IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201306 MARCH 8, 2013

Public Hearing for HIP Program

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 the Family and Social Services Administration will hold public hearings on a Medicaid 1115 waiver renewal submission to the Centers for Medicare & Medicaid Services to extend the Healthy Indiana Plan (HIP) demonstration project for calendar years 2014-2016. The hearings will be held:

- On March 20, 2013, at 1:30 p.m. at the Indiana Government Center South, Conference Center Room C, 402 West Washington Street, Indianapolis, Indiana 46204-2744
- On March 22, 2013, at 1:30 p.m. at the Indiana State House, Room 156B, 200 W. Washington Street, Indianapolis, Indiana 46204-2786

A live free webcast of the event will be available and open to the public at the first hearing on March 20, 2013, at 1:30 p.m. Eastern Time, online at webinar.IN.gov/HIP. Audio may be played through a participant's computer speakers or headphones. Comments of participants can be made online via the web chat box during the hearing and will be recorded. A telephone conference line will also be available for anyone wishing to call in during the time of the hearing. The dial-in number is 1-661-673-8600, Participant Access Code: 1088925#. Participants may incur and are responsible for any long-distance telephone charges.

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 toward 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 non-disabled 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 healthcare 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 healthcare services, and (7) ensure State fiscal responsibility and efficient management of the program. HIP will be evaluated based on progress toward these goals.

HIP currently covers approximately 39,000 individuals. The purpose of this 1115 waiver renewal is to continue HIP for three years 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 toward 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 threshold 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 copayments for nonemergency use of the emergency room (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 application, 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 total $5.1B, $5.4B, and $5.8B (state and federal) in 2014, 2015, and 2016 respectively. The expected savings via the waiver for each of those years, respectively, total $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.

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 W. Washington Street, Room 451, Indianapolis, Indiana 46204 and are open for public inspection. The documents may also be viewed at 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.

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at (317) 655-3240 in the Indianapolis local area or toll-free at 1-800-577-1278.

COPIES OF THIS PUBLICATION

If you need additional copies of this publication, please download them from indianamedicaid.com. To receive email notices of future IHCP publications, subscribe to IHCP Email Notifications.

TO PRINT

A printer-friendly version of this publication, in black and white and without graphics, is available for your convenience.