

Section 7: Public Comment

FSSA held public hearings for this five-year Section 1115 waiver application pursuant to the requirements set forth at 42 CFR 431.408. A copy of the full public notice that announced the two public hearings is included in Appendix A of this waiver application. The notice was posted on the agency's website at the web address of the Section 1115 waiver program's homepage: HIP.in.gov. In addition, notice was also published in the Indiana Register on May 21, 2014. OMPP also published notice in the Indiana Health Care Provider (IHP) Bulletin, which was sent electronically to all IHCP providers. 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. Electronic copies of all documents related to the HIP 2.0 waiver application were also available on the HIP website.

In accordance with the notice, public hearings were conducted on May 28 and May 29, 2014 as scheduled and publicized, at the Indiana Government Center Conference facilities and the Indiana State House. Six individuals testified regarding the HIP 2.0 proposal on May 28, 2014, and thirteen individuals testified on May 29, 2014. A court reporter transcribed both hearings. Both hearings were made available to the public via a telephone conference line and a live, free webcast.

On June 4, 2014, FSSA presented this HIP 2.0 waiver application to the Medicaid Advisory Committee, the State's Medical Care Advisory Committee that operates in accordance with 42 USC §431.12. Also, pursuant to state law, the HIP 2.0 waiver application was presented to the Indiana Budget Committee on June 20, 2014. During the meeting, legislators active on the Budget Committee were able to review and comment on the waiver.

The State received a significant amount of public comments during the 30 day public comment period, including forty-four (44) mailed letters and five hundred sixty two (562) emails, of which approximately one hundred fifty-five (155) were unique substantive comments while the remaining emails were either duplicates or petitions and form letters. The below summary combines the testimony offered at the public hearings as well as the multitude of diverse comments received via mail and email.

7.1 Summary of Public Comments

The majority of the substantive comments were supportive of the expansion of the HIP program. Many individuals and organizations were particularly enthusiastic in sharing their support for the proposed program modifications contained in the HIP 2.0 waiver, including the (i) removal of enrollment caps, (ii) elimination of lifetime and annual limits, (iii) the inclusion of state plan benefits for pregnant women and medically frail, (iv) reduction in lock out, (v) tiered flat rate contributions, and (vi) the bifurcation of the program. Many commenters, including one of Indiana's largest safety net providers, also expressed appreciation of the aspects of the program that will remain intact, specifically the key design features of the original program which promote personal responsibility and consumerism.

Members of the healthcare community, including the Indiana Hospital Association, the Indiana State Medical Association, and numerous hospitals, expressed support for the HIP 2.0 waiver as

an innovative, consumer-directed, private market approach to expanding coverage. 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. The Indiana Hospital Association wrote, "HIP 2.0 contains the right mix of incentives that will allow us to move the front door to the health care system from the emergency room to a primary care physician's office." Members of the healthcare community also supported HIP's higher provider reimbursement rates and the associated decrease in cost-shifting to the private market.

Due to the active and engaged stakeholders in communities across the State, most of the comments received were robust, sharing not only support and praise for the plan, but also specific suggested modifications to the proposed waiver. Some organizations, which generally supported the overall proposal also cited concerns related to the exclusion of certain benefits, such as non-emergency transportation (two comments) as well as the breadth of provider networks (three comments). A total of eleven (11) commenters shared specific implementation and/or operational suggestions covering diverse topics such as use of enrollment brokers, recertification processes, and cost containment policies. Many of these organization also stressed the importance of the need for strong consumer assistance and public education prior to implementation, and recommended that FSSA engage stakeholders through an advisory committee throughout implementation.

The State received thirty-four (34) comments related to the proposed HIP 2.0 financial contribution policies. A total of twenty-four (24) commenters expressed concerns regarding the required cost-sharing and related non-payment penalties, although the majority of these commenters, seventeen (17), still voiced support for the overall HIP proposal. Several of these commenters expressed general concern related to the affordability of the cost-sharing provisions for this population. However, other commenters expressed enthusiastic support of the affordability of the program as compared to the costs associated with the available Marketplace plans. The State received several supportive comments regarding HIP's personal responsibility mechanisms, including the financial contribution policies. Several commenters specifically supported the reduction of the lock-out period from twelve to six months, as it will continue to provide member incentive for monthly contributions, while also minimizing time without coverage for those unable to pay. Many commenters noted that HIP's cost-sharing provisions and non-contribution penalties have been successful in encouraging HIP members to become active participants in their own healthcare.

The three managed care organizations (MCOs) currently serving HIP members, commented that members seem to take pride in paying their monthly contributions. These entities supported HIP's consumer oriented program, and indicated that HIP's member responsibility provisions positively contribute to member health outcomes. The MCOs noted, in comparison to other Medicaid enrollees, HIP members have lower emergency room use and lower inpatient admissions, are more likely to complete recommended preventive services, and are more engaged in their coverage options through call centers and web portals. Two of the health plans stressed the importance of maintaining the commercial health plan attributes of the current program, including the continued waiver of the retroactive coverage period, as it would be

administratively burdensome to implement and would also undermine the purpose of the POWER account.

The State also received six (6) comments regarding the required copayments for the non-emergency use of hospital emergency department (ED). All comments were in favor of the ED copayment structure, citing positive results in utilization under the current HIP program. Anthem Blue Cross and Blue Shield testified that non-urgent ED utilization for its HIP members declined by 15.3% from 2011 to 2013, and ran 33% lower than its Hoosier Healthwise population in 2013, which they attribute to the dual incentives of copayments and for receipt of preventive care.

There was a subset of commenters that expressed discomfort with Medicaid expansion in general, regardless of the form of the expansion. An online petition organized by the Foundation for Government Accountability generated three hundred fourteen (314) supporters from citizens across the State expressing general opposition to Medicaid expansion in the State. On the other end of the spectrum, there was also a subset of commenters that expressed a preference for the expansion of traditional Medicaid rather than HIP. Many of these commenters expressed that while the HIP 2.0 waiver proposal was preferable to no action, a traditional Medicaid expansion as outlined by the federal government in the ACA would have been simpler and more inclusive. The State also received several comments from individuals urging expansion of HIP for the same reason. One commenter stated that HIP is the right answer for Indiana, asking, “Why reinvent the wheel?” since the program is already working for so many low-income Hoosiers.

A considerable number of comments were received during the public comment period which supported the overall HIP 2.0 proposal, but expressed concerns regarding the exclusion of certain services and providers in the waiver: (1) chiropractic services, and (2) institution for mental disease (IMD) providers. Each are discussed in more detail below.

1. Chiropractic Services

One hundred forty-two (142) comments were received advocating the addition of chiropractic services to the HIP 2.0 benefits. However, ninety-four (94) of the total comments opposing the exclusion of chiropractic services were form letters submitted on behalf of the patients at several chiropractic offices.

In general, the majority of the commenters cited the cost-effectiveness of chiropractic services and its ability to mitigate many different health problems. Other commenters expressed concerns related to transitioning current Medicaid recipients to HIP, which will disrupt their care by removing a service many individuals rely on.

2. Institutions for Mental Diseases (“IMD”) Exclusion

The long-standing CMS exclusion of IMD providers (“IMD Exclusion”) prohibits federal financial participation for inpatient mental health services provided to Medicaid eligible adults between 21 and 64 years of age that are provided in certain institutions that meet the definition of

an IMD. The State received two hundred seven (207) comments related to the IMD Exclusion. These commenters urged the inclusion of private free-standing psychiatric facilities under the HIP program. One hundred eighty (180) of the total comments were form letters of support received from various community organizations supporting the inclusion of a particular facility.

All commenters supported the HIP 2.0 waiver in general, however, they urged the State to include coverage for inpatient mental health services provided by free-standing psychiatric hospitals. All commenters discussed the significant access issues facing the State. The multitude of substantive comments received from free-standing psychiatric centers described long wait lists, as well as the high number of patients these facilities are forced to refer out each year due to the IMD Exclusion policy. They explain that these patients end up being forced to either travel long distances for services out of the community and disrupting continuity of care, or they end up in local emergency departments or even the legal system when they experience a crisis while waiting for an inpatient bed to become available.

7.2 State Response

The State appreciates all comments received either during a public hearing or shared with the State in writing. This HIP 2.0 waiver application addresses many of the comments received, as it is currently drafted. However, the State has reviewed all comments in depth and will consider many of the comments in its discussions with CMS and in context of the program evaluation and outcomes data related to HIP's design features and the impact on the goals of the program.

Due to the substantial volume of comments received on the exclusion of chiropractic services and IMD providers, the State will respond to each individually.

1. Chiropractic Services

Commenters provided the State with significant data and research studies purporting to demonstrate both the cost-effectiveness and positive health outcomes associated with chiropractic services compared to traditional medicine. While the State appreciates the important role of chiropractic services in the healthcare market, the covered benefits that are included in the HIP 2.0 waiver proposal are based on a commercial market base benchmark plan. In accordance with 45 CFR 156.100, the State selected the largest commercial HMO plan offered in the state to serve as the essential health benefit (EHB) benchmark plan for the HIP program. This plan did not include chiropractic services. The State selected the base benchmark plan that provides the most appropriate benefits for the program consistent with the limitations established in the ACA and federal regulations.

To clarify, based on several concerns raised during the public comment period, the benefit plan excludes chiropractic therapeutic treatment, which is based on the service not the provider. The program will not reimburse for these services regardless of the provider rendering the service (doctors of chiropractic, doctors of osteopathic medicine, doctors of medicine, or physical therapists). In addition, doctors of chiropractic are not excluded from the program, and may provide covered services to HIP members as medically appropriate.

Several commenters expressed concern that current Medicaid members will be transitioned to HIP and no longer be able to access chiropractic services. To clarify, all HIP members receiving state plan benefits (pregnant women, medically frail, and current Section 1931 parents and caretakers) will be able to access chiropractic care, as the service will continue to be included as a state plan benefit.

2. IMD Exclusion

In response to the several public comments received regarding the IMD exclusion and access to appropriate and timely acute, patient services for the HIP 2.0 population, the State closely reviewed the available data. The IMD exclusion, which prohibits federal financial participation (“FFP”) for medically necessary, inpatient mental health services provided in freestanding psychiatric hospitals with greater than sixteen (16) beds, has resulted in significant access issues related to the provision of acute, inpatient mental health services for adult Medicaid beneficiaries, ages twenty-one (21) through sixty-four (64) in all States and the lack of access to appropriate and timely mental health services for such beneficiaries.¹ Indiana has not been immune to the aforementioned access issue, and with the implementation of HIP 2.0, as the commenters note, the access issue will significantly increase due to HIP’s expansion to approximately 350,000 currently uninsured adults. It is estimated that 22.3% of the uninsured adults who will be eligible for HIP 2.0 suffer from serious psychological distress, 15.2% suffer from serious mental illness, and 24% suffer from substance use disorders.² Assuring access to this population will be a significant challenge for the State as evidenced by over one half of Indiana counties being considered a mental health professional shortage area by the Health Resources and Services Administration.³

Because of the IMD exclusion, only freestanding psychiatric hospitals with sixteen (16) or fewer inpatient beds and general acute care hospitals with psychiatric inpatient beds will be eligible to treat the new HIP 2.0 population for medically necessary, covered services related to acute, inpatient mental health needs. It is estimated that there are 568 adult inpatient psychiatric beds in general hospitals in Indiana and 153 adult inpatient psychiatric beds in private freestanding

¹ NAMI, *Medicaid Expansion & Mental Health Care*, May 2013, at www.nami.org, last accessed June 20, 2014.

² SAMHSA, *Enrollment under the Medicaid Expansion and Health Insurance Exchanges. A Focus on Those with Behavioral Health Conditions in Indiana*, at http://www.samhsa.gov/shin/content/PEP13-BHPREV-ACA/NSDUH_state_profile_Indiana.pdf, last accessed June 18, 2014. The term “serious psychological distress” or “SPD” is defined by SAMHSA as “a nonspecific indicator of past year mental health problems, such as anxiety or mood disorders.” SPD is defined as having “a score of 13 or higher on the K6 scale, which measures symptoms of psychological distress during the 1 month in the past 12 months when respondents were at their worse emotionally.” The term “serious mental illness” is defined by SAMHSA as “a designated term for persons aged 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within DSM-IV (APA, 1994) that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities.” SAMHSA defines “substance use disorder” as “abuse of or dependence on alcohol or an illicit drug.”

³ ISDH, *Mental Health Professional Shortage Area – MAP*, at www.state.in.us/isdh/23471.htm, last accessed June 20, 2014; HRSA Website, at www.hrsa.gov/shortage/, last accessed June 20, 2014. “Mental health HPSAs are based on a psychiatrist to population ratio of 1:30,000. In other words, when there are 30,000 or more people per psychiatrist, an area is eligible to be designated as a mental health HPSA.”

psychiatric hospitals with sixteen (16) or fewer beds for a total of 721 adult inpatient psychiatric beds in Indiana that are eligible for reimbursement under HIP 2.0.⁴ There are an estimated additional 142 adult inpatient psychiatric beds in private freestanding psychiatric hospitals that will be unavailable to the HIP 2.0 population for acute, inpatient mental health services, which are covered benefits under the plan.⁵ It is highly unlikely that the 721 adult inpatient beds will suffice to meet the increased need for providers who have the ability to provide the acute, inpatient mental health services that will be required for the new adult population under HIP 2.0.

Moreover, there are only 26 general hospitals that offer the aforementioned adult inpatient psychiatric beds for all 92 counties in Indiana, which results in significant travel and wait times for individuals in need of emergency psychiatric services.⁶ Providing access to all available providers to provide acute, inpatient mental health services to the new HIP 2.0 population will be important to preventing long wait times, emergency room boarding, untimely or inappropriate emergency treatment resulting in further decompensation of those with mental health issues and to assure quality of care. Thus, due to the significant access problem raised in the public comments, the State is committed to bringing this issues to CMS' attention and discussing possible solutions.

7.3 Summary of Waiver Changes Following Public Comment Period

While all comments received will inform the State in its discussions with CMS and the potential development of the Special Terms and Conditions, the State made the following changes and modifications to the waiver following the public comment period:

- Inclusion of a waiver for individuals above 300% FPL with End Stage Renal Disease (ESRD);
- Part time students will receive job referrals through Gateway to Work;
- Addition of hearing aids to the HIP benefit package due to required adjustments to ABP;
- Updated description of chiropractic care in the benefits table to align with the current description of services in the state plan;
- A technical revision was made to a footnote describing advanced practice registered nurse (APRNs) per a comment received from the Indiana State Nurses Association;
- Clarification was provided regarding the requirements to transition to HIP Plus from HIP Basic at redetermination;
- POWER account contributions were adjusted to reflect more detailed data available regarding the current contribution averages for the 51%-100% FPL group;
- To reinforce HIP's personal responsibility goals, the State added language to maintain the current HIP policy requiring debt collection when a HIP enrollee returns to the program;
- Clarification was provided that other than the specific modifications proposed in the waiver, the State is requesting that all other aspects of the current HIP program remain intact; and

⁴ NAMI Indiana, Ind. Council of Comm. Mental Health Ctrs., Inc., *Mapping Indiana's Mental Health Crisis Services*, 2014.

⁵ *Id.*

⁶ *Id.*

- Technical corrections were made to the requested waivers listed in Section 8.

Other than the changes noted above, the content of this application is identical to the copy of the application initially posted on the FSSA website on May 15, 2014.

Appendix A: 2014 Notice of Public Hearing

Indiana Family and Social Services Administration

Notice of Public Hearing and Public Comment Period

Pursuant to 42 CFR Part 431.408, notice is hereby given that: (1) on May 28, 2014, at 9:00 a.m., at the Indiana Government Center South, Conference Center Room B, 402 West Washington Street, Indianapolis, Indiana 46204-2744; and (2) on May 29, 2014, at 1:00 p.m., at the Indiana State House, Room 156-B, 200 West Washington Street, Indianapolis, Indiana 46204-2786, the Indiana Family and Social Services Administration (“FSSA”) will hold public hearings on the Healthy Indiana Plan 2.0 1115 demonstration waiver (“HIP 2.0 Waiver”) application that will be submitted to the Centers for Medicare and Medicaid Services (“CMS”) to extend and expand the current Healthy Indiana Plan (“HIP”) for calendar years 2015 through 2019. Both public hearings will be accessible via web conference at <http://www.webinar.in.gov/hip/>. In addition, FSSA will present the HIP 2.0 Waiver to the Medicaid Advisory Committee on Wednesday, June 4, 2014 at 10:00 a.m. at the Indiana War Memorial, Shoup Hall, 431 North Meridian Street, Indianapolis, IN 46204.

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

The Healthy Indiana Plan (“HIP”), which passed the Indiana General Assembly in 2007 with bipartisan support, builds upon the state’s long and successful history with consumer-driven health plans. The HIP 2.0 Waiver proposes a series of modifications to the current HIP program (“HIP 2.0”) and seeks to expand the program to all non-disabled adults between the ages of 19 and 64 with household income below 138% of the federal poverty limit (“FPL”). HIP 2.0 will continue to offer its members, via private health insurance carriers, a High Deductible Health Plan (“HDHP”) paired with a Personal Wellness and Responsibility (“POWER”) account, which operates similarly to a Health Savings Account (“HSA”). This private health insurance experience provides an alternative to traditional Medicaid and promotes consumerism by requiring members to have “skin in the game,” which empowers them to demand price and quality transparency as they make cost-conscious health care decisions and take responsibility for their health. HIP, in its current form, is scheduled to expire on December 31, 2014.

FSSA is submitting the HIP 2.0 Waiver concurrently with a separate Healthy Indiana Plan 1115 waiver extension request (“HIP Extension Waiver”), which seeks to extend the current HIP program in its existing form through 2017. FSSA is submitting the HIP Extension Waiver as an alternative to the HIP 2.0 Waiver in order to preserve the current HIP program in the event CMS does not approve the HIP 2.0 Waiver.

OBJECTIVES

HIP 2.0 furthers HIP’s core objectives: 1) reduce the number of uninsured, low income Hoosiers and increase access to healthcare services; 2) promote value-based decision-making and personal health responsibility; 3) promote disease prevention and health promotion to achieve better health outcomes; 4) promote private market coverage and family coverage options to reduce network and provider fragmentation within families; 5) facilitate HIP member access to job training and stable employment to reduce dependence on public assistance; and 6) assure State fiscal responsibility.

BENEFICIARIES, ELIGIBILITY, & FINANCING

HIP 2.0 offers health care coverage to non-disabled individuals between the ages of 19 and 64, who have household incomes below 138% of the FPL and who are not otherwise eligible for Medicaid or Medicare. Income eligibility for HIP is determined using the modified adjusted gross income (“MAGI”) methodology with a 5% disregard. HIP 2.0 augments the existing program by offering HIP to individuals previously excluded from the program due to the program’s eligibility restrictions and the enrollment caps. First, Section 1931 parents and caretaker relatives, who are currently covered under the Hoosier Healthwise (“HHW”) program, will be transferred to HIP. In addition, HIP 2.0 will remove the existing 36,500 enrollment cap on non-caretaker adults allowed to participate in the program.

Recognizing the strong tie between work and health, HIP 2.0 promotes employment by introducing the HIP’s Gateway to Work program. This program requires all HIP members who are unemployed or working less than 20 hours a week to be referred, as a condition of eligibility, to the State’s workforce training programs and work search resources. Full-time and part-time students will be exempted from the referral for each year they are enrolled in a postsecondary education institution or technical school.

HIP 2.0 enrollment, including the addition of Section 1931 parents and caretaker relatives, is projected to expand HIP coverage to approximately 600,000 by demonstration year five. Over the five-year demonstration period (2015-2019), HIP 2.0 is expected to cost approximately \$2.4 billion in state funds, and \$20.9 billion in total combined state and federal funds. The table below provides the estimated state and federal costs divided by year.

Estimated State and Federal Program Costs 2015-2019 (in millions)

Calendar Year	Demonstration Year	Expenditures without Waiver	Total HIP 2.0 Expenditures	State Share of HIP 2.0 Expenditures	Waiver Margin
2015	1	\$ 2,779.7	\$ 3,145.2	\$ 358.2	(\$365.4)
2016	2	\$ 4,064.6	\$ 4,077.3	\$ 329.8	(\$12.7)
2017	3	\$ 4,481.1	\$ 4,349.2	\$ 511.2	\$ 131.9
2018	4	\$ 4,775.6	\$ 4,554.6	\$ 570.7	\$ 221.0
2019	5	\$ 5,089.4	\$ 4,796.6	\$ 637.2	\$ 292.8

BENEFITS AND HEALTH CARE DELIVERY SYSTEM

HIP offers its members a High Deductible Health Plan (HDHP) paired with the Personal Wellness and Responsibility (POWER) account, which operates similarly to a Health Savings Account (HSA), used to fund the plan’s \$2,500 deductible, as more fully described in the cost-sharing section below. Current HIP benefits are authorized as Secretary-approved coverage. HIP is not presently benchmark-equivalent coverage as it does not cover maternity services and includes a \$300,000 annual and \$1 million lifetime coverage limit. HIP 2.0 benefits will be updated to offer a comprehensive benefits plan that meets Alternative Benefit Plan (“ABP”) requirements. Preventive services, such as annual examinations, smoking cessation programs, and mammograms are covered without charge to the member and are not included in the deductible amount. After the \$2,500 deductible is met through the utilization of POWER account funds, the HIP program includes a comprehensive benefit package, which includes physician services, inpatient/outpatient hospital services, maternity services, emergency transportation, prescription drugs, diagnostic services, durable medical equipment and medical supplies, rehabilitative services, home health services, and mental health and substance abuse services. HIP 2.0 will eliminate the lifetime and annual coverage limits, and maternity services will be added as an option in all HIP benefit plans. However, the State intends to maintain its waiver for non-emergency transportation.

Under HIP 2.0, members who consistently make required contributions to their POWER account will maintain access to a new “HIP Plus” plan that includes enhanced benefits, such as dental and vision coverage. Members under 100% FPL who do not to make monthly POWER account contributions will be placed in the “HIP Basic” plan, a more limited benefit plan, which will also require co-payments for all services in lieu of the monthly POWER account contributions. Members under 100% FPL will have a choice of 1) the HIP Basic benefit package that applies co-payments to services or 2) the enhanced HIP Plus benefit package that requires members to make contributions to their POWER account; while members above 100% FPL will utilize the HIP Plus plan.

Enrollees who are pregnant, Section 1931 parents and caretaker relatives, or qualify as medically frail will be enrolled in HIP but will receive benefits equivalent to coverage on the State Plan. Consistent with 42 CFR §440.315(f), an individual will be considered “medically frail” if he or she has one or more of the following: 1) disabling mental disorder; 2) a chronic substance abuse disorder; 3) serious and complex medical condition; 4) physical, intellectual, or developmental disability that significantly impairs the individual’s ability to perform one or more activity of daily living; or 5) a disability determination, based on Social Security Administration criteria. The State will implement robust retrospective and prospective screening processes to identify medically frail individuals through the HIP application process as well as through claims data.

In addition, the HIP 2.0 Waiver also proposes the implementation of a new optional defined contribution premium assistance program, HIP Employer Benefit Link (“HIP Link”), designed to support individuals wishing to purchase their employer-sponsored insurance (“ESI”). Eligibility for HIP Link will be determined as follows: (i) individual must be eligible for HIP but not considered medically frail, (ii) individual must be 21 years of age or older, (iii) individual must have access to and be eligible to participate in their ESI, and (iv) the employer must be contributing at least 50% of the premium cost. The State will not provide wrap-around benefits, as election to participate in the ESI plan through HIP Link is optional. To ensure the quality of ESI plans, all small group plans must provide essential benefits and all large group and self-insured plans are subject to the minimum value requirements and are recognized as minimum essential coverage.

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

COST SHARING REQUIREMENTS

HIP utilizes two forms of cost-sharing: POWER account contributions and co-payments to promote consumerism and personal responsibility. The State ensures these costs do not exceed 5% of family income. HIP provides each member with an HSA-like account - the POWER account - to cover the plan’s deductible. Instead of traditional cost-sharing of premiums and co-payments, most HIP members make upfront monthly contributions to the POWER account. The State pre-funds the difference between the member’s required annual POWER account contribution and the plan’s deductible to ensure adequate funding for deductible expenses early in the benefit period. Once the POWER account contribution is made, the individual has no additional cost-sharing except for a co-payment for inappropriate emergency department usage. HIP 2.0 will maintain the existing cost-sharing structure with the following modifications:

1. *Adjusting the required contributions and calculation methodology.* Currently, as a condition of eligibility, all members are required to make monthly POWER account contributions based on a sliding fee scale, reflecting approximately 2% of the member’s household income. HIP 2.0 proposes to replace the current member contributions with a new flat rate contribution level based on FPL as set forth in the table below. The set contribution levels are intended to simplify program administration, facilitate clear communication with members, and increase affordability. In addition, members choosing to enroll in their ESI plans through the HIP Link option will be required to pay the same monthly contributions consistent with the HIP Plus levels set forth below.

POWER Account Flat Rate Monthly Contributions by FPL

FPL	Proposed Monthly Contribution	2012 Average Monthly Contribution
<22%	\$3	\$7.94
23%-50%	\$8	\$10.32
51%-100%	\$15	\$17.77
101%-138%	\$25	\$39.69*

* The amount shown represents the average 2012 monthly contribution for members 100-150% FPL.

2. *Modifying non-payment penalties.* Under the current HIP structure, members must make regular monthly contributions to their POWER account, or face disenrollment from the program and a 12 month lock-out period. Due to proposed changes in the program structure, the HIP 2.0 would modify the non-payment penalties. Specifically, for members at or above 100% FPL, the State plans to maintain the current lock-out structure for non-payment, but with a reduction in the lock-out period from 12 months to 6 months. By contrast, for individuals below 100% FPL, in lieu of disenrollment, the member would be transferred to the HIP Basic plan, which, as described above, would provide a reduced benefit package and require co-payments for all services, in accordance to the table below. Although HIP Basic plan members will not be

required to make POWER account contributions, the members will continue to manage a POWER account in order to continue to promote HIP’s principles of consumerism.

HIP Basic Plan Co-payment Schedule

Service	HIP Basic Plan Co-Pay Amounts
Preventive Care Services	\$0
Outpatient Services	\$4
Inpatient Services	\$75
Preferred Drugs	\$4
Non-preferred drugs	\$8
Non-emergency ED visit	Up to \$25

3. *Increasing the POWER account maximum.* HIP 2.0 seeks to increase the amount of the POWER account to \$2,500 (rather than the current \$1,100) to better align with the current HSA standard and increase the amount of dollars members are managing. However, despite the increase in the deductible, the required member contribution will not increase, and, instead, the State would contribute more to the account, thereby providing more dollars for the member to directly manage.
4. *Modifying the POWER account rollover process.* The POWER account roll-over process will be modified under HIP 2.0 to reflect the overall increase in the POWER account value, alteration in member contributions, and increased State contributions to the account. HIP Plus members who have a remaining POWER account balance at the end of the year will be able to roll over their share to the next plan year. As an added bonus, if the HIP Plus member receives their recommended preventive care services during the year, the State will match their rollover amount, doubling the amount of the member’s personal share of the POWER account. The total amount will then be used to reduce required contributions in future plan years. Members in the HIP Basic plan are only eligible to reduce their required HIP Plus annual contributions in the following year by up to half if they receive recommended preventive care services while on the HIP Basic plan.
5. *Introducing a graduated co-payment amount for inappropriate emergency department (ED) utilization.* HIP currently charges co-payments to discourage inappropriate use of emergency services. Non-caretakers must currently pay \$25 co-payments for inappropriate ED use, while parents and caretaker relatives must pay \$3. The HIP 2.0 Waiver seeks to test a graduated co-payment applicable to all HIP members (except pregnant women) regardless of HIP benefit package or FPL, whereby the first inappropriate emergency department visit would require an \$8 co-payment; and subsequent inappropriate visits would require a \$25 co-payment. ED copayments will be waived for any member who contacts their MCE’s 24 hour nurses hotline prior to utilizing a hospital ED.
6. *Alternative cost-sharing structure for pregnant women.* In accordance with federal law, pregnant women will be exempt from all cost-sharing for the duration of their pregnancy and for 60 days following delivery.

HYPOTHESES & EVALUATION

The HIP 2.0 Waiver will investigate the following research hypotheses related to each program goal:

1. **Goal 1: Reduce the number of insured low income Hoosiers and increase access to health care services.**
 - a. Hypotheses:
 - i. HIP will reduce the number of insured Hoosiers with income under 138% FPL.
 - ii. HIP will increase access to quality health care services among the target population.
 - b. Evaluation:
 - i. Track rates of uninsured Hoosiers with income below 138% FPL.

- ii. Track the number of Hoosiers served by the HIP program.
- iii. Track member feedback for perceived access to different types of healthcare services before and after enrollment in the HIP program.
- iv. Measure geo-access standards for primary and specialty care for all health plans.
- v. Measure member health plan satisfaction indicators.

2. Goal 2: Promote value-based decision making and personal health responsibility.

a. Hypotheses:

- i. HIP policies will encourage member compliance with required contributions and provide incentives to actively manage POWER account funds.
- ii. HIP Plus members will exhibit more cost-conscious healthcare consumption behavior than HIP Basic members and traditional Hoosier Healthwise members.
- iii. HIP's emergency department ("ED") utilization policies (including the graduated copayments for non-emergent use of the ED) will deter inappropriate ED utilization.

b. Evaluation:

- i. Track initial HIP Plus vs. HIP Basic enrollment by FPL.
- ii. Track HIP members making initial and subsequent POWER account contributions.
- iii. Track and compare average remaining POWER account balances.
- iv. Track HIP Plus member POWER account rollover rates and the average amount by which contributions are reduced in the next benefit period for base rollovers and preventive care rollovers.
- v. Track the average amount by which required contributions are discounted for HIP Basic members transitioning to HIP Plus at redetermination.
- vi. Track the copayment collection rate for HIP Basic members.
- vii. Track health service utilization rates for the following groups (controlling for health status, age and other relevant variables)—HIP Plus members, HIP Basic members who enrolled in HIP Plus at the end of the period, and HIP Basic member who do not enroll in HIP Plus at the end of the period.
- viii. Compare annual rates of inappropriate ED utilization between HIP population for the years before and after the change in ED policy.
- ix. Compare annual rates of alternative urgent care setting utilization between HIP population for years before and after the change in ED policy.
- x. Survey HIP members on whether the copayment for non-emergency use of the ED caused them to seek services with their primary care physician or alternative urgent care setting.
- xi. Compare annual rates of members seeking prior authorization through the nurses' hotline prior to seeking ED services.
- xii. Compare annual rates of members paying increased copayments based on repeated inappropriate ED utilization.

3. Goal 3: Promote disease prevention and health promotion to achieve better health outcomes.

a. Hypothesis:

- i. HIP will effectively promote member use of preventive, primary and chronic disease management care to achieve improvements health outcomes.

b. Evaluation:

- i. Track and compare health service utilization rates between HIP and traditional Medicaid members.
- ii. Track and compare POWER account rollover and contribution discount rates for HIP Plus members and HIP Basic members who enroll in HIP Plus at the end of a benefit period.
- iii. Track preventive care utilization rates and trends among different age and gender groups.
- iv. Track participation in health plan's chronic disease management programs.

4. **Goal 4: Promote private market coverage and family coverage options to reduce provider and network fragmentation within families.**
 - a. Hypotheses:
 - i. HIP Link will increase the proportion of Hoosiers under 138% FPL covered by employer-sponsored insurance (ESI).
 - ii. HIP's ESI premium assistance option for family coverage will increase the number of low income families in which the parents and children have access to the same provider network.
 - b. Evaluation:
 - i. Track Hoosiers with income under 138% FPL covered by ESI over the demonstration.
 - ii. Track Hoosiers with income under 138% FPL receiving defined contribution premium assistance to purchase ESI each year of the demonstration.
 - iii. Track the number of parents eligible for and utilizing premium assistance for their children to enroll in the family coverage ESI plan in lieu of CHIP.

5. **Goal 5: Facilitate HIP member access to job training and stable employment to reduce dependence on public assistance.**
 - a. Hypothesis:
 - i. Referrals to the Department of Workforce Development employment resources at the time of application will increase member employment rates over demonstration.
 - b. Evaluation:
 - i. Track the number of HIP applicants referred for work search and job training assistance.
 - ii. Track the number of HIP members who participate in work search/job training programs.
 - iii. Compare rates of full and part-time employment among the enrolled population at application and after six months, one year, and two years into the program.
 - iv. Track the number of HIP individuals transitioning off the program due to increased income.

6. **Goal 6: Assure State fiscal responsibility and efficient management of the program.**
 - a. Hypothesis:
 - i. HIP will remain budget-neutral for both the federal and state governments.
 - b. Evaluation:
 - i. Conduct budget neutrality analysis and document adherence to waiver margin.

WAIVER & EXPENDITURE AUTHORITIES

The following includes a list of waiver and expenditure authorities for the HIP 2.0 Waiver:

1. **Amount, Duration, Scope, and Comparability** Section 1902(a)(10)(B)
 To the extent necessary to enable Indiana to vary services offered to individuals within eligibility groups or within the categorical eligible population, based on differing managed care arrangements or in the absence of managed care arrangements. To the extent necessary to enable Indiana to offer an alternative limited benefits package to HIP members under 100% FPL who do not make their POWER account contributions.

2. **Freedom of Choice** Section 1902(a)(23)
 To the extent necessary to enable Indiana to restrict the freedom of choice of providers for demonstration eligibility groups.

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

To the extent necessary to enable Indiana to prohibit re-enrollment for 6 months for HIP members above 100% FPL who are disenrolled for failure to make POWER account contributions. To the extent necessary to enable Indiana to delay provision of medical coverage until the first day of the month following an individual's first contribution to the POWER account.

4. Methods of Administration: Transportation Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53
To the extent necessary to enable Indiana not to assure transportation to and from medical providers for HIP members, except for those who are exempt from Alternative Benefit Plans and receiving State Plan benefits, including pregnant, individuals determined to be medically frail, and Section 1931 parents and caretaker relatives.

5. Eligibility Section Section 1902(a)(10)(A)
To the extent necessary to enable Indiana not to provide medical coverage for HIP members enrolled in the HIP Plus plan above 100% FPL until the first day of the month following an individual's first contribution to the POWER account, or for members under 100% FPL who fail to make an initial POWER account payment within 60 days following the date of eligibility.

6. Amount, Duration, and Scope of Services Section 1902(a)(10)(B)
To the extent necessary to enable Indiana to offer to HIP members, known as "the adult group" in the proposed rule at 42 CFR 435.119, benefits that differ from the benefits offered to the categorically needy group.

7. Retroactive Eligibility Section 1902(a)(34)
To the extent necessary to enable Indiana not to provide medical coverage to HIP members in the HIP Plus plan for any time prior to the first of the month following an individual's first contribution to the POWER account, and to allow Indiana not to provide medical coverage to HIP members initially enrolled in the HIP Basic plan until after the date of the eligibility determination.

8. Prepayment Review Section 1902(a)(37)(B)
To the extent necessary to enable Indiana not to ensure that prepayment review be available for disbursements by members of HIP to their providers.

9. Cost-Sharing Section 1916A
To the extent necessary to enable Indiana to require POWER account contributions for members in the HIP Plus plan, co-payments up to 5% of household income for HIP members in the HIP Basic plan, and graduated co-payments up to \$25 for all HIP members, except pregnant women, using a hospital emergency department for non-urgent care.

10. Vision and Dental Coverage Section 1902(a)(34)
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 HIP who are enrolled in the HIP Basic plan for failure to make POWER account contributions.

REVIEW OF DOCUMENTS AND SUBMISSION OF COMMENTS

The proposed HIP 2.0 Waiver documents are available for public review at the FSSA, Office of General Counsel, 402 W. Washington Street, Room W451, Indianapolis, Indiana 46204. The documents may also be viewed online at www.HIP.in.gov.

Written comments regarding the HIP 2.0 Waiver may be sent to the FSSA via mail at 402 West Washington Street, Room W374, Indianapolis, Indiana 46204, Attention: Steve Holt or via electronic mail at HIP2.0@fssa.in.gov through June 21, 2014.

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