.

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- Chronic disease is prevalent among members. More than a quarter of those enrolled from January 2008 through June 2010 have been diagnosed with pulmonary, skeletal and connective tissue, cardiovascular, metabolic, or skin diseases. In addition, more than 40% of members have been diagnosed with or treated for psychiatric conditions, including non-chronic depression.
- Non-caretakers were more likely than caretakers to be diagnosed with chronic diseases and are nearly twice as likely to be diagnosed with conditions that are considered to be medium or high cost (24 versus 13 percent), which is consistent with the age differences between these two groups.
- The health plans continued to use several strategies to manage the chronic conditions of their members, including telephone support, disease management programs, and online tools.
- Analysis conducted by Milliman shows that while HIP enrollees experience significant chronic disease burden, that during enrollment in the program use of prescription medication increases and inpatient, outpatient, emergency room usage, and physician services decline. This suggests that HIP members are managing their chronic conditions with prescription medication and, as a result, need fewer direct health services.

Goal 6: Provide appropriate and quality-based health care services

- A critical goal for HIP is to provide appropriate and quality-based health care services and HIP appears to be achieving this goal.
 - Overall satisfaction appears to be high among HIP members. Respondents to the CAHPS surveys administered by the health plans report high levels of satisfaction with their plans—levels that, in most cases, are comparable to or higher than national averages for Medicaid plans. For example, Anthem’s plan average composite score for customer service (which includes the percent reporting they always or usually got information they needed from the plan’s customer service line, and the percent reporting they always or usually were treated with respect by customer service staff) was 89.3 %, a statistically significant difference from the 2011 national average score of 79.7 % putting them in 90th percentile. Likewise, 83.6 % of MDwise members were always or usually satisfied with their experiences with receiving care and getting appointments in a reasonable time, also a statistically significant difference from the 2011 national average. 2011 was the first year data was added from MHS CAHPS results and it is positive to note that, similarly, 83.7 percent of MHS members were always or usually satisfied with receiving care and getting appointments in a reasonable time (“getting care quickly”).
 - Mathematica’s 2010 survey of HIP members also indicates high levels of satisfaction with the HIP program overall. Approximately 87% of respondents who were new to

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HIP and 97% of respondents who were established were “Very Satisfied” or “Somewhat Satisfied” with the HIP Program.

- Data from the State’s Intranet Quorum, the State’s issue management system, are consistent with the CAHPS data and do not indicate that members have any serious concerns about the performance of the plans.

Goal 7: Assure State fiscal responsibility and efficient management of the program

- The HIP program continues to meet its budget neutrality requirements. According to the estimates by the program’s actuary, Milliman Inc., the State had a waiver margin of \$94 million during the first year of the demonstration,³⁰ which exceeded the projected waiver margin of roughly \$28 million for that year. The HIP achieved this margin despite enrolling more non-caregivers than had been projected. The large margin resulted from the savings achieved for the HHW populations (3 to 6 percent over the projected per member per month (PMPM) rates for this group) and the substantial savings achieved for the HIP caregivers (16 percent over the projected per member per month rate).
- The enabling state legislation requires HIP to be a fiscally sound program. As of the end of calendar year 2012, the HIP program appeared to be achieving this goal. State documentation indicates that:
 - The HIP program continued to meet its budget neutrality goals as of the end of 2012.
 - Contract negotiations with the health plans address the costs of care.
 - Analysis of the funding mechanisms for HIP finds that state funding was adequate during the program’s first five years. Cigarette tax revenues, while declining, were sufficient to meet the program’s needs, and the proportion of HIP members contributing to their POWER accounts remains steady.

4.2 Future Goals of the Demonstration

If the program continues, 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 to investigate the effects of consumer directed health plan design on enrollee care seeking behavior. The State expects that changes to HIP due to modifications to IC 12-15-44.2 that allow plans to make payments to POWER accounts as disease management incentives may positively impact enrollee behavior. The impact of these contributions on enrollee care seeking behavior will be studied. The State will also study the impact of the required minimum contribution on enrollment and care seeking behavior.

4.3 Health Plan Performance-External Quality Review

In 2010, Burns & Associates, Inc. conducted an external quality review (EQR) of Anthem and MDwise for calendar year 2010. The EQR assessed the performance of the health plans in six areas: (1) cultural competency initiatives, (2) program integrity, (3) accessibility and availability of providers, (4) retrospective authorizations, claim denials, and claim disputes, (5) validation of performance measures,

³⁰ The waiver margin is the difference between expenditures and the spending limit established in the STCs.

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and (6) validation of performance improvement projects. Plans were assessed independently, and assessments were made for both HIP and HHW programs. OMPP continues to contract with an EQR assessor and results are made available to CMS.

Overall, the EQR found that both plans were fully compliant in the areas assessed. The following outlines some important findings and recommendations:

- Both Anthem and MDwise have undertaken numerous initiatives related to cultural competency, but the EQR recommended that the plans utilize the U.S. Department of Health and Human Service's Office of Minority Health's Culturally and Linguistically Appropriate Services (CLAS) standards as a tool to ensure that their cultural competency work plans follow these recommended guidelines. In addition, the EQR recommended that Anthem make more materials available in Spanish, and that both plans better use the race and ethnicity data from OMPP in conjunction with claims data to better target health disparities within the HIP population. Anthem has submitted and OMPP has approved additional materials in a Spanish format. All plans have reported that they maintain race and ethnicity data in their respective systems. The Culturally and Linguistically Appropriate Services (CLAS) standards were implemented with re-bid in 2011. The plans have done internal gap analysis to identify and meet the standards.
- Both plans are following credentialing and recredentialing policies and procedures for HIP, and in early 2010, both plans placed a renewed emphasis on investigating fraud and abuse cases. For example, the plans expanded staff assigned to investigations, and increased the number of investigations they conducted in 2010. They also recommended that since the investigations team is newer at MDwise, that MDwise adopt an ongoing training schedule, similar to what Anthem uses.
- Few clinical issues were disputed in either retroactive authorization or claims disputes, except in ER cases where the 'prudent layperson' rule was cited (and in those cases, the EQR agreed that these denials were made appropriately in cases where they had adequate records to assess this). In addition, most claims denials occurred for administrative reasons, usually because the service was out-of-network or the provider submitted the claim dispute too late (both HIP plans use a "60 day" rule for filing a claim dispute, which complies with the State's administrative rule [405 IAC 1-1.6]). Although the EQR recognized that 'out-of-network' and untimely filing of claims are legitimate reasons for a denial, they suggested that more education, aimed at members about the differences between in- and out-of-network services, and at providers on the timeframe required to dispute claims, is needed. The use of in-network services and the importance of a PMP have been further highlighted throughout the updated member handbooks. Provider education on claims submission is offered by the plans as well as the State's fiscal agent.
- Reviews of the validity of the processes used to report four performance measures in HIP found the data used by the plans appeared to be valid, but the EQR did suggest that improvements could be made. For example, the data reported in Anthem's and MDwise's

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provider claims dispute reports appeared to be valid, but there were different interpretations between the plans as to what information to provide in the report, so that the results cannot be compared between the plans. OMPP updated the reporting manual for 2011 to further identify and define the needed information for this report. OMPP has been working with the plans to ensure that the information is comparable across plans.

The EQR report does 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. For example, Anthem's newly hired staff to investigate fraud and abuse was cited as having a very strong process for handling investigations, and among the HHW and HIP plans, "...best illustrated to the EQR how the results from Special Investigations Unit investigations often get fed back as improved processes on the front end to other parts of the organization to prevent fraud and abuse." MDwise was cited for its cultural competency programs, including that MDwise "releases all of its materials in English and Spanish, avoiding the need for Spanish-speaking members to have to specifically request these materials."

After the release of the EQR report in November 2010, the plans took steps to address EQR recommendations regarding provider education. For example, MDwise is providing additional provider education through one-on-one contact and through newsletters. In 2011, Anthem began distribution of a new member handbook for the HIP and HHW programs, and the plan also began sending letters to any provider treating an Anthem member who is in the plan's case management or disease management program, to try to improve care coordination.

Section 5: Requested Program Changes

During the 2011 legislative session, the Indiana legislature passed IC 12-15-44.2 and made changes to HIP; additionally, further guidance and analysis supports minor changes to HIP. The State seeks waiver authority to implement both legislative changes and the changes stemming from recently released guidance. These changes include:

- Requirement for HIP enrollees to make a minimum contribution of \$160 annually, or \$13.33 per month. This requirement is limited by income and no enrollee will pay more than 5% of income towards health costs.
- Ability for health plans to contribute towards members' POWER accounts as incentives for healthy behavior.
- Reduction of the HIP eligibility level to 138% FPL to reduce overlap between HIP and Exchange coverage
- Elimination of the requirement to be uninsured for 6 months or to not have access to employer sponsor insurance as eligibility factors.
- Modification of co-payments for non-emergency use of the emergency room to align with January 2012 Notice of Proposed Rulemaking (NPRM).
- Modification to the State's budget neutrality agreement based on its experience to date and proposed changes.

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5.1 Requested Change: Minimum Contribution

During the original negotiations with the CMS, it was presumed that all individuals would be making a POWER Account contribution, and the amount of the sliding scale was adjusted to ensure that no individual exceeded the 5% of income limit on cost-sharing, including consideration of CHIP premiums. However, after applying the CMS rules of how income is counted, there were individuals who did not make contributions. On average over the life of the program, HIP has approximately 20% of participants that are not making contributions to their POWER account and this number has been as high as 35%. During the 2011 session, the Indiana General Assembly passed legislation to correct this issue and instituted a minimum contribution of \$160 (IC 12-15-44.2-11).

The sliding scale to calculate member contributions will still be in place, and the legislation limits the minimum contribution to the sliding scale that is in the original waiver. Members will be required to contribute their minimum monthly contribution (\$13.33 a month) until they meet the sliding scale limit. The State will also consider all contributions being made by the household including CHIP and Medicare premiums in calculation of the 5% contribution limit. This assures that no individual exceeds the CMS limit of 5% cost-sharing. Once the sliding scale percentage limit is met the State will fund the account. Please see Section 8 on cost sharing for detailed plans to ensure these individuals do not exceed the applicable percentage of income limiting their contributions. For HIP members that do not currently pay a POWER account contribution, the State has developed a plan to transition them to contributing enrollees. Please see the transition plan under Section 9 for more detail.

5.2 Requested Change: Managed Care Entity Contributions

While the 2013 waiver extension notice granted Indiana's request to allow not-for-profit entities to make contributions into the POWER account, CMS did not indicate if MCEs can make contributions to the POWER account. The 2011 legislation at IC 12-15-44.2 also allows for the HIP contracted MCEs to contribute to the individual's POWER account. Contributions must be linked to a health related incentive, such as completion of a risk assessment or participation in a smoking cessation program. Again, the original drafters had intended to allow the MCEs to provide health related incentives to individuals through the POWER account. However, the legislation did not specify this and therefore all health related incentives have been paid or given directly to individuals outside the POWER account. Allowing MCEs to pay health incentives to the POWER account aligns with HIP's philosophy and should strengthen the incentive for individuals to invest in health promotion efforts. The new legislation indicates that MCE contributions cannot reduce the individual's required minimum contribution or be greater than HIP's \$1,100 deductible. However, this option allows MCEs to offer financial incentives through the POWER account to members for positive health behaviors. Allowing MCEs to contribute to the POWER account is in line with program goals of harnessing consumerism to improve health behaviors and allows members the chance to earn additional subsidies to their POWER account.

5.3 Requested Change: FPL Adjustment

The Supreme Court of the United States declared that the expansion of the Medicaid population authorized under the PPACA is optional and up to the discretion of the State. At present, the State of Indiana has not determined if it will participate in this expansion. Indiana's 2011 HIP legislation reduces the HIP eligibility threshold to 138% FPL (133% with 5% income disregard), for enrollees that are not

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eligible for Medicaid under another category (such as aged, blind, or disabled populations, pregnant women, children, etc.). This will assure there is limited overlap with the tax credits available through the Exchanges. Please see the eligibility information in Section 6 for more details on Medicaid and HIP eligibility and the transition plan in Section 9 for more details on the process for transitioning to the revised FPL limit.

To bring HIP in line with PPACA requirements, it is the State's intent to change HIP eligibility from 200% FPL to 138% FPL (133% with 5% income disregard) effective January 1, 2014. Eligibility would be maintained to 200% through 2013 and the State would begin the transition to 138% FPL in October 2013 at the time of Exchange open enrollment. If the state elects to expand Medicaid, HIP coverage will begin in January 2014 for non-caretaker adults who enroll during the open enrollment period (see Section 9 for the Transition Plan).

A reduction of the eligibility threshold to 138% of FPL is not expected to adversely impact a large percentage of HIP members. While data is not presently available for the precise number of HIP enrollees over 138% FPL, in December 2012, 10% (3,966) of HIP members were over 150% FPL and 8% (3,165) were between 125% and 150% FPL; the vast majority of HIP members (82%) are under 125% FPL and will not be affected by this change. For those members who will be transferred from HIP to subsidized commercial products on the Exchange, the State has developed a plan to aid HIP enrollees in this transition. Please see the transition plan at Section 9 for more details.

5.4 Requested Change: Benefits

The new legislation provides the Secretary of the Indiana Family and Social Services Administration the ability to adjust the HIP benefits to be in line with the new benchmark benefits. At this time, we are not requesting any changes to the current HIP benefit package. Based on the State Medicaid Director Letter issued November 20, 2012 addressing the Essential Health Benefits (EHB) Benchmark requirements for the Medicaid program, a preliminary analysis of HIP benefits and the EHB requirements was completed and limited variance was found. The State requests additional guidance around the expectations for the Alternative Benefit Plan analysis for Secretary Approved coverage. In addition, while the State is not currently requesting changes to the benefit plan, we would like to add pregnancy coverage to HIP. It is understood that while initially excluded from HIP by the enabling legislation, that maternity coverage is a requirement under plans covered by EHB. The addition of pregnancy coverage would gain administrative and program efficiencies by eliminating the process that requires members to transfer from HIP to pregnancy Medicaid for the duration of their pregnancy. These topics are discussed in more detail in section 7.

5.5 Requested Change: Cost-sharing

The NPRM covering Medicaid premiums and cost-sharing published in the Federal Register January 22nd 2013 modified the amount that can be charged for non-emergency use of the ER. Encouraging appropriate ER use is a key goal of the HIP program and HIP has included co-payments for non-emergency use of the ER since inception. Previous co-payments for non-emergency use of the ER

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ranged from \$3 to \$25 depending on caretaker status and income. To align with the proposed rule, we request approval to change HIP co-payments for non-emergency use of the ER to \$8 per visit or the CMS updated rate for years after 2015. The flat rate for all enrollees is expected to bring some simplification to program administration. As indicated by the proposed rule, this co-payment will apply to all covered individuals in HIP. As is specified by HIP enabling legislation, POWER Account contributions may not fund HIP co-payments for non-emergency use of the ER.

5.6 Requested Change: Eligibility Factors

To align with PPACA requirements, the 2011 legislation that updated HIP removed the requirements that to be eligible for HIP an individual has to have been uninsured for at least 6 months and not have access to employer sponsored insurance. Per the modified legislation, these are only eligibility factors for HIP through December 31st, 2013 and we request they be removed as an eligibility factor for HIP starting in 2014.

5.7 Requested Change: Budget Neutrality

Since HIP extended coverage to non-caretakers that are not currently eligible for Medicaid, the original HIP demonstration project included a budget neutrality agreement. The State based its budget neutrality agreement on diverted Disproportionate Share Hospital (DSH) funding, savings projects, and limited expenditure growth in the HHW population. As a result, CMS agreed to allow the State to cover 34,000 non-caretakers. This number was adjusted in 2009 to 36,500 and remains at this level through the current demonstration year. The 2013 budget neutrality agreement does not divert DSH and the savings projects are complete.

The HIP program continues to meet and exceed its budget neutrality requirements and therefore the State requests an adjustment to reflect the current scenario, and also to adjust for the PPACA changes. Due to the savings projects the State implemented, the waiver margin has far exceeded projections and requires adjustment. In addition, since non-caretakers are now eligible for Medicaid, the State requests bringing non-caretakers to the "without waiver" side of the equation, starting in 2014. We have prepared the budget neutrality documents to reflect 2014-2016 and these are included as an attachment.

As of January 1, 2014 all individuals under 138% FPL will become eligible for Medicaid, regardless of caretaker status, therefore the State requests that non-caretaker adults be treated similar to the caretaker adults, in the budget neutrality agreement starting in 2014 and not subject to an enrollment cap. As discussed in section 6.6 HIP legislation limits program enrollment to what can be supported by available funding.

Indiana proposes to continue the agreed trend from the original demonstration project for the HHW population through the waiver demonstration period. Please see the financing attachment for the specifics on the requested changes to the budget neutrality agreement.

Section 6: Eligibility

For the current demonstration extension period from January 1, 2013 to December 1, 2013 HIP eligibility will continue to extend to 200% FPL. Individuals will be HIP eligible if they are between 19 and 64 years

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of age, have been uninsured for at least 6 months, are not otherwise eligible for Medicaid, and do not have access to employer sponsored insurance. In order to prepare for the PPACA, as directed by IC 12-15-44.2, the State proposes to begin to make eligibility changes to coordinate with the PPACA provisions starting on 10/1/2013. From 1/1/2013 to 9/30/2013 income for new applicants and redeterminations will be calculated using the current income calculation process. The final eligibility regulation states that it is considering allowing states to convert to modified adjusted gross income (MAGI) prior to 2014 using an 1115 demonstration. The HIP demonstration would like to take advantage of this opportunity. To coordinate with Exchange open enrollment periods, income for new HIP applicants will be calculated as of 10/1/2013 based on MAGI. This waiver requests changing eligibility to 138% FPL as of January 1, 2014; however, from 10/1/2013 to 12/31/2013 HIP applicants will continue to be eligible to 200% FPL based on MAGI. The regulation also prevents individuals from being excluded for coverage due to a MAGI calculation prior to March 31, 2014. Indiana believes that implementing MAGI for HIP consistent with the open enrollment period increases operational effectiveness; however, to maintain consistency with the proposed regulation, Indiana will allow individuals found ineligible, to also be reviewed based on the current eligibility process between October 1, 2013 and March 31, 2014.

The State will prepare to transition HIP members that are above 138% FPL to the Exchange (federal or state). Indiana proposes to schedule a special redetermination period for all HIP enrollees whose current eligibility information indicates they are over 138% FPL in January, 2014. At this point all enrollees will have their eligibility redetermined based on MAGI; please see the transition plan in Section 9 for more details.

6.1 Populations Ineligible for HIP

Individuals eligible for services under traditional Medicaid are described below in Table 7. None of these populations will participate in HIP and therefore, none of these populations will have POWER accounts.

Table 7: 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 towards the cost of care 1902 (f)

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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)

6.2 Populations Eligible for HIP

The populations described below in Table 8 are the current HIP eligible populations that will be covered through October 2013. Due to PPACA implementation and changes to IC 12-15-44.2 eligibility for HIP will change between 2013 and 2014, if the waiver is approved. Table 9 notes the revised eligibility that will be effective 1/1/2014. Details about how these eligibility changes will be implemented can be found in the transition plan.

Table 8: HIP Program Eligibility January 1, 2013 to December 31, 2013.

Description	FPL and/or other qualifying criteria *MAGI income calculation begins 10/1/2013 consistent with Exchange open enrollment period	Demonstration Eligibility Group
Demonstration Eligible Groups January 1, 2013 to December 31, 2013		
Custodial parents and caretaker relatives currently excluded from the Medicaid State plan who have been uninsured for at least 6 months, and who are not otherwise eligible for comprehensive Medicaid benefits or Medicare.	Income up to the AFDC income limit for the particular family size as indicated in the State Plan with resources in excess of \$1,000	Parents and Caretakers
Custodial parents and caretaker relatives of children eligible for Medicaid or CHIP who have been uninsured for at least 6 months, and who are not otherwise eligible for comprehensive Medicaid	Income above the AFDC income limit for the particular family size as indicated in the State Plan and up to and including 200% FPL; no resource limit.	Parents and Caretakers

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benefits or Medicare.		
Non-custodial parents and childless adults (19-64) who do not meet the criteria of HIP Caretakers, who have been uninsured for at least 6 months, and who are not otherwise eligible for comprehensive Medicaid benefits or Medicare.	0% FPL through 200% FPL; no resource limit. At no point in time may the number of individuals exceed 36,500.	Non-caretaker Adults

October 1, 2013 the State will begin to determine eligibility based on MAGI. Non-caretakers who meet the criteria for Medicaid eligibility under the PPACA, but who cannot enroll directly in HIP due to the non-caretaker enrollment cap will be enrolled in HIP coverage effective January 1, 2014. The requirements that an individual have been uninsured for at least six months and not have access to employer sponsored insurance are removed from the HIP eligibility criteria effective January 1, 2014. Individuals who apply between October 1, 2013 and December 31st, 2013 and are otherwise eligible but ineligible due to these criteria will be granted coverage effective January 1, 2014.

Table 9: Healthy Indiana Plan (HIP) Program Eligibility January 1, 2014 to December 31, 2015

Description	FPL and/or other qualifying criteria	Demonstration Eligibility Group(s)	Consistent with below group(s) prior to January 1, 2014
Demonstration Eligible Groups January 1, 2014 to December 31, 2015			
Adults ages 18 to 64 who are not otherwise eligible for comprehensive Medicaid benefits or Medicare.	Income under 138% FPL per the Modified Adjusted Gross Income (MAGI) guidelines with 5% disregard, payment of POWER account contribution, no resource limit	Adults (As described in the final rule at 42 CFR 435.119 “the adult group”, parents/caretakers below 23% FPL will not be in HIP.)	Parents and Caretakers, Non-Caretaker Adults

6.3 Eligibility Exclusions

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

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- Those eligible for comprehensive Medicaid under the State Plan (see Table 9) with the exception of the forthcoming family planning option.
- Those eligible for Medicare.
- Pregnant woman for the purpose of pregnancy related services.
- Those otherwise eligible for Medical assistance.
- Those with income in excess of 200% FPL.
- Those who have had insurance in the past six months.
- Those have access to an employer-sponsored health plan.
- 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.

As described in sections 5.3 and 5.6 this waiver renewal request includes changes to the eligibility criteria for the HIP program. If these requests are granted, beginning in January 2014 individuals over 138% FPL based on MAGI will no longer be eligible for HIP and individuals who have been insured in the last 12 months or have access to an employer-sponsored health plan will not be excluded from HIP eligibility. Assuming these requested changes are granted, the below individuals will be excluded from HIP coverage starting January 2014.

- Those eligible for another Medicaid category under the State Plan (see Table 9), with the exception of the forthcoming family planning option.
- Those eligible for Medicare.
- Those otherwise eligible for medical assistance.
- Those with MAGI in excess of 138% FPL (133% with 5% disregard).
- They are excluded from HIP eligibility for 12 months if they fail to pay a POWER account contribution within 60 days; not inclusive of the first POWER account contribution.

Currently the HIP enabling legislation excludes pregnant woman for the purposes of pregnancy related services as these individuals are transferred to pregnancy Medicaid to receive these services. As discussed in sections 5.4 and 7, we have outstanding questions about maternity coverage in HIP and seek guidance on this topic. If pregnancy coverage is added to HIP then pregnant woman will no longer be excluded from the program beginning in 2014. However, if HIP remains without a maternity benefit as is currently the case, then the current process will remain and those in need of pregnancy related services will be transferred to pregnancy Medicaid.

To align with the Exchange enrollment period, starting October 1, 2013, the State will begin to use MAGI income calculation to determine HIP eligibility. Between October 1, 2013 and December 31, 2013 HIP applicants disqualified from HIP coverage due to access to employer-sponsored health plans or insurance in the last six months but otherwise eligible for HIP will be enrolled in HIP coverage effective January 1, 2014. During this same period, non-caretakers who cannot be immediately enrolled due to the enrollment cap will be granted coverage effective January 1, 2014 and placed on the waitlist.

The State submitted a family planning option State Plan Amendment (SPA) per the direction of the Indiana General Assembly and this SPA has been approved. Enrollment in family planning only services

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category (MA E) began January 1, 2013. HIP eligibility indicates that a person cannot be eligible for other Medicaid programs. The family planning aid category eligibility criteria will overlap with the HIP eligibility criteria. Therefore, we wish to clarify in the waiver that individuals eligible for the family planning aid category are not ineligible for HIP. The family planning option does not provide comprehensive medical services rather coverage is limited to family planning services and products only. While an applicant may be eligible for both programs, an individual can only participate in one of the programs; HIP or the family planning SPA. Persons participating in HIP have access to comprehensive medical services including family planning, as long as they make their POWER account contributions. An individual may participate in the family planning optional category, and receive family planning services without any contribution. The purpose of this policy is to ensure that barriers are not erected for individuals to elect the coverage that is right for them, whether that be family planning or HIP.

6.4 The Exchange and HIP

At this time, Indiana is not pursuing a state-based Exchange, however, has not yet determined if it will pursue a partnership Exchange (HIX), or will fully cede Exchange functions to the federal government. Regardless of Exchange model, FSSA will work to coordinate with the Exchange to ensure that HIP eligibles have a seamless enrollment experience.

6.5 Special Redetermination Period

Based on the Indiana Code, the income standards for HIP change January 1, 2014. HIP will initiate a special redetermination period starting January 1, 2014 for all individuals whose current eligibility information shows they may have income in excess of 138% FPL based on MAGI. Individuals who are determined ineligible for HIP based on income will be assisted with screening for eligibility for premium tax credits and in pursuing coverage options through the Exchange. Please see the transition plan in Section 9 for more details.

6.6 Enrollment Limit

The original HIP legislation was explicit 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 contemplated achieving this by means of (1) eliminating the disregard for HIP caretakers and (ii) placing an enrollment cap on HIP adults. (See approved STC 21 and 22). If Indiana elects to expand Medicaid and HIP is the coverage vehicle, then for this waiver demonstration period through 2014 through 2016, it is expected that there will be sufficient funding that a cap is not needed. However, considering other scenarios, dependent on funding and consistent with the enabling legislation, the HIP program will be monitored to ensure that revenue is sufficient to support enrollment levels. Going forward the State will request enrollment limits as necessary to ensure that HIP costs do not exceed available revenue.

Section 7: Benefits

The benefits provided by HIP are described below.

HIP offers the following coverage:

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- 1) A basic commercial benefits package once annual medical costs exceed \$1,100.
- 2) A POWER account valued at \$1,100 per adult to pay for initial medical costs. The POWER accounts provide incentives for participants to utilize services in a cost-efficient manner. HIP members make monthly contributions to their POWER accounts depending on their income level and the State funds the remainder of the account.
- 3) \$500 in “first dollar” preventive benefits; these benefits are at no cost to HIP members and will not deplete their POWER account.

Table 10: 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 Room	Co-payment for services determined to be non-emergency : \$6 for adults 100% FPL to 133% FPL, \$3 for adults up to 100% FPL
Urgent Care	
Physical/Occupational/Speech Therapy	25-visit annual maximum for each type of therapy
Radiology/Pathology	
Pharmacy and Blood	Generic preference, 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

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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	

The benefits package for HIP is not benchmark equivalent, as it does not cover maternity care or non-emergency transportation and includes a \$300,000 annual and \$1,000,000 lifetime limit. Milliman, Inc. conducted an analysis comparing HIP to a benchmark benefit plan included as an attachment. Currently, HIP has waivers for the requirement to offer these services and seeks continuation of these waivers.

The new legislation provides the Secretary of FSSA the ability to adjust the HIP benefits to be in line with the new benchmark benefit requirements. Based on the November 20, 2012 Medicaid Director Letter and the Essential Health Benefit requirements the state has conducted a preliminary analysis of the HIP benefits in comparison to Indiana’s default Essential Health Benefit benchmark plan.

The State Medicaid Director Letter issued November 20, 2012 advises Medicaid Agencies on the process for meeting the Essential Health Benefit Benchmark requirements through the Medicaid Benchmark.

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This process indicates that Secretary-approved coverage needs a completed analysis of the benefits offered in comparison to a base benchmark plan. As noted, in August 2010, Milliman certified that the current HIP benefits do not meet the benchmark equivalent standard based on the PPACA coverage requirements. As such, HIP is not a benchmark-equivalent plan and would be considered Secretary approved coverage.

Preliminary analysis has been completed comparing HIP benefits to Indiana's commercial default base-benchmark plan though Indiana has not completed an actuarial analysis of these benefits at this point, as the requirements for such an analysis are still unknown. However, the preliminary benefit comparison between the commercial EHB default HIOS submission and HIP indicates that, overall, the HIP benefits align with the benefits of the default commercial EHB benchmark. However, there are some areas of variation around which the State will need additional guidance.

Specifically additional guidance is needed around maternity coverage. The HIP enabling legislation specifically excludes pregnant woman from eligibility for pregnancy related services. Currently, when an individual in HIP becomes pregnant they are transferred out of HIP to Medicaid for the duration of their pregnancy and afterwards they can reenroll in HIP. However, the 2011 legislation gave the Secretary of FSSA the ability to add benefits as required to meet PPACA requirements. Indiana expects that some administrative efficiencies will be gained by adding pregnancy coverage to HIP instead of transferring pregnant woman out of HIP for pregnancy coverage. The PPACA lists maternity coverage and newborn care as a required essential benefits in §1302(b)(1)(D). However, when defining those eligible for Medicaid's benchmark coverage plan in §2001(a)(1)(C) the provision excludes those who are pregnant as they are already eligible for Pregnancy Medicaid. Indiana seeks additional guidance from CMS on this issue and requests clarification on what programs can enroll pregnant women under 138% FPL with the 5% income disregard.

Section 8: Cost-Sharing

Currently, HIP utilizes two forms of cost sharing. First, it requires copayments for non-emergency ER visits. Second it requires individuals to contribute to their POWER accounts. Collectively, the State assures that individuals do not make contributions that exceed 5% of their income. Contributions to POWER accounts are used to pay for health care services received before the deductible is met. POWER account contributions are made on a sliding fee scale basis and are detailed below. Currently caretakers, consistent with the CMS standard, do not pay more than 5% of their annual income in combined cost sharing (POWER account contributions and ER copays). Caretakers make required POWER account contributions on a sliding scale up to only 4.5% of their income, leaving room for any potential ER copays. Non-caretakers in the current HIP program have up to 5% for their required POWER account contribution and pay a flat \$25 for all non-emergency ER visits.

Independent legal analysis of the HIP POWER account contributions—included as an attachment-- indicates that POWER account contributions should not be classified as premiums. Section 1916A of the Social Security Act defines "premium" to include "any enrollment fee or similar charge." The enrollee contribution to the POWER account is not an "enrollment fee;" rather, it is a contribution towards the \$1,100 amount in the account. In that way, it is closer to either a deductible or co-insurance (although,

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unlike those two, it does not relate to a particular service at the time it is paid). Unlike a premium payment, HIP enrollees continue to own their required contributions and in the event of disenrollment from the program any of their remaining contributions are returned to them.

Per CMS rules for HIP caretakers, the total aggregate amount of (1) POWER account contributions, (2) HIP copayments, (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 then notifies the HIP program manager that the member has reached the 5% maximum contribution amount and the date it occurred. The member is not required to pay any further POWER account contributions or ER co-payments for the rest of the 12-month benefit period. OMPP is working on an automated process that will monitor and verify members spending on POWER account contributions, CHIP premiums and copayments and ensure that these payments do not exceed 5% of income.

8.1 Copayments

Overall, copayments will change to accommodate the new status of non-caretakers as indicated by the PPACA. Since HIP eligibility will align with the PPACA Medicaid expansion group in 2014, those over 138% FPL will no longer be eligible for HIP as of January 1, 2014. Copayments for non-emergency use of the ER are displayed below. After 2014 and PPACA implementation, the higher copayment for HIP Adults will be eliminated, as at that time they become a categorically eligible Medicaid group. As indicated in section 5.5 and starting in 2014, HIP intends to align with the proposed co-payments for non-emergency use of the emergency room at 42 CFR 447 and the copayment will be \$8 or the updated co-payment amount for non-emergency use of the ER as specified by the proposed regulation.

Table 11: Waiver Extension Current Demonstration Year 6 Cost Sharing January 1, 2013 to December 31, 2013 (current HIP waiver)

Population	Non-Emergency ER Use Co-Payment Amount	Power Account Contribution
HIP Caretakers With Incomes Above the AFDC Income Limit as Indicated in the State Plan through 100% FPL	\$3 per visit	Not more than 2% of income
HIP Caretakers Above 100 % through 150% FPL	\$6 per visit	3% to 4% of income
HIP Caretakers Above 150 % through 200% FPL	Lower of 20 percent of the cost of the services provided during the visit, or \$25	Not more than 4.5% of income
HIP Adults	\$25 per visit	2% to 5% of income based on FPL

Table 12: Waiver Extension Demonstration Year 7 to 9 Cost Sharing January 1, 2014 to December 31, 2016

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Population	Non-Emergency ER Use Co-Payment Amount	Power Account Contribution
Adults With Incomes Above the AFDC Income Limit as Indicated in the State Plan through 100% FPL based on MAGI	\$8 per visit or updated copayment amount per CMS guidance	Not more than 2% of income
Adults with incomes >100% FPL through 125% FPL based on MAGI	\$8 per visit or updated copayment amount per CMS guidance	Not more than 3% of income
Adults with incomes >125% FPL through 138% FPL based on MAGI	\$8 per visit or updated copayment amount per CMS guidance	Not more than 4% of income

8.2 POWER Account

The POWER account is an HSA styled account that HIP enrollees use to cover HIP’s \$1,100 deductible and is the centerpiece of the HIP plan. In the majority of cases both enrollees and the State contribute to the POWER account. Since the beginning of the HIP program between 20% and 35% of POWER accounts have been fully funded by the State as the individuals were not required to pay a POWER Account contribution. The cornerstone of the HIP program is to promote personal responsibility and consumerism in the healthcare system and including non-contributors in the program is contrary to the program’s goals; these individuals have no “skin in the game” or incentive to be cost conscious consumers.

The HIP program emphasizes personal responsibility, and the vast majority (92%) of POWER account contributors pays their POWER account contributions on time. HIP enrollees who do not pay any contributions are not expected to have the same degree of personal responsibility as they cannot be disenrolled for failure to pay a contribution. Potentially related to the paying of contributions, these non-contributors have higher non-emergency use of the ER (66.8 visits per 1000 enrollees vs. 34.7 visits per 1,000 enrollees for contributors). The utilization differences between contributors and non-contributors suggest that paying a contribution may impact responsible care seeking behavior.

As discussed previously, HIP has not experienced problems with affordability, and a Mathematica survey of HIP members found of established members that 69% of contributors consider the amount of their POWER account contribution to be ‘just right’, while 7% indicate they could pay an even greater contribution; 17% indicate the contribution is a little too much and only 5% of HIP established enrollees felt their contribution was far too much.³¹ Under HIP, employers are also able to contribute up to 50% of an individual’s required contribution and non-profits are able to contribute up to 75% of an individual’s required contribution.

During the 2010 legislative session, the Indiana legislature modified IC 12-15-44.2. These modifications include language that requires members to contribute a minimum amount to their POWER account to

³¹ Results from Mathematic 2010 Survey of HIP Members.

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ensure that all individuals are making contributions and have the appropriate consumer incentives, or “skin in the game.” The minimum amount required is an annual contribution of \$160 but not more than 2% of income for an enrollee under 100% FPL, 3% of income for and enrollee from 100% to 125% FPL and 4% of income for an enrollee 125% to 150% FPL. The percentage limits in the enabling legislation may prevent very low income adults from making the full minimum contribution. In contrast to the Affordable Care Act’s Premium Tax Credits, contributions to POWER Accounts, other Medicaid cost sharing, and copays are limited to a total percentage of income. While an individual covered on a tax credit would be subject to only the maximum out-of-pocket cost-sharing limit, individuals covered by HIP have all cost sharing limited to no more than 5% of income, dependent on FPL. Table 13 indicates the proposed POWER account contributions. Individuals will contribute the required minimum monthly contribution until they meet their income limit and then required contributions for those individuals will be suspended.

Table 13: POWER Account Contributions 2014 to 2016

Annual Household Income	Minimum POWER Account Contribution	Maximum POWER Account Contribution	Estimated maximum annual/monthly contribution Individual	Estimated maximum annual /monthly contribution Family of 4
All enrollees less than 25% FPL	\$160 annually but not more than 2% of annual income	Not more than 2% of income	\$54.46/ \$13.33	\$111.76/ \$13.33
All enrollees between 25% and 50% FPL	\$160 annually but not more than 2% of income	Not more than 2% of income	\$108.90/ \$13.33	\$223.50/ \$18.63
All enrollees between 50% and 75% FPL	\$160 annually	Not more than 2% of income	\$163.36/ \$13.61	\$335.26/ \$27.94
All enrollees between 75% and 100% percent FPL	\$160 annually	Not more than 2% of income	\$217.80/ \$18.15	\$447.00/ \$37.25
All enrollees above 100 through 125 percent FPL	\$160 annually	Not more than 3% of income.	\$408.39/ \$34.03	\$838.14/ \$69.85
All enrollees above 125 percent FPL	\$160 annually	Not more than 4% of income.	\$579.35/ \$48.28	\$1,100/ \$91.67

HIP’s current demonstration year allows not-for-profit entities to make up to 75% of an individual’s required contribution and employers have always been able to make up to 50% of an individual’s required contribution. Individuals who receive sponsorship from not-for-profits or employers may pay

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less than the displayed minimum contributions. Enrollees pay their contributions in equal monthly installments, and are also permitted to pay the entire sum up front. HIP members that struggle to pay the required minimum contribution will be able to seek employer or non-profit support.

The original authorizing language for HIP indicated that only the State, employers, and individuals can make contributions to the POWER account. IC 12-15-44.2 allows not-for-profit organizations to assist with contributions and contribute up to 75% of the enrollee's contribution requirement. This request was approved in the 2013 HIP waiver. Not-for-profits are not allowed to contribute 100% of the member's POWER account contribution because a central tenant of the HIP program is for all individuals to contribute to their care. HIP currently allows employers to contribute up to 50% of an individual's contribution to the POWER accounts and extending this option to not-for-profit organizations fits with the program's goals to provide affordable, consumer directed coverage. An employer's contribution limit will remain at 50% of the enrollee's contribution requirement.

For those members who do not currently contribute, and who will be required to start contributing on their first redetermination period after January 1, 2014 the State has developed a transition plan described in detail in the next section (section 9).

The State will continue to ensure that the POWER account is fully funded from the beginning of individual enrollment and will continue to contribute to ensure that the deductible can be met if expenses occur at the beginning of the enrollment period. Health plans are required to collect the POWER account contribution from individuals, and individuals will not receive HIP coverage until the first day of the coverage month after the first contribution is received. This is the current policy and the State requests no changes to this.

The required minimum contribution of \$160 represents 5% of income for an individual making \$3200 a year, or 29% FPL. IC 12-15-44.2-11 that contains the language instituting the minimum contribution also contains language that limits maximum contributions. The language from IC 12-15-44.2-11 concerning the minimum contribution requirements and limiting maximum amounts is excerpted below.

At least one hundred sixty dollars (\$160) per year and not more than the following applicable percentage of the individual's annual household income per year, less any amounts paid by the individual under the Medicaid program under IC 12-15, the children's health insurance program under IC 12-17.6, and the Medicare program (42 U.S.C. 1395 et seq.) as determined by the office:

- *Two percent (2%) of the individual's annual household income per year if the individual has an annual household income of not more than one hundred percent (100%) of the federal income poverty level.*
- *Three percent (3%) of the individual's annual household income per year if the individual has an annual household income of more than one hundred percent (100%) and not more than one hundred twenty-five percent (125%) of the federal income poverty level.*
- *Four percent (4%) of the individual's annual household income per year if the individual has an annual household income of more than one hundred twenty-five percent (125%) and not more than one hundred fifty percent (150%) of the federal income poverty level.*

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- *Five percent (5%) of the individual's annual household income per year if the individual has an annual household income of more than one hundred fifty percent (150%) and not more than two hundred percent (200%) of the federal income poverty level.*

To track entire family spending on Medicaid services, the State is implementing a process to automatically monitor member expenditures and ensure that POWER account contributions, CHIP premium payments, and copayments never exceed 5% of a member's income in line with CMS guidelines. This implementation is consistent with the requirements outlined in the January 2013 NPRM on cost-sharing requirements.

Section 9: HIP 1115 Waiver Renewal Transition Plan

OMPP has developed a transition plan for two scenarios, based upon CMS' approval or denial of the HIP 1115 demonstration waiver extension. Should the State's waiver request be denied, the State will begin dismantling the HIP program in July 2013 as described in Plan B. If the waiver is approved, the State will proceed with Plan A.

Plan A: 1115 receives approval for three year extension (2014, 2015 & 2016)

Once the State receives approval from CMS, FSSA will publish a press release and notify all legislators of the waiver approval and the plan for the program going forward.

The changes addressed in this transition plan, which directly affect HIP members, are (1) the reduction of the upper eligibility threshold from 200% FPL to 138% effective January 1, 2014, and (2) the requirement of a minimum member POWER account contribution of \$160 annually (subject to a 5% income limit) or approximately \$13/month.. "Plan A" addresses the continuation of the waiver and is subdivided to address several populations affected by changes to the 1115 waiver from its original demonstration to the proposed structure in this waiver extension. "Plan A" populations are:

- (1) Per IC 12-15-44.2 and the Affordable Care Act, current HIP members between 138% FPL and 200% FPL who will no longer be eligible for HIP coverage in 2014, but will be eligible for an Exchange product.
- (2) HIP currently operates a waitlist for approximately 40,000 non-caretaker adults. It is assumed that the majority of these individuals may either be eligible for enrollment in HIP, if the State elects to expand Medicaid coverage, or an Exchange product and tax subsidy in 2014.
- (3) HIP members who currently make no contributions to their HIP POWER accounts ("zero contributors") due to current income counting requirements, but will be required to contribute \$160 annually beginning at the start of their renewal period in 2014, as required by State statute, and if approved by CMS.

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(4) HIP members under 138% FPL who will maintain HIP eligibility, but may be affected by the \$160 annual contribution to the POWER account. These members are currently contributing less than \$160 annually.

Trainings will take place with the MCEs (Anthem, MDwise, MHS and ESP administrators) as well as provider and other community based organizations. The goal of the trainings is to prepare key stakeholders for the upcoming changes so they may begin planning, as necessary, how to best assist HIP members in the transition. Information will also be available on FSSA's HIP website (www.HIP.in.gov).

(1) Current HIP members between 138% FPL and 200% FPL

A waiver extension for three years will result in program changes at the end of demonstration year six for current members between 138% FPL and 200% FPL, provided that the request to reduce HIP eligibility to 138% FPL is granted. Individuals with MAGI income between above 100% FPL will become eligible for Exchange subsidies beginning January 1, 2014 and per Indiana code those over 138% FPL based on MAGI would no longer be eligible for HIP, pending CMS approval of the eligibility threshold. The March 2012 release of the final rule for 42 CFR Parts 431, 433, 435, and 457 *Medicaid Program: Eligibility Changes under the Affordable Care Act of 2010* relating to modified adjusted gross income (MAGI), state the following:

“Proposed §435.603(a)(1) and (2) set forth the basis and scope of this section. At proposed §435.603(a)(3), we implement 1902(e)(14)(D)(v) of the Act, as added by section 2002(a) of the Affordable Care Act, which specifies that, in determining ongoing eligibility of individuals enrolled in the Medicaid program as of January 1, 2014, the financial methodologies based on MAGI shall not be applied until the next regularly-scheduled redetermination of eligibility after December 31, 2013 or March 31, 2014, if such individual otherwise would lose eligibility as a result of the shift to MAGI-based methodologies before such date.”

As of January 1, 2014 individuals between 138% and 200% FPL will no longer be eligible for HIP as a result of the HIP change in the eligibility threshold effective on that day, not as a result of a change to MAGI calculation. The following is proposed for individuals between 138% and 200% FPL, who are enrolled in HIP prior to 2014. In keeping with the philosophy that those under 138% FPL will be enrolled in Medicaid, if the State elects to expand Medicaid, and over 138% FPL will be enrolled in a Qualified Health Plan with tax subsidies, the transition plan modifies the redetermination period, such that individuals enroll in a QHP early in 2014. This plan reduces duplication of services offered through multiple programs. The plan for transitioning individuals between 138% and 200% FPL is as follows:

- Upon waiver extension approval from CMS and no later than July 1, 2013, FSSA will commence putting together a change order for the Indiana Client Eligibility System (ICES) and the claims/MMIS system to reflect the eligibility threshold change, effective January 1, 2014.

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- For individuals enrolled in HIP above 138% FPL under current eligibility standards, a special redetermination period will commence January 1, 2014. Letters will be sent to individuals identified as between 138% and 200% FPL, by October 2013, notifying them of the special redetermination date and of their potential eligibility for coverage through the Exchange. This process aligns the redetermination dates with Exchange enrollment periods.
- October 1, 2013 - A letter regarding changes to the HIP program will be mailed no later than October 2013 to HIP members between 138% and 200% FPL notifying the member that based on the income information the State has, the member may lose HIP eligibility if, at redetermination, their income remains over 138% FPL. The letter will note that a second letter will be mailed by January 1, 2014 advising the member to complete the redetermination, how to complete the redetermination, and if found ineligible for HIP but eligible for a tax subsidy, how to enroll in an Exchange product.
- October 1, 2013 - A letter will be sent to all enrollment centers informing them of the changes to the program for individuals between 138% FPL and 200% FPL and how to assist an individual in enrolling in an Exchange product
- The State will develop online training materials for stakeholders to assure there is widespread communication about the changes.
- January 1, 2014 – Redetermination letters will be mailed to individuals above 138% FPL based on MAGI. Individuals will have 60 days to complete their redetermination packet. If found eligible for HIP, they will remain enrolled in HIP. If income remains above 138% FPL based on MAGI at redetermination, these individuals will be referred for tax subsidy screening.
 - Phone numbers will be provided in the letters for each MCE as well as the Exchange, such that individuals could begin selecting products once they receive their eligibility determination from the State or Exchange. Information on other available Medicaid products and where to obtain and submit an application will be included in the letter.
 - The State will track the progress of the population and may also consider outbound phone calls to members that have not responded.
 - For individuals who are found eligible for a tax subsidy, the State will close out the POWER account. .
- March 31, 2014 – Termination letters will be sent to HIP members who did not complete their redetermination. These letters will include information on how to enroll in an Exchange product or reapply for HIP. Members will be eligible to appeal this determination according to FSSA appeals processes if they feel the decision was made in error.

(2) Individuals currently on the HIP waitlist

The State will take steps necessary to inform individuals on the HIP waitlist that they will be eligible for HIP, if the State elects to expand Medicaid, or an Exchange product in January 2014.

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- October 2013 – At the time of the Exchange open enrollment, ICES will issue letters to individuals on the HIP waitlist, in batches, stating that they may be eligible for HIP and that there will no longer be a waitlist for the program. Individuals will need to reapply for the program in order to prove they are still eligible and will need to file this application no later than 45 days from the date of the letter. A phone number will be provided on the letter for individuals to call should they have questions or need assistance. The enrollment broker would be leveraged to assist with any returned letters and subsequent outreach to clients, as noted in the prior section.
 - Case numbers of individuals who are sent application invitation letters will be flagged in ICES so DFR will know who to process as waitlist applicants.
 - In processing eligibility, access to employer sponsored insurance and insurance within the last 6 months will only disqualify individuals through December 31st, 2013. Individuals with these disqualifications but otherwise eligible for HIP will be granted coverage effective January 1, 2014.
 - If application is received by DFR by the due date (within 45 days), but without all required documentation to determine eligibility, they will complete the same follow up to obtain verification.
 - All applicants over 138% FPL will be screened for tax subsidy eligibility, in coordination with the Exchange’s open enrollment period. From October 1, 2013 to December 31, 2013 HIP will maintain eligibility levels to 200% FPL; however, tax subsidy screening for the eligible portion of the HIP population will promote streamlined transitions to Exchange coverage for this population.
- Coverage would not begin until January 1, 2014 for non-caretakers from the waitlist who are determined eligible for HIP.
- If the State elects not to expand Medicaid, individuals on the HIP waitlist will be notified of their Exchange coverage options through the process described above.

(3) Current members who currently make no contributions to HIP POWER accounts (“zero contributors”)

- As soon as waiver approval is received from CMS, FSSA will run a data query to identify all HIP members who currently do not make POWER account contributions. A letter will be sent to these HIP members informing them that they will be required to make POWER account contributions beginning on their first redetermination after January 1, 2014 and that employers may contribute up to 50% and not-for-profit groups may contribute up to 75% of their monthly payment (no more than 100% of a member’s contribution may be contributed on behalf of the member to the account in any one benefit period). Individual required contributions will not be phased in until their redetermination period.
- The State will also work with not-for-profit entities and community based organizations to inform them of this recent change.
- The State will meet with the MCEs and other stakeholders to walk staff through the program changes. MCEs will be asked to help coordinate the effort and to be prepared to work with their members to make the transition.

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- Changes will be made to FSSA's eligibility (ICES) and claims management systems (MMIS). It will be particularly important to ensure that no one has a zero contribution and that the default contribution is never zero, but is at least \$160 annually or approximately \$13/month subject to the income limits present in statute.
- After January 1, 2014 at each individual's appointed redetermination period, the individual will be given information regarding their new POWER account and how to appeal the decision.
- The appeal process for HIP will not change with waiver renewal. Individuals will be required to file an appeal in writing. Once an appeal is received and processed an appeals hearing will be scheduled with Hearings and Appeals.

(4) Those under 138% FPL who maintain eligibility may be affected by the changes to the POWER account rules, as their POWER account contribution may increase.

The same process as described in item (3) will be followed, with the difference being that the letters will be tailored to those who may have a change in the amount of their POWER account contribution due to the minimum contribution. The letters will continue to describe the opportunity for not-for-profit and employer participation.

Plan B: 1115 does not receive approval for 3 year extension & the program is dismantled

Should the State not receive approval to continue the 1115 waiver, the State will begin dismantling the HIP program by July 2013. The State will require at least six months of preparation to ensure the transition runs smoothly. The last day of the program will be December 31, 2013. Appropriate steps will be taken to ensure that all members are aware of the closure of the program and of other options that might be available to them.

- Upon denial from CMS:
 - FSSA will publish a press release and notify all State and Federal Indiana legislators of the denial and the impending termination of the program. The FSSA HIP website (www.HIP.in.gov) will be updated to indicate the future of the program.
 - Letters will be sent to all HIP members informing them that, due to waiver denial, the program will end on December 31, 2013. The letters will note that HIP members may continue to receive coverage for healthcare services through December 31, 2013, should they continue to meet eligibility requirements. The letters will also contain information on other products that could be available to these members upon the closure of the program, such as other Medicaid categories, the PCIP, exchange coverage, and commercial insurance.
 - Letters will also go out to individuals on the HIP waitlist notifying them of the closure of the program and the subsequent discontinuance of the waitlist. The waitlist will immediately close and no additional individuals will be placed on the waitlist.
 - The above process will be repeated, to ensure that communication is received.

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- The State will begin negotiations with the three MCEs to amend their contracts to terminate the HIP portion of their combined HHW and HIP contracts.
- The State will develop a plan to utilize the remaining dollars in the HIP fund.
- Letters and bulletins will be sent to Medicaid providers, enrollment centers, community based organizations and other key stakeholders of the change informing them of the end of the program.
- FSSA will commence making necessary changes to its eligibility and claims management systems to ensure that members are terminated and that no capitation payments are made to health plans.
- July 2013 - FSSA will stop processing new HIP applications. Any application in process will be denied due to termination of program. Redeterminations will cease, and individuals will be left in the HIP program until the end of the year. DFR staff will be trained to inform clients that HIP is no longer an option, and applications will be removed from the website and local offices.
- December 2013 – Letters will go out to each HIP member informing them that their coverage was terminated; there will be no appeal rights associated with this termination as the program will have ended. The letters will detail the options that will be available beginning in 2014 via the Exchange, other Medicaid programs, and the commercial market.

Section 10: Evaluation reports

Mathematica developed an evaluation plan for HIP during the HIP initial demonstration period. HIP is meeting its program goals and providing quality care to clients. During the extension period, Indiana expects to continue to make some modification to the evaluation design and to focus on new areas of study. Evaluation reports address HIP's progress on program goals in addition to the evaluation questions present in the Special Terms and Conditions (STCs).

Evaluation reports will include evaluation on the below HIP goals:

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

During the waiver extension period evaluation reports will continue to include responses to the below 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 during the period of exhaustion of their benefit and the beginning of the next coverage term?
2. How many HIP participants reach their \$1,000,000 lifetime benefit maximum? How do they go about meeting their health care needs after their HIP benefits are exhausted?

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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 MCO?
4. How many enrollees are reassigned from HIP MCOs each year to ESP? How many are reassigned from ESP to a HIP MCO?
5. What percentage of the potentially eligible population enrolls in HIP? How does the percentage vary by major population subgroups (HIP Caretakers, HIP Adults) and income level?
6. What are the consequences of requiring HIP participants with family income less than 150 percent of the 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 premiums?
7. To what extent has HIP impacted the uninsurance rate in Indiana?
8. To what extent has HIP reduced uncompensated care provided by Indiana's federally funded health clinics?
9. 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?

During the waiver extension period the State also intends to investigate if the minimum contribution requirement effectively changes the care seeking behavior on current non-contributors and encourages more cost conscious consumption of health care services.

Section 11: Public Comment

FSSA held public hearings for this three-year 1115 waiver extension according the requirements under 42 CFR 431. The notice that announced two public hearings is included in Appendix A of this renewal request, and it was published in the *Indiana Register* on February 20, 2013. The full notice was also posted on the agency's website at the web address of the 1115 waiver program's homepage: HIP.in.gov. Electronic copies of all documents related to the three year waiver extension were also available on the website. In addition, OMPP published the notice in the *Indiana Health Care Provider (IHCP) Bulletin*, which was sent electronically to all IHCP providers. In accordance with the notice, public hearings were conducted March 20 and 22, 2013. The hearing held on March 20 was made available to the public via a telephone conference line and a live, free webcast. The hearing held on March 22 was also made available to the public via 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.

Additionally, as part of the normal legislative process, hearings were held in the Senate Health and Provider Services Committee and the House Public Health Committee regarding pending legislation.³² Legislators provided and received testimony regarding the Healthy Indiana Plan waiver and Medicaid expansion at the February 13, 2013 committee meetings, and agency staff attended these committee hearings. Many of the individuals who testified during the legislative hearings on February 13 offered public comment during the aforementioned hearings on March 20 and 22.

³² Testimony taken in regards to Senate Bill 551 and House Bill 1591.

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11.1 Summary of Public Comments

The hearings on March 20 and March 22, 2013 were held as scheduled and publicized, at the Indiana Government Center Conference facilities and the Indiana State House. Eleven individuals testified on March 20, and nine individuals testified on March 22. A court reporter transcribed both hearings. Comments were also received in writing by e-mail and regular mail. A total of twenty individuals testified at the HIP hearings, and fifty-nine written comments were received. The below summary combines the comments offered at the public hearings and via mail or email.

Over seventy-nine comments were received by the agency. The majority of comments were generally supportive of the HIP program and/or expanding Medicaid. In particular, Anthem and MDwise, two of the managed care entities (MCEs) serving HIP members, provided testimony that noted HIP enrollees are more likely to engage in care programs and follow through on personal health accountability. These entities supported HIP's consumer oriented program. They further indicated HIP's member responsibility provisions positively contribute to member health outcomes and provide evidence that a contribution model delivers cost-effective outcomes regardless of contribution level. The MCEs noted, in comparison to other Medicaid enrollees, HIP members have lower emergency room use and lower inpatient admissions, are more likely to schedule and attend physician office visits, are more engaged in their coverage options through call centers and web portals, have high rates of completion of recommended preventive services, and are more likely to comply with prescription medication regimens.

Supportive comments were received with respect to using the HIP program to expand Medicaid. Individuals commented HIP is a landmark program. One individual noted HIP "has been a central component in the State's effort to provide quality, cost-effective health coverage for low income adults." Further testimony stated that HIP offers a foundation for the expansion of Medicaid in Indiana, and could be leveraged in an expansion to decrease costs and increase quality of care. Support was voiced for HIP's personal responsibility mechanisms, including cost-sharing mechanisms and incentives for obtaining preventive care services, and including these mechanisms in a potential Medicaid expansion.

Members of the business community, including the Indiana Chamber of Commerce and the Indiana Manufacturers Association, and provider community, including the Indiana Hospital Association, the Indiana State Medical Association, and numerous hospitals, expressed support for HIP as an innovative, consumer-directed, private market approach to expanding Medicaid. They stated any Medicaid expansion in Indiana must be aware of long term fiscal implications, and support was lent to HIP as a fiscally sound approach to a coverage expansion. Some of these organizations gave praise to HIP's ability to decrease use of the emergency room and increase use of preventive care, to improve consumer behavior including seeking the cost of procedure prior to receiving them, and to yield high enrollee satisfaction. They supported HIP's higher provider reimbursement rates and the associated decrease in cost-shifting to the private market. Additionally, some testimony noted POWER account contributions are vital to the success of the HIP program and need to remain intact to ensure the program is successful moving forward.

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Comments consistently urged CMS to promptly respond to the HIP waiver request to ensure continued coverage in 2014 and to further the discussion in the state around a potential Medicaid expansion. Some individuals commented only with regards to support of a Medicaid expansion and did not address support or lack of support for the HIP program.

Five comments received in writing or through testimony expressed concern around certain features of the program including: the lifetime and annual maximums, the twelve month lock-out period for failure to pay a premium, the requirement to not have access to employer sponsored insurance, the non-caretaker waitlist, and non-provided benefits including chiropractic, dental, and vision services. These comments also addressed concerns about multiple types of coverage within a family unit and HIP integration with the federally-facilitated exchange. One commenter noted support for expansion of HIP's cost-sharing requirements to include copayments beyond the copayment for non-emergency use of the ER. Those who commented regarding the aforementioned recommendations to the program indicated support for the renewal of HIP and the use of HIP for a potential Medicaid expansion provided their concerns are addressed.

Eight comments received in writing or through testimony expressed concern about the HIP waiver renewal or use of HIP as the foundation of a Medicaid expansion. These individuals cited concerns related to: potential cost-sharing for pregnant women in HIP, co-payments for non-emergency use of the ER, the requirement for individuals to make POWER Account contributions, churn between HIP and other Medicaid programs and the Exchange, the relative cost of HIP compared to other Medicaid programs, and the ability to scale the program to cover the entire Medicaid expansion population.

11.2 State Response to Comments

The State appreciates all comments received. In its discussions with CMS and through the potential development of the Special Terms and Conditions, the State will consider these comments in context of the outcome data around HIP's design features and the impact on the goals of the program.

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 comment period and public hearings. The content of this application is identical to the advanced copy application submitted to CMS on February 13, 2013.

Section 12: Types of waivers being requested

The State is requesting the below waivers.

Title XIX Waivers

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

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or on the absence of managed care arrangements. Individuals enrolled in the Hoosier Healthwise program receive additional benefits such as case management and health education that may not be available to other Medicaid beneficiaries not enrolled in Hoosier Healthwise.

1. 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.

2. 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.

3. 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).

4. 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.

5. 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.

6. Income and Resource Test **Section 1902(a)(10)(C)(i)**

To the extent necessary to enable Indiana to exclude funds in the POWER account from the income and resource tests established under State and Federal law for purposes of determining Medicaid eligibility for Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults). Indiana will request this waiver for 2013 only. In 2014, asset tests will not be allowed under federal law.

7. Freedom of Choice **Section 1902(a)(23)**
insofar as it incorporates
42 CFR 438.52(a)

To the extent necessary to enable Indiana to provide only one choice of plan for individuals in Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults) who are identified as having certain high-risk conditions.

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8. 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.

9. 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.

10. Cost-Sharing

Section 1916A

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

**11. Dental and Vision Coverage for Certain HIP Caretakers
and HIP Adults**

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).

12. Income Limit

Section 1902(a)(10)(a)(I)(VIII)(i)

To the extent necessary to enable Indiana to limit enrollment to levels that can be supported by the state's cigarette tax fund.

The current STCs grant HIP the below waivers. The State believes that these waivers are no longer necessary for the HIP program and does not request that their inclusion in the waiver renewal.

13. 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.

14. Disproportionate Share Hospital (DSH) Payments

Section 1902(a)(13)(A)

insofar as it incorporates Section 1923(c)(1)

To the extent necessary to allow Indiana to divert of a portion of DSH payments made to hospitals to cover the demonstration population.

Section 13: Financing Reports

Please see attached financing report prepared by Milliman Inc.

2013 HIP 1115 WAIVER RENEWAL APPLICATION

Appendix A: 2013 Notice of Public Hearing

Notice of Public Hearing

Under 42 CFR Part 431 and the final rule under PART 431 in the February 27, 2012, issue of the Federal Register, 77 FR 11678-11700, notice is hereby given that:

(1) on March 20, 2013, at 1:30 p.m., at the Indiana Government Center South, 402 West Washington Street, Conference Center Room C, Indianapolis, Indiana; and

(2) on March 22, 2013, at 1:30 p.m., at the Indiana State House, 200 West Washington Street, Room 156B, Indianapolis, Indiana;

the Family and Social Services Administration will hold public hearings on a Medicaid 1115 waiver renewal submission to the Centers for Medicare and Medicaid Services to extend the demonstration for the Healthy Indiana Plan (HIP) for calendar years 2014-2016. The current 1115 waiver is set to expire on December 31, 2013. As a result of recent changes to Medicaid eligibility initiated by the Patient Protection and Affordable Care Act (ACA) and changes authorized by the Indiana General Assembly at [IC 12-15-44.2](#), the waiver renewal application includes the authorized modifications to HIP, as well as requests for minimum contributions, the ability for managed care entities (MCEs) to contribute towards members' required contribution, cost-sharing changes, changes to eligibility factors, and adjustments to federal poverty level (FPL) bands.

The HIP demonstration project was approved in December 2007, and the program began on January 1, 2008. HIP currently covers nondisabled adults between the ages of 19-65 who meet the following qualifying criteria: income less than 200% FPL, no access to employer-sponsored insurance, and no health coverage within the six month period prior to application. The program includes a \$1,100 deductible and creates Personal Wellness and Responsibility (POWER) accounts to fund the deductible. Individuals are required to make income driven monthly contributions to the POWER account, and the state funds the remainder of the account to ensure that the \$1,100 deductible can be met. Minimal copayments of \$3, \$6, or \$25 are charged for nonemergency use of the emergency room, per the current HIP program. In 2014, the current copayments will be replaced with a flat \$8 copayment authorized by proposed federal regulations (42 CFR 447.54).

HIP is delivered via risk-based managed care and provides a basic commercial benefit package once medical costs exceed \$1,100. Additionally, \$500 in first dollar preventive benefits is provided at no cost to the individual. There are seven program goals in the proposed 1115 waiver application: (1) reduce the number of uninsured low-income Hoosiers, (2) reduce barriers and improve statewide access to health care services for low-income Hoosiers, (3) promote value-based decision making and personal health responsibility, (4) promote primary prevention, (5) prevent chronic disease progression with secondary prevention, (6) provide appropriate and quality-based health care services, and (7) ensure state fiscal responsibility and efficient management of the program. HIP will be evaluated based on progress towards these goals.

2013 HIP 1115 WAIVER RENEWAL APPLICATION

HIP currently covers approximately 39,000 individuals. The purpose of this 1115 waiver renewal is to continue HIP for three years to continue and to make other ACA-related changes. Changes to the program in this waiver extension, authorized in IC 12-15-44.2, include:

- A requirement for enrollees to make a minimum contribution to their POWER Account of \$160 annually (but guarantees that individuals will not pay more than 5% of their income towards health costs).
- An ability for HIP-contracted MCEs to contribute to the individual's POWER account. Contributions must be linked to a health related incentive, such as completion of a risk assessment or participation in a smoking cessation program. MCE contributions cannot reduce the individual's required minimum contribution or be greater than HIP's \$1,100 deductible. However, this option allows MCEs to offer financial incentives through the POWER account to members for positive health behaviors. Allowing MCEs to contribute to the POWER account is in line with program goals of harnessing consumerism to improve health behaviors and allows members the chance to earn additional subsidies to their POWER account.
- Changes HIP eligibility levels to 133% FPL (with 5% income disregard) starting on January 1, 2014. The current eligibility threshold is 200% FPL.
- Changes the requirement that to enroll in HIP an individual must have been uninsured for at least six months and not have access to employer sponsored insurance as authorized by IC 12-15-44.2.
- Changes co-payments for non-emergency use of the ER to align with proposed cost-sharing guidance.

In the first five years of the 1115 demonstration project, HIP covered 105,135 individuals. Current enrollment for the program is approximately 39,000 individuals. Based upon the financial documents prepared with the waiver, the program renewal could cover up to a total of 165,000 parents and 262,000 adults. Changes to the budget neutrality agreement have been made to reflect the ACA changes. Per the memorandum included with the waiver application "1115 Waiver Renewal-Budget Neutrality Filing", and assuming coverage for the optional Medicaid expansion population, expected expenditures are \$5.1B, \$5.4B, and \$5.8B (state and federal) in 2014, 2015, and 2016 respectively. The expected savings, respectively, via the waiver for each of those years, are \$144.3M, \$156.0M, and \$168.6M (state and federal).

The state will identify individuals under 21 years of age who qualify for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services and assure that EPSDT services will be provided to those individuals who qualify. In addition, if an individual is recognized as part of a Tribal Nation, the state assures that required services will be provided to qualified individuals. The methods and standards for payment are consistent with the current program: not less than (1) the federal Medicare reimbursement rate for the services provided or (2) a rate of 130% of the Medicaid reimbursement rate for a service that does not have a Medicare reimbursement rate.

2013 HIP 1115 WAIVER RENEWAL APPLICATION

Copies of the HIP waiver renewal documents are now on file at the Indiana Family and Social Services Administration, Office of the General Counsel, 402 West Washington Street, Room 451, Indianapolis, Indiana 46204 and are open for public inspection. The documents may also be viewed at: www.HIP.in.gov

Written comments may be sent to the aforementioned address to the attention of Barbara Nardi or to barbara.nardi@fssa.in.gov through the date of the second hearing on March 22, 2013.