Healthy Indiana Plan ***Summary Budget Neutrality Estimates - Waiver Renewal***

Scenario: Reflects experience through September 30, 2012
Updated January 30, 2013

Without Waiver Summary	DY 01	DY 02	DY 03	DY 04	DY 05	DY 01 - DY 05
XIX - Mandatory Populations	1,616,415,042	1,803,138,698	1,962,293,196	2,049,017,852	2,154,403,856	9,585,268,644
HIP Parents	22,228,587	70,693,403	107,249,634	117,359,803	120,745,923	438,277,350
HIP Adults	-	-	-	-	-	
DSH	83,528,693	94,035,871	90,394,363	81,584,952	85,748,289	435,292,169
Total	***1,722,172,322***	***1,967,867,972***	***2,159,937,193***	***2,247,962,607***	***2,360,898,068***	***10,458,838,163***

With Waiver Summary	DY 01	DY 02	DY 03	DY 04	DY 05	DY 01 - DY 05
XIX - Mandatory Populations	1,543,238,768	1,637,171,176	1,450,455,897	1,743,888,714	2,131,618,657	8,506,373,212
HIP Parents	25,142,197	72,654,464	111,694,686	123,857,471	129,574,337	462,923,156
HIP Adults	-	-	-	-	-	-
Waiver Populations	55,209,913	166,552,300	116,603,212	92,243,968	102,712,334	533,321,728
Total	***1,623,590,879***	***1,876,377,941***	***1,678,753,795***	***1,959,990,153***	***2,363,905,328***	***9,502,618,095***
Waiver Margin	***98,581,443***	***91,490,032***	***481,183,398***	***287,972,454***	***(3,007,260)***	***956,220,067***

Coverage Estimates	DY 01	DY 02	DY 03	DY 04	DY 05	DY 01 - DY 05
Test A						
Limit	1,699,943,735	1,897,174,570	2,052,687,559	2,130,602,804	2,240,152,145	10,020,560,813
Expenditures	1,598,448,682	1,803,723,476	1,567,059,109	1,836,132,682	2,234,330,991	9,039,694,940
Limit less Expenditures	101,495,053	93,451,094	485,628,449	294,470,122	5,821,154	980,865,873
Test B						
Limit	22,228,587	70,693,403	107,249,634	117,359,803	120,745,923	438,277,350
Expenditures	25,142,197	72,654,464	111,694,686	123,857,471	129,574,337	462,923,156
Limit less Expenditures	(2,913,610)	(1,961,062)	(4,445,051)	(6,497,668)	(8,828,414)	(24,645,805)
Combined Test A and Test B	98,581,443	91,490,032	481,183,398	287,972,454	(3,007,260)	956,220,067
Cumulative Combined Test	98,581,443	190,071,475	671,254,873	959,227,327	956,220,067	
Anticipated Enrollment						
HIP Parents	5,926	18,052	26,233	27,496	27,097	104,803
HIP Adults	9,389	26,377	18,863	14,065	14,381	83,075
Total	**15,315**	**44,429**	**45,095**	**41,561**	**41,478**	**187,879**

Healthy Indiana Plan ***Summary Budget Neutrality Estimates - Waiver Renewal***

Scenario: Reflects experience through September 30, 2012
Updated January 30, 2013

Without Waiver Summary	DY 06	DY 01 - DY 06
XIX - Mandatory Populations	2,289,771,857	11,875,040,501
HIP Parents	124,295,636	562,572,986
HIP Adults	-	-
DSH	-	435,292,169
Total	***2,414,067,493***	***12,872,905,656***

With Waiver Summary	DY 06	DY 01 - DY 06
XIX - Mandatory Populations	2,211,722,985	10,718,096,197
HIP Parents	134,330,854	597,254,009
HIP Adults	-	-
Waiver Populations	103,628,092	636,949,820
Total	***2,449,681,931***	***11,952,300,026***
Waiver Margin	***(35,614,438)***	***920,605,630***

Coverage Estimates	DY 06	DY 01 - DY 06
Test A		
Limit	2,289,771,857	12,310,332,670
Expenditures	2,315,351,077	11,355,046,017
Limit less Expenditures	(25,579,220)	955,286,653
Test B		
Limit	124,295,636	562,572,986
Expenditures	134,330,854	597,254,009
Limit less Expenditures	(10,035,218)	(34,681,024)
Combined Test A and Test B	(35,614,438)	920,605,630
Cumulative Combined Test	920,605,630	
Anticipated Enrollment		
HIP Parents	26,718	131,521
HIP Adults	14,446	97,521
Total	**41,164**	**229,042**

Healthy Indiana Plan ***Summary Budget Neutrality Estimates - Waiver Renewal***

Scenario: Reflects experience through September 30, 2012
Updated January 30, 2013

Without Waiver Summary	DY 07	DY 08	DY 09	DY 01 - DY 09
XIX - Mandatory Populations	2,795,763,755	3,001,124,284	3,221,978,632	20,893,907,172
HIP Parents	821,343,600	868,859,680	919,139,146	3,171,915,411
HIP Adults	1,641,482,400	1,739,405,581	1,843,168,314	5,224,056,296
DSH	-	-	-	435,292,169
Total	***5,258,589,755***	***5,609,389,544***	***5,984,286,093***	***29,725,171,047***

With Waiver Summary	DY 07	DY 08	DY 09	DY 01 - DY 09
XIX - Mandatory Populations	2,710,043,710	2,907,129,558	3,118,949,351	19,454,218,817
HIP Parents	762,735,600	806,865,628	853,557,502	3,020,412,739
HIP Adults	1,641,482,400	1,739,405,581	1,843,168,314	5,224,056,296
Waiver Populations	-	-	-	636,949,820
Total	***5,114,261,710***	***5,453,400,767***	***5,815,675,167***	***28,335,637,671***
Waiver Margin	***144,328,045***	***155,988,777***	***168,610,925***	***1,389,533,376***

Coverage Estimates	DY 07	DY 08	DY 09	DY 01 - DY 09
Test A				
Limit	2,795,763,755	3,001,124,284	3,221,978,632	21,329,199,340
Expenditures	2,710,043,710	2,907,129,558	3,118,949,351	20,091,168,637
Limit less Expenditures	85,720,045	93,994,725	103,029,281	1,238,030,704
Test B				
Limit	2,462,826,000	2,608,265,261	2,762,307,461	8,395,971,707
Expenditures	2,404,218,000	2,546,271,209	2,696,725,816	8,244,469,034
Limit less Expenditures	58,608,000	61,994,052	65,581,644	151,502,673
Combined Test A and Test B	144,328,045	155,988,777	168,610,925	1,389,533,376
Cumulative Combined Test	1,064,933,674	1,220,922,451	1,389,533,376	
Anticipated Enrollment				
HIP Parents	165,000	167,190	169,409	501,599
HIP Adults	262,000	265,930	269,919	797,849
Total	**427,000**	**433,120**	**439,328**	**1,299,448**

Requirement 42 CFR 431.408	**State Compliance**
Provide at least a 30 day comment period and public notice. Notice must include: Comprehensive program description Program goals and objectives Description of current and new beneficiaries Describe proposed health care delivery system Eligibility requirements Benefit coverage Cost-sharing Estimated expected change in annual enrollment Estimated expected change in annual expenditures Financial analysis of any changes to the demonstration Hypothesis and evaluation parameters Specific waiver and expenditure authorities Locations and internet address where copies of the demonstration application are available for public review and comment. Postal and internet e-mail address for written comments and time frame (min 30 days) for which comments will be expected. Location date and time of at least two public hearings	• Notice was published in the Indiana Register • Notice is available at HIP.in.gov via links to the FSSA calendar • Waiver documents are available at HIP.in.gov • Bobbi Nardi (Office of General Counsel) is the contact listed on the notice • Two hearings included in notice
Public notice Publish public notice process, public input process, planned hearings, the demonstration application and a link to the relevant Medicaid demonstration pages on the CMS website on main page of the public website of State agency responsible for making applications for demonstrations or on a demonstration specific webpage.	The HIP notice and all supporting documents are posted on the main page of HIP.in.gov
Public notice Publish abbreviated notice to include summary description of demonstration, location & times of two or more public hearings and an active link to full public notice document on states website Publish in the state's administrative record *or* newspapers of widest circulation in each city with a population over 100,000 provided such notice is at least 30 days prior to the submission of the demonstration application.	Completed – Used the same notice in all venues versus creating an abbreviated notice such that no matter where the notice was viewed, all information was available. The notice was published in the Indiana Register.
Public notice State must also utilize additional mechanisms such as electronic mailing list to notify interested parties of the demonstration application	OMPP issued a bulletin
Public hearings 20 days prior to submission conduct at least 2 public hearings on separate dates at separate locations Must use telephonic and/or web conference capabilities for at least two required public hearings	Hearing 1: March 20 at 1:30pm in Indiana Government Center, Conference Center Room C Hearing 2: March 22 at 1:30pm in State House room 156B Both hearings are being webcast and there is a telephone conference. The information for these is in the notice on the website
Public hearings Must use 2 of the follow public forums: Medical Care Advisory Committee Commission or other similar process option to public State legislative process Any other similar process for public input	State is using the process FSSA OGC uses for Medicaid rules, etc to gain public input. We used this for the first HIP waiver request in 2012. HIP has previously been testified on via the State legislative process, including in 2011 during the passage of SEA 2011 authorizing HIP as the healthcare reform vehicle.
Tribal consultation and seeking advice from Indiana health providers and urban Indiana organizations	IN has no Indian health providers or federally recognized tribes with a government center in IN.

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 (ICHP) 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.[1] 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.

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.

[1] Testimony taken in regards to Senate Bill 551 and House Bill 1591.

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.

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.

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.

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.