

**CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS**

NUMBER: 11-W- 00296/5

TITLE: Healthy Indiana Plan (HIP) 2.0

AWARDEE: Indiana Family and Social Services Administration

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Healthy Indiana Plan (HIP) 2.0 section 1115(a) Medicaid demonstration (hereinafter “demonstration”) to enable Indiana to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted a waiver of requirements under section 1902(a) of the Social Security Act (the Act). These STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state’s obligations to CMS during the life of the demonstration. The demonstration will be statewide and is approved for a 3-year period, from February 1, 2015 through January 31, 2018.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Objectives
- III. General Program Requirements
- IV. Populations Affected
- V. Benefits
- VI. Optional HIP Employer Benefit Link (HIP Link) Program
- VII. HIP 2.0 POWER Accounts
- VIII. HIP 2.0 Cost Sharing
- IX. Delivery System
- X. General Reporting Requirements
- XI. General Financial Requirements
- XII. Budget Neutrality Determination
- XIII. Evaluation
- XIV. Monitoring
- XV. Health Information Technology
- XVI. T-MSIS Requirements
- XVII. Schedule of Deliverables

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

Attachment A: HIP Link Program Protocol (reserved)

Attachment B: POWER Account Contributions and Copayments Infrastructure Operational Protocol (reserved)

Attachment C: POWER Account Contributions and Copayments Monitoring Protocol (reserved)
Attachment D: Emergency Room Co-pay Protocol (reserved)
Attachment E: Evaluation Design (reserved)

II. PROGRAM DESCRIPTION AND OBJECTIVES

This section 1115(a) demonstration provides authority for the state to offer HIP 2.0, which provides health care coverage for adults through a managed care health plan and an account similar to a health savings account called a Personal Wellness and Responsibility (POWER) account. Under HIP 2.0, Indiana is building on and changing its previous HIP program in multiple ways including the creation of new benefit packages and the establishment of a broader incentive structure for encouraging healthy behaviors. Some of those changes, like the creation of Basic, Plus and HIP Link benefit packages are being implemented through the state plan. Other changes are effective through this demonstration, which provides authority for the charging of POWER account contributions, the implementation of healthy behavior incentives, and a premium assistance program for individuals with employer sponsored insurance (ESI).

With this demonstration, Indiana expects to achieve the following to promote the objectives of title XIX:

- Promoting increased access to health care services;
- Encouraging healthy behaviors and appropriate care, including early intervention, prevention, and wellness;
- Increasing quality of care and efficiency of the health care delivery system; and
- Promoting private market coverage and family coverage options through HIP Link to reduce network and provider fragmentation within families.

Over the 3-year period, Indiana seeks to demonstrate the following:

- Whether a monthly payment obligation linked to a POWER account will result in more efficient use of health care services;
- Whether the incentives established in this demonstration for beneficiaries to obtain preventive services and engage in healthy behaviors will result in better health outcomes and lower overall health care costs; and
- Whether POWER account contributions in lieu of cost sharing for individuals participating in the HIP Plus Plan will affect enrollment, utilization, and the use of preventive and other services by beneficiaries.

Under HIP 2.0, beneficiaries who consistently make required monthly contributions to their POWER Account will maintain access to an enhanced benefit plan, known as “HIP Plus”, which will include enhanced benefits such as dental and vision coverage. HIP Plus is intended to encourage personal responsibility, improve healthy behaviors, and develop cost conscious consumer behaviors among all beneficiaries. Beneficiaries with income at or below 100 percent of the FPL who do not make monthly POWER account contributions will be defaulted to a more limited benefit plan meeting alternative benefit plan requirements (known as “HIP Basic.”) The

HIP Basic plan will require co-payments for all services in amounts that would be permitted in the state plan rather than the monthly POWER account contributions required to participate in the HIP Plus plan. Additionally, individuals with access to employer sponsored insurance (ESI) that meets state standards may choose to participate in their ESI, with a POWER account to fund out-of-pocket costs. All beneficiaries will have the opportunity to have their POWER account contributions reduced in subsequent years for completion of preventive services and through successfully managing their POWER accounts.

III. GENERAL PROGRAM REQUIREMENTS

- 1. Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
- 2. Compliance with Medicaid and Children’s Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid program and CHIP, expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.
- 3. Changes in Federal Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to allow the state to provide comment.
- 4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
 - a. If changes in requirements under federal law need state legislation to be implemented, the changes must take effect on the earlier of: 1) the day such state legislation becomes effective, 2) the last day of the first legislative session that meets on or after the 60th day following the change in federal law; 3) the day specified in federal law for implementation of the change.
 - b. Should there be changes in the FFP associated with the demonstration, the state may seek to end the demonstration (as per paragraph 9 of this section) or seek an amendment (as per paragraph 7 of this section).
- 5. State Plan Amendments.** Medicaid eligibility will be determined in accordance with the approved Medicaid state plan. Any change to eligibility must be made through an

amendment to the Medicaid state plan. The Medicaid state plan shall be the controlling authority except to the extent that a requirement is not waived or listed as inapplicable to an expenditure authority. These STCs do not waive Medicaid requirements, but contain operational limits and instructions on how the state may implement waivers of Medicaid requirements.

Should the state amend the state plan to make any changes to eligibility for any population affected by the demonstration, upon submission of the state plan amendment, the state must notify CMS demonstration staff in writing of the pending state plan amendment, and request any necessary corresponding technical corrections to the demonstration.

- 6. Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, and budget neutrality that are specifically authorized under the demonstration project must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7, except as provided in STC 3.
- 7. Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

 - a. An explanation of the public process used by the state, consistent with the requirements applicable to amendments listed in paragraph 14 of this section, prior to submission of the requested amendment;
 - b. A data analysis worksheet which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detail projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
 - c. An up-to-date CHIP allotment neutrality worksheet, if necessary;
 - d. A detailed description of the amendment including impact on beneficiaries, with

sufficient supporting documentation and data supporting the evaluation hypotheses as detailed in the evaluation design in section XIII; and

- e. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. Extension of the Demonstration. States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the governor or chief executive officer of the state must submit to CMS either a demonstration extension request or a transition and phase-out plan consistent with the requirements of paragraph 9 of this section.

- a. Compliance with Transparency Requirements at 42 CFR §431.412.
- b. As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR §431.412 and the public notice and tribal consultation requirements outlined in STC 14.

9. Demonstration Phase Out. The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

- a. **Notification of Suspension or Termination.** The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft plan to CMS. The state must submit the notification letter and a draft plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with 42 CFR 431.408. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and the extent to which the state incorporated the received comment into the revised plan. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of the phase-out activities. Implementation of activities must be no sooner than 14 days after CMS approval of the plan.
- b. **Transition and Phase-out Plan Requirements.** The state must include, at a minimum, in its plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights, if any), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the program for the affected beneficiaries, and ensure ongoing coverage for those beneficiaries determined eligible, as well as any community outreach activities including community resources that are available.

- c. **Phase-out Procedures.** The state must comply with all applicable notice requirements found in 42 CFR §431.206, §431.210, and §431.213. In addition, the state must assure all applicable appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and §431.221. If a demonstration participant is entitled to and requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category. 42 CFR §435.916.
- d. **Exemption from Public Notice Procedures 42.CFR §431.416(g).** CMS may expedite the federal and state public notice requirements in the event it determines that the objectives of title XIX and XXI would be served or under circumstances described in 42 CFR §431.416(g).
- e. **Federal Financial Participation (FFP).** If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services, continued benefits as a result of beneficiaries' appeals and administrative costs of disenrolling beneficiaries.

10. Post Award Forum. Within six months of the demonstration's implementation, and annually thereafter, the state shall afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can either use its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The state must include a summary of the comments in the quarterly report associated with the quarter in which the forum was held. The state must also include the summary in its annual report.

11. Expiring Demonstration Authority. For demonstration authority that expires prior to the demonstration's expiration date, the state must submit a transition plan to CMS no later than 6 months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:

- a. **Expiration Requirements.** The state must include, at a minimum, in its demonstration expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights, if any), the process by which the state shall conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

- b. **Expiration Procedures.** The state must comply with all applicable notice requirements found in 42 CFR Sections 431.206, 431.210 and 431.213. In addition, the state must assure all applicable appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR Sections 431.220 and 431.221. If a demonstration participant requests and is entitled to a hearing before the date of action, the state must maintain benefits as required in 42 CFR Section 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.
- c. **Federal Public Notice.** CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR Section 431.416 in order to solicit public input on the state's demonstration expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state's demonstration expiration plan. The state must obtain CMS approval of the demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than 14 days after CMS approval of the plan.
- d. **Federal Financial Participation (FFP).** FFP shall be limited to normal closeout costs associated with the expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals and administrative costs of disenrolling participants.

12. Withdrawal of Waiver Authority. CMS reserves the right to amend and withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XIX. CMS will promptly notify the state in writing of the determination and the reasons for the amendment and withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn or amended, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiaries' appeals and administrative costs of disenrolling participants.

13. Adequacy of Infrastructure. The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

14. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The state must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the implementing

regulations for the Review and Approval Process for Section 1115 demonstrations at 42 CFR Section 431.408, and the tribal consultation requirements contained in the state's approved state plan when any program changes to the demonstration are proposed by the state.

- a. In states with federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 CFR Section 431.408(b)(2)).
- b. In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal and/or renewal of this demonstration (42 CFR Section 431.408(b)(3)).
- c. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

15. Federal Financial Participation (FFP). No federal matching for service expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

16. Deferral for Failure to Provide Deliverables on Time. The State agrees that CMS may require the state to cease drawing down federal funds until such deliverables are timely submitted in a satisfactory form, until the amount of federal funds not drawn down would exceed \$5,000,000.

IV. POPULATIONS AFFECTED

1. Eligibility Groups Affected By the Demonstration. This demonstration affects individuals ages 19 through 64 who are eligible in the new adult group under the state plan that is described in 1902(a)(10)(A)(i)(VIII) of the Act, and 42 CFR § 435.119, and who receive services described in the alternative benefit plans (ABP) under the state plan, unless otherwise excluded as described in paragraph 2 of this section. HIP 2.0 will also affect parents and caretaker relatives under the state plan who are eligible under 42 CFR 435.110, low-income 19 and 20 year old dependents who are eligible under 42 CFR 435.222, and also parents and caretaker relatives who are eligible under the state plan for Transitional Medical Assistance (TMA) under Section 1925 of the Act who become eligible for TMA after February 1, 2015, unless otherwise excluded as described in paragraph 2 of this STC.

All affected groups derive their eligibility through the Medicaid state plan, and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as expressly listed as waived in this demonstration, subject to the operational limits as described in these STCs. All Medicaid eligibility standards and

methodologies for these eligibility including the conversion to a modified adjusted gross income standard January 1, 2014, remain applicable.

Table 1. Medicaid State Plan Groups Affected by the Demonstration		
Medicaid State Plan Group	Population Description	Funding Stream
New adult group including individuals who are medically frail	Individuals ages 19 through 64 who are eligible in the new adult group under the state plan that is described in 1902(a)(10)(A)(i)(VIII) of the Act, including individuals who meet the definition of medically frail consistent with 42 CFR Section 440.315(f).	Title XIX
Parents & caretaker relatives eligible under 42 CFR 435.110 and low-income 19 & 20 year old dependents under 42 CFR 435.222	Parents and caretakers and low-income 19 & 20 year old dependents with income under the State's AFDC payment standard in effect as of May 1, 1988 (section 1931 parents and caretaker relatives and low-income 19 & 20 year old dependents), converted to a	Title XIX
Transitional Medical Assistance (including individuals who are medically frail)	Former Parent & Caretaker relatives eligible for a minimum of six and a maximum of 12 months of continued coverage under Transitional Medical Assistance	Title XIX

- 2. Excluded Populations.** The following individuals are excluded from the demonstration, even if otherwise within the populations described in paragraph 1 of this section: Individuals eligible for another Medicaid category under the State Plan except for pregnant women who choose to remain in HIP per Section VI STC 2(g).
- a. Individuals eligible for Medicare at the time of enrollment. If an individual becomes eligible for Medicare after enrolling in HIP 2.0, then disenrollment from HIP 2.0 would become effective starting the date of Medicare Part B eligibility and in accordance with Medicaid and Medicare rules and regulations.
 - b. Effective April 1, 2015, American Indian/Alaska Natives (AI/AN) who have elected to opt out of HIP 2.0 will receive coverage through a fee-for-service delivery system unaffected by the demonstration. Individuals in the new adult population who opt out still will receive coverage as specified under the

state plan in the HIP Plus ABP. Individuals who opt out who are eligible as parents and caretaker relatives, or receiving TMA will not receive an ABP but will receive all benefits otherwise specified in the state plan.

- 3. Effective Date of Coverage.** For individuals who participate in HIP Plus, coverage will be effective no later than the first day of the month in which the initial POWER account contribution or fast track pre-payment is made. For individuals with income at or below 100 percent of the FPL who do not pay POWER account contributions for access to the HIP Plus plan, coverage will be effective the first day of the month in which the 60-day payment period expires. For individuals found presumptively eligible, who are subsequently determined eligible for full eligibility, there shall be no gap in coverage between presumptive coverage and HIP Plus or HIP Basic coverage as described in paragraph 5 of this section. For such individuals, at state option, the effective date of HIP coverage may be begin at the end of the PE period (or earlier) so long as there is no gap in coverage.

This waiver of effective date of coverage (reasonable promptness) is conditioned as described in the terms outlined in paragraph 5 of this section related to presumptive eligibility standards.

- 4. Retroactive Coverage.** The state is not obligated to provide retroactive coverage. The state shall submit data after one year, to allow for evaluation of whether there are gaps in coverage that would be remediated by the provision of retroactive coverage. As part of the evaluation:
- a. The state will submit a description of its renewal process;
 - b. The state will provide data on its new passive verification renewal process, conducted in accordance with 42 CFR §435.916, by September 1, 2015.
 - c. The state will provide data on uncompensated care reported by providers as it relates to the lack of retroactive coverage.
 - d. The State will implement a transition program for the Section 1931 group that will reimburse providers for costs for services provided prior to their effective date of coverage. This program will be in effect for minimum of one year and may be limited to new applicants (defined as those not covered through HIP or Medicaid within the past two years or those who meet certain exceptions as described in Section VII STC 12 d) who:
 - i. Did not gain coverage through presumptive eligibility;
 - ii. Received medical care within the 90 days prior to the effective date of eligibility; and

- iii. Submitted for reimbursement within 90 days of the individual's receipt of the bill for such care.
- e. The State will provide data by November 1, 2015 regarding the program including:
- i. The number of individuals with costs paid under the program
 - ii. The total amount of costs paid
 - iii. The average cost per person
 - iv. The number and type of providers paid
 - v. The type of costs incurred, including the specific conditions with which they are associated
 - vi. Survey data from beneficiaries and providers about unreimbursed costs for this population, including amounts not reimbursed under this program.
- f. Should CMS determine that individuals in the Section 1931 group (or the providers who serve them) are incurring costs that would have been reimbursed by Medicaid in the absence of the demonstration, the transition uncompensated care payment program shall continue for the remainder of the demonstration. CMS and the state shall consider whether any revisions to the program are needed, including existing and any further program limitations, based on the data regarding the state's renewal processes and the data regarding the program.

5. Presumptive Eligibility. The state shall include Federally Qualified Health Centers, Rural Health Centers, Community Mental Health Centers, and Health Department sites in an expanded presumptive eligibility program, to allow potentially eligible individuals to gain temporary coverage. All provisions of 42 CFR 435.1103 and 435.1110 are applicable to these entities in determining presumptive eligibility. Individuals determined presumptively eligible for HIP will maintain presumptive coverage for a minimum of 60 days. The 60 day minimum coverage period for presumptive eligibility does not apply for (1) members who become eligible to begin HIP coverage prior to the expiration of the 60 day timeframe, (2) members who do not file an application within the timeframe specified in 435.1101, and (3) members who are found ineligible for Medicaid during their 60 day presumptive eligibility period. Once determined eligible for HIP, members may transition to HIP as outlined below. At state option, Indiana can reclassify presumptive eligibles as eligible in the new adult group for up to 3 months prior to the effective date of coverage as outlined in paragraph 3.

- a. HIP Plus coverage will begin the first day of the month following: (i) the month in which the individual's fast track prepayment or POWER account contribution as applicable was made, or (ii) the month in which the individual was found eligible for HIP, whichever is later, with no gap in coverage.

- b. For individuals below 100 percent FPL, who do not make a POWER account contribution, HIP Basic coverage will begin the first of the month following the expiration of their payment period with no gap in coverage.
- c. For individuals above 100 percent FPL who do not make a contribution before their payment period expires there will be no continued coverage.

6. Presumptive Eligibility Standards. In order to demonstrate that presumptive eligibility is fully accessible to any applicant needing coverage immediately, the State will provide the following deliverables:

- a. A report detailing that 90 percent of potentially qualifying entities are trained and participating by September 1, 2015. Potential qualifying entities that have refused or not responded to opportunities to participate will not be counted.
- b. Monthly reporting on:
 - i. The percentage of all applications that come through presumptive eligibility.
 - ii. The percentage of eligibility determinations following a presumptive period as a share of determinations made on all types of applications.
- c. Annual survey of entities eligible to conduct presumptive eligibility on the effectiveness of the presumptive eligibility process.
- d. By December 1, 2015, based on the initial nine months of experience, the state shall propose a minimum standard for the percentage of eligibility determinations following a presumptive period as a share of determinations made on all types of applications. That standard shall be in effect in the remaining demonstration years beginning calendar year 2016.
- e. If in any six month period, beginning January 2016 through June 2016, the average percentage falls below the standard in subsection d, the waiver of effective date of coverage (reasonable promptness) will not be in effect for the next six month period.

7. Option for American Indian/Alaska Native Individuals. Individuals identified as AI/AN are affected by this demonstration unless they opt out to obtain coverage under the state plan through a fee-for-service (FFS) service delivery system unaffected by the demonstration, as described in Section IV Paragraph 2. Individuals who are AI/AN and who participate in the demonstration will be enrolled in the HIP Plus ABP with no POWER account contribution or cost-sharing requirements. Eligibility for AI/AN individuals will begin effective the first day of the month in which the application was received. During the application process all individuals who indicate AI/AN status will be asked to provide verification of AI/AN status and simultaneously given the opportunity to opt out of HIP Plus into FFS. Eligible AI/AN individuals who opt out of HIP during the application process will begin benefits in FFS. All AI/AN individuals

who begin benefits in HIP Plus may opt-out of HIP Plus to FFS at any time. AI/AN individuals who opt out of HIP Plus may elect to move back to HIP Plus at their annual redetermination.

- a. Prior to April 1, 2015, AI/AN individuals who apply for HIP will be asked to provide verification of AI/AN status. Individuals will be given the chance to opt out and benefits will begin effective the date of application.
- b. **Access to Tribal or Urban Indian Organization (I/T/Us).** An eligible AI/AN individual, whether enrolled in a HIP 2.0 managed care plan or not, will be able to access covered benefits through any Indian Health Service (IHS), Tribal or Urban Indian Organization (collectively, I/T/U) facility funded through the IHS and enrolled as an Indiana Medicaid provider.
- c. **Cost Sharing.** AI/AN individuals are exempt from cost sharing and POWER account contributions as set forth in the state plan and through this demonstration. AI/AN individuals who receive services directly by an I/T/U or through referral under Purchased/Referred Care services (or otherwise) shall not be responsible for any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing or similar charges.
- d. **Payments to I/T/Us.** Payments to an I/T/U or a health care provider through referral under Purchased/Referred care services for services provided to an eligible AI/AN shall not be reduced by the amount of any enrollment fee, premium, or similar charge, or by the amount of any deduction, copayment, cost sharing or similar charges. I/T/U facilities are entitled to payment notwithstanding network restrictions pursuant to section 206 of the Indian Health Care Improvement Act, (IHCA).
- e. **Notices to AI/ANs.** As part of the application process, applicants will have an opportunity to verify their Native American status using appropriate verification documents. As part of the verification process, notice will be provided to AI/AN individuals explaining that AI/ANs may opt-out of a HIP 2.0 managed care plan and receive Medicaid state plan coverage through a FFS system with access to covered benefits I/T/U facilities.

V. BENEFITS

1. **HIP 2.0 Benefits.** HIP beneficiaries, other than Section 1931 parents and caretaker relatives, low-income 19 and 20 year old dependents, and recipients of Transitional Medical Assistance (TMA), will receive benefits available in one of the state's approved ABPs. Such beneficiaries will have access to the HIP Plus plan containing an enhanced benefit package that includes adult vision and dental as additional state plan services. Such beneficiaries with income at or below 100 percent of the FPL (other than AI/AN individuals) who do not make their required monthly POWER account contributions within the sixty (60) day payment period, will be defaulted to

the HIP Basic benefit plan.

Beneficiaries who are Section 1931 parents and caretaker relatives, low-income 19 and 20 year old dependents, and recipients of TMA will be enrolled in HIP 2.0, but will receive all benefits as described in the state plan. Beneficiaries in the new adult group who qualify as medically frail will be enrolled in HIP 2.0, but will also receive ABP coverage equivalent to coverage in the state plan.

Individuals in the HIP Link program will receive an ABP benefit package that meets Section 1937 requirements, including Essential Health Benefits. The State will review employer plans to ensure they adhere to the Alternative Benefit Plan benefit standard.

Table 2. Benefit Plan Options					
Eligibility Group	HIP Basic ABP	HIP Plus ABP	HIP Link ABP	ABP that is the State Plan Benefit Package	State plan benefits
Adult group, individuals with income at or below 100% of the FPL	X	X	X		
Adult group, individuals with income above 100% of the FPL		X	X		
Adult group, medically frail			X	X	
Section 1931 parents and caretaker relatives, low-income 19 & 20 year old dependents, and TMA eligibles (including individuals who are			X		X

- 2. Non-Emergency Medical Transportation (NEMT).** In DY 1, the state is not obligated to provide NEMT to individuals enrolled in the new adult group except for pregnant women and individuals determined to be medically frail. This waiver authority will be provided for one year and then evaluated, allowing the state and CMS to consider the impact on access to care.

CMS may only consider a request to amend this STC if the state has submitted an amendment request in conformity with Section III, paragraphs 6 and 7, and an evaluation of NEMT as described in Section XIII, paragraph 4.

3. **EPSDT for individuals up to age 21.** Both HIP Basic and HIP Plus shall include all Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits that would be available under the approved state plan for individuals up to age 21.

VI. OPTIONAL HIP EMPLOYER BENEFIT LINK (HIP LINK) PROGRAM

1. **General Description.** The HIP Link program is an optional program for all HIP 2.0 eligible individuals with access to qualifying employer-sponsored insurance (ESI) who are age 21 and older. If an individual chooses to participate in the HIP Link program for a 12 month period, the individual will receive premium assistance and assistance with cost sharing (including copayments, deductibles, and out of pocket expenses) under their ESI through provision of a POWER account valued at \$4,000 per year. The individual must have, at a minimum, the opportunity at the end of each 12 month period to elect to continue or not continue HIP Link enrollment.
2. **Eligibility.** Eligibility for HIP Link will be determined as follows:
 - a. The individual must be eligible for HIP 2.0;
 - b. The individual must be 21 years of age or older;
 - c. The individual must have access to and be eligible to participate a qualifying employer-sponsored plan;
 - d. The employer must contribute at least 50 percent to the employee's total ESI premium cost;
 - e. The ESI plan shall be reviewed by the state for confirmation that benefits comply with the requirements for an Alternative Benefit Plan under the approved state plan and to determine whether the premium assistance for the plan is cost effective as detailed in the HIP Link Protocol. The State may choose not to certify an employer health plan based on other criteria;
 - f. Individuals in HIP Link shall have no delay in coverage; the state shall place individuals into coverage no later than as described in STC 3 in Section IV, pending enrollment in ESI as necessary; and
 - g. Pregnant women may choose to remain in HIP Link at their option.
3. **HIP Link Protocol.** Attachment A contains a preliminary protocol for HIP Link. The state must submit a revised protocol 120 days after approval of this demonstration describing the HIP Link program including the requirements for both beneficiaries and employers. The protocol must be approved by CMS before implementing the HIP Link program. The protocol should include:
 - a. A description of the HIP Link program;

- b. Cost sharing requirements for HIP Link participants including examples of the interplay between the employer premium contribution, employee premium contribution, and state premium contributions, and the POWER account;
- c. The benefits and cost sharing requirements for employer sponsored plans in the program;
- d. The criteria and process by which the state shall review and certify employer plans for the HIP Link program;
- e. The process by which the state shall reimburse employers for the state premium contribution and administer the POWER accounts for HIP Link beneficiaries;
- f. A protocol that ensures that those who lose access to ESI or whose plan is no longer Link eligible will be enrolled promptly into HIP Plus without a gap in coverage and that sets forth any adjustment to the individual's POWER account (affecting only the unspent value of the POWER account);
- g. The counseling process and related materials used to counsel prospective beneficiaries;
- h. Any circumstances that would allow an individual to disenroll from HIP Link and enroll into HIP Plus, including the ongoing process to self-identify as being medically frail and move out of HIP Link and into the ABP that is the state plan benefit package; and
- i. The appeals procedure for HIP Link beneficiaries.

4. HIP Link POWER Account. The state will establish a HIP Link POWER account with a value of \$4,000 for an individual per year. Accounts for eligible individuals enrolled with the same ESI plan may be combined into one and the state will determine if additional funds are needed. As explained in more detail in the HIP Link Protocol, the funds in the HIP Link POWER account will be used to pay for the cost of the employee's premium contribution to the ESI plan in excess of the amounts set forth in the paragraph below, and for any cost-sharing incurred by the beneficiary in seeking services including copays, deductibles, and coinsurance costs for services covered on their ESI plan. Individuals will not be required to contribute to the POWER account, but will be required to contribute amounts through payroll deduction for ESI coverage as described in the paragraph below. When an individual loses Medicaid eligibility mid-year, the state may terminate the POWER account.

5. HIP Link Employee Premium Contributions. HIP Link enrolled members will contribute to their ESI through a payroll deduction by their employer. This deduction will be identified by the state to the employer and will not exceed 2 percent of monthly household income but may not be less than one dollar per month. The payroll deduction is the responsibility of the HIP Link enrollee, and will not be payable through the POWER account.

VII. HIP 2.0 POWER ACCOUNTS

1. **General Description.** The POWER account is styled like a health savings account arrangement under a consumer-directed health plan. The POWER account will hold state and beneficiary contributions (including beneficiary contributions donated by employers or other entities). Except for those who elect HIP Link enrollment, in which case the POWER account funds will be used to pay premium and cost sharing amounts as described above, the POWER account funds will be used to pay for the first \$2,500 in claims; claims beyond the initial \$2,500 will be fully covered through capitation payments or other payments made by the state. Except for HIP Link enrollees, POWER accounts may not be used to pay for beneficiary copayments.
2. **Beneficiary and State Contributions.**
 - a. **All HIP eligible beneficiaries** will be eligible for HIP Plus. HIP Plus requires beneficiaries to make a monthly contribution to their POWER accounts limited to 2 percent of their income but not less than one dollar, whichever is greater.
 - b. **Beneficiaries with income above the poverty line** will lose eligibility for HIP Plus if they fail to pay their monthly contributions within the 60 day grace period. At the end of the grace period, such beneficiaries who fail to pay the monthly contribution will be terminated from coverage after proper notice and subject to a 6-month lockout of coverage, with the exception of those who are medically frail, including those who are determined medically frail in the TMA group receiving state plan benefits, or who fall under a designated “qualifying events” category, as discussed in paragraph 12 of this section. Individuals who do not pay their initial contribution and never fully enroll in HIP Plus are not subject to lockout for non-payment. Individuals subject to a lockout will not be able to reenroll until the end of the lockout period; payment of unpaid debt shall not be a condition of re-enrollment at the end of the lockout period but may be owed as a debt.
 - c. **Beneficiaries with income at or below poverty.** Beneficiaries with income at or below 100 percent of the FPL will lose HIP Plus copayment protection (and HIP Plus benefits for those in the new adult group) if they fail to pay their monthly contributions within the 60 day grace period. Effective the first day following the expiration of the grace period, these beneficiaries will be automatically enrolled in HIP Basic, with no gap in coverage. In HIP Basic, the beneficiary would then be responsible for paying co-payments but not monthly POWER account contributions. The minimum monthly contribution amount to access HIP Plus is one dollar per month. The beneficiary would have the option to resume making monthly POWER account contributions and enroll in HIP Plus during the annual redetermination process or upon receipt of rollover. The state may add additional times for movement from HIP Plus to HIP Basic at the state’s discretion.
 - d. Medically frail beneficiaries, Section 1931 Parents and Caretaker Relatives, low-income 19 and 20 year old dependents, and individuals receiving TMA will have the

same cost sharing opportunity as described in subsection (b) or (c) above, to either make monthly POWER account contributions consistent with HIP Plus, or to transition to co-payments consistent with the HIP Basic plan. Medically frail beneficiaries above the 100 percent of the FPL who do not make monthly POWER account contributions shall have cost sharing described in paragraph 12 of this section.

- e. **State Contributions.** The state will annually contribute to the POWER account for each beneficiary (other than those enrolled in HIP Link) an amount equal to the difference between the required beneficiary contribution and \$2500. The state will make an initial \$1300 POWER Account contribution promptly upon the beneficiary's full enrollment with the MCO. The MCO will be responsible for reimbursing providers up to the full \$2500 amount regardless of the beneficiary's current POWER Account balance, as described in paragraph 6. At the conclusion of the 12 month benefit period, the MCO and State shall reconcile the POWER account to determine any amounts owed by the State to cover the difference between the State's total annual POWER account contribution and the initial \$1300 contribution.

3. Determination of Beneficiary Contribution Amounts

- a. Contributions will be determined based on the beneficiary's household income, so that the household's POWER account contributions do not exceed two percent of household income, subject to a minimum one dollar contribution. When added to other cost sharing incurred by the beneficiary's family members, the household's out of pocket expenses shall not exceed five percent of a beneficiary's gross quarterly household income. Required beneficiary contributions will be reduced by the amounts of contributions made by third parties to the POWER account on behalf of the beneficiary. Permissible contributions may be made by employers or other entities as indicated in Section VII, paragraph 8.
- b. In families with two enrolled spouses, each beneficiary will have their own POWER account. However, the total of both beneficiaries' required POWER account contributions cannot exceed 2 percent of the monthly household income, subject to the one dollar minimum contribution amount.
- c. The state shall notify beneficiaries of POWER account payment requirements upon eligibility determination. The state shall determine the amount of a beneficiary's monthly contribution based on the modified adjusted gross income and will notify the beneficiary and MCO of this amount. The MCO must bill for and collect this contribution amount from beneficiaries. Monthly invoices shall include information about how to report any change income, shall inform individuals of the consequences of nonpayment (disenrollment from all coverage, or disenrollment from HIP Plus and default into HIP Basic) and that payment of a POWER account contribution means an individual can now only change plans for cause and how enrollment broker can help.

- d. The state shall develop mechanisms to allow for a ten dollar (\$10.00) initial fast track POWER Account pre-payment that makes available immediate enrollment into HIP Plus effective the first date of the month in the month in which payment is received, once an individual has been determined eligible. This option will be available only to individuals who through an initial screening process are not found to be pregnant, below age of 19, receiving Social Security Income (SSI), or potentially disabled. The pre-payment invoice must include a notice explaining that the individual has not yet been determined eligible for HIP benefits, but the initial fast track pre-payment must be paid within sixty (60) calendar days from the date of invoice to allow enrollment into HIP Plus (effective the first date of the month in the month in which payment is received, once the eligibility has been determined. Effective April 1, 2015 the state shall make fast track payment available as part of the HIP 2.0 application. After April 1, 2015 the date of invoice shall be the date of application for individuals who have provided for payment as part of the application. For all other individuals initially screened eligible for HIP, the invoice shall be dated no later than five business days after the date of application.
 - e. The initial fast track invoice shall notify potentially eligible members that the pre-payment is an optional payment that is fully refundable if the individual is determined not to be eligible for HIP. The initial fast track pre-payment is the minimum amount required to obtain HIP Plus benefits, however, the member will remain responsible for the full amount of the POWER Account contribution during the first month of coverage and such amount will be included on the subsequent month POWER Account invoice. If the member's POWER Account contribution is less than the fast track pre-payment, the MCO shall credit the fast track pre-payment against the member's required POWER Account contributions. Further, the initial fast track invoice must also include a prominent notice stating in substance that the individual has the right to select another MCO only before the fast track payment is made.
 - f. The state shall describe the fast-track prepayment process in the operational protocol as described in section VIII paragraph 4. The state's presumptive eligibility processes, as described in section IV, shall also allow for an initial fast track POWER account pre-payment.
 - g. POWER account contributions by beneficiaries will be made through payments to the MCO in which the beneficiary is enrolled. Further details of how such payments can be made to an MCO will be provided in the operational protocol as described in section VIII paragraph 4.
- 4. Grace Period/Payment Period.** Applicants will have 60 days from the date of the payment invoice to make the required monthly contribution. Beneficiaries will have 60 days from the first day of the coverage month for which the POWER account contribution is owed to make the required monthly contribution.

5. Recalculation of Beneficiary POWER Account Contribution Amount. At a

minimum, at annual redetermination or anytime the state is made aware that the beneficiary's income has changed during the current coverage term, the state shall determine whether and adjustment to the beneficiary's POWER account contribution is necessary. During the current coverage term or changes of income at redetermination, recalculated POWER contributions are effective the first of the month following the recalculation. Any overpayments made by the member reduce the next month(s) contribution.

6. At redetermination, the state shall notify the MCO of the beneficiary's POWER account contribution for the new coverage term. The new POWER account contribution will be effective at the start of the new coverage term. If applicable, within 120 days, the MCO will:
 - a. Reduce the beneficiary's POWER account contribution for the new coverage term by the amount of the beneficiary's POWER account contributions that were rolled over; and
 - b. Notify the beneficiary of this roll-over amount, as well as the new amount to be billed to the beneficiary in equal monthly installments in the new coverage term.

7. "Up -Front" POWER Account Contribution by the State through the MCO.

In the case where a covered service may exceed the member's current POWER Account balance, the MCO must reimburse the provider for the balance according to its normal claims processing procedures. The MCO can recover the funds it paid on the member's behalf with future POWER account contributions paid by the member. Additional balances owed by the State will be reconciled after the end of the benefit period.

- a. If a beneficiary is terminated under the provisions in paragraphs 12 and 13 of this section, the MCO will reconcile the POWER account within 120 days and notify the state of any outstanding balance. The beneficiary may accrue a debt in the amount of the deductible that would have been due had the state imposed a deductible for coverage, to the extent authorized under state law. Debt owed may include the beneficiary's pro rata share of claims (as described in Attachment B) paid during the coverage period, but not to exceed the following amounts:
 - i. For individuals with income at or below 100 percent FPL, the sum of the unpaid required monthly contributions during months in which the beneficiary received HIP Plus coverage.
 - ii. For individuals with income over 100 percent FPL, an amount that does not exceed 10% of the cost of services received.
- b. Such debt shall not be required to be paid as a condition of retaining or regaining coverage. If the member has made monthly POWER account contributions in excess of the pro rata share of claims incurred then the member is owed a refund.

Prior debt owed may be deducted from member refunds and rollover. Any additional refunds are also subject to a 25 percent penalty if the member was terminated from the program for non-payment of Power Account contributions. The 25 percent penalty will not apply if the individual qualifies as listed in paragraph 12 (d).

- c. Additionally, the aggregate contributions paid and debt incurred during a calendar quarter cannot exceed more than 5 percent of the individual's quarterly income per 42 CFR 447.78.
- d. The MCO may attempt to collect unpaid POWER account contributions and debts from the beneficiary, but may not report the debt to credit reporting agencies, place a lien on an individual's home, refer the case to debt collectors, file a lawsuit, seek a court order to seize a portion of the individual's earnings. The MCO also may not "sell" the debt for collection by a third-party. Further, while the debt is collectible by the state, re-enrollment is not conditional on repayment.

7. Employer Contributions. Employers are permitted and encouraged to contribute to their employees' POWER accounts. There are no limits on the amounts that an employer can contribute to a beneficiary's POWER account except that an employer's contribution must be used to offset the beneficiary's required contribution only—not the state's.

8. Contributions from other third parties. Third parties are permitted to contribute to a beneficiary's POWER account contribution. There are no limits on the amounts third parties can contribute to an beneficiary's POWER account except that the contribution must be used to offset the beneficiary's required contribution only—not the state's. Health care provider or provider-related entities making contributions on individuals' behalf must have criteria for providing assistance that do not distinguish between individuals based on whether or not they receive or will receive services from the contributing provider(s) or class of providers. Providers may not include the cost of such payments in the cost of care for purposes of Medicare and Medicaid cost reporting and cannot be included as part of a Medicaid shortfall or uncompensated care for any purpose.

9. POWER Account Card. The MCO must issue a card to each beneficiary upon enrollment in HIP 2.0.

- a. The MCO shall send the beneficiary a monthly update each time a contribution by the beneficiary, employer (if applicable), or other individuals or entities as applicable (see paragraphs 7 and 8 of this section) is credited to the beneficiary's POWER account in order to reflect the new balance.
- b. The MCO must track all contributions received from the beneficiary, state, employer (if applicable), and other individuals or entities.

- c. The card may be used by beneficiaries only to pay for required HIP covered services applicable to the member's HIP benefit plan and performed by network providers. The card may not be used to pay for copayments.
- d. For covered services provided out-of-network, if the out-of-network provider lacks the capacity to conduct the transaction using the beneficiary's card, or for in-network providers who lack such capacity, the MCO will reimburse the out-of-network provider, and will debit the beneficiary's POWER account.
- e. The MCOs are required to have an internal system of safeguards for the cards and to manage the POWER accounts. The state shall actively monitor plans and their management of the POWER accounts either through a separate annual audit or will require the plans to fund annual independent audits.

10. Use of POWER Account Funds.

- a. POWER account funds can only be used to pay required beneficiary cost sharing (deductible) for the first \$2500 of the cost of the claims for covered services, except that rollover amounts as described in paragraph 11 of this section may be used to reduce required beneficiary contributions to the POWER account for the rollover year.
- b. **Preventive Benefits.** Preventive services required under 42 USC 300gg-13 are covered. Beneficiaries shall not be required to pay any cost sharing for these services and services will not be reimbursed using the beneficiary's POWER account. Preventive services not defined under 42 USC 300gg-13 are subject to a \$500 cap in any coverage year. Preventive services in excess of the \$500 cap are covered, but count against the POWER Account.

11. Roll-Over of POWER Account Funds. At the end of twelve months of eligibility, there may be a balance remaining in the POWER account. A portion of the remaining balance may be carried forward to reduce the beneficiary's required POWER account contribution in the subsequent benefit period. The balance available to be carried forward will depend on successful completion of age and gender specific preventive services as described Section VII.

- a. **HIP Plus Rollover** – HIP Plus beneficiaries with a balance remaining at the end of the benefit period are eligible to roll-over a portion of the remaining balance to the subsequent benefit period to offset future monthly contributions. If the beneficiary completes age and gender appropriate preventive services the portion of the remaining balance will be doubled by the state and rolled over for the new enrollment period. This rollover amount could reduce or eliminate required contributions for the new enrollment period but may not exceed the member's total required POWER account contribution for the year. However, the beneficiary will forfeit eligibility to have unused funds rolled over into a new enrollment period if the beneficiary was ever dis-enrolled from HIP 2.0 during the enrollment year.

The rollover amounts for HIP Plus beneficiaries will be calculated as follows:

- i. First the beneficiary's portion of the remaining POWER account balance (beneficiary share) is determined by the following formula:

Amount of the beneficiary's required annual contribution for the expiring term
Plus Any beneficiary balance rolled over from the previous twelve months
Divided by 2,500

- ii. Second, the Base Rollover Amount is determined as follows:

Beneficiary share multiplied by the remaining balance in the POWER account

- iii. The Final Rollover Amount is determined based on whether the beneficiary obtained recommended preventive services. The preventive services bonus is applied to the base roll over amount as follows to determine the final rollover amount:

If preventive services are completed during the enrollment year:
Base Rollover Amount x 2 = Final Rollover Amount

If preventive services are not completed during the plan year:
Base Rollover Amount x 1 = Final Rollover Amount

- b. **HIP Basic Rollover** –A HIP Basic beneficiary is eligible for a discount on HIP Plus contributions in a subsequent plan year if (1) there is a balance remaining in the in the POWER account at the end of the enrollment year, and (2) the beneficiary obtains age and gender appropriate preventive services as described in Section VI. This discount is limited to 50 percent of the beneficiary's required HIP Plus POWER account contribution.

The rollover amounts for beneficiaries participating in the HIP Basic plan are calculated as follows:

- i. First, the rollover percentage is calculated by the following

formula: Remaining balance in the POWER account
Divided by 2,500 (the fully funded POWER account
total)

Multiplied by 100 to yield a percentage capped at 50 percent

- ii. The determination of the final discounted contribution amount for participation in the HIP Plus plan for the following year would be determined as follows:

Required contribution for the subsequent year based on FPL
Minus (Rollover Percentage multiplied by the required contribution)

- c. **Rollover and Member Debt** – The insurer may collect beneficiary debt from the beneficiary portion of rollover funds determined in accordance with the rollover calculations set forth above.

12. Non-Payment of Monthly POWER Account Contribution.

a. Beneficiaries Eligible for HIP Plus and HIP Link.

If a beneficiary with income above 100 percent of the FPL does not make a required monthly contribution within the grace period, the beneficiary will be dis-enrolled and locked out of coverage for HIP 2.0 for 6 months, unless the beneficiary lost coverage due to a “qualifying event” as described below. Any debt accrued (see Attachment B), may be owed to the health plan in which the individual was previously enrolled, but will not prevent re-entry into HIP 2.0.

i. Before terminating the beneficiary --

1. Per 42 CFR 457.570(b), the state shall review eligibility for all other eligibility categories under the State’s Title XIX program including notifying the beneficiary the option of requesting a medically frail status review; and
2. The MCO must provide at least two written notices advising the beneficiary of the delinquent payment, the date by which the contribution must be paid to prevent disenrollment, the option for medically frail screening and the beneficiary’s appeal rights. The first notice must be sent to the beneficiary on or before the seventh day of the month of coverage for which the POWER account contribution was to be applied and must state that the beneficiary will be dis-enrolled and terminated from participation in HIP 2.0 if payment is not received prior to the date specified in the notice. Notices shall include information about reporting any changes in income.

- b. **Beneficiaries Eligible for the HIP Basic Plan.** Beneficiaries with income at or below 100 percent of the FPL have the opportunity to participate in the HIP Plus plan, if they make required monthly POWER account contribution of no more than 2 percent of their income. However, if such beneficiary does not pay required monthly POWER account within the grace period, they will be automatically defaulted to the HIP Basic Plan with no gap in coverage or lockout period. Beneficiaries will continue to maintain a POWER account.

- c. **Medically Frail, 1931 Parents and Caregivers and low-income 19 & 20 year old dependents.** Any beneficiaries who are in the new adult group or TMA and who are medically frail or qualify as 1931 parents and caregivers, low-income 19 and 20 year old dependents, or TMA are exempt from any lockout of coverage.

- i. Medically frail beneficiaries with income above 100 percent of the FPL are required to make monthly POWER account contributions. In the event that such

a beneficiary does not make a payment within the sixty (60) day grace period the beneficiary shall --

1. Remain in their existing benefit package;
2. Be required to pay copayments as required under the HIP Basic plan; and
3. Continue to be billed for monthly POWER account contributions, however payment of contributions are not a condition of eligibility.

ii. The beneficiary's total required payments (cost sharing or contributions, including debt to the plan) may not exceed 5 percent of household income during any quarter. Maintenance of HIP Plus coverage requires a minimum contributions of one dollar per month for those in households with income below 5 percent of the FPL. Any debt collected by the health plan shall be subject to STC 9. The state must provide detail on the debt collection process including such timeframe for which collection may occur in the operational protocol described in section VIII paragraph 4.

iii. Medically frail beneficiaries with income at or below 100 percent of the FPL, 1931 parents and caregivers, and low-income 19 and 20 year old dependents, may pay monthly POWER account contributions in lieu of copayments. In the event that such a beneficiary does not make a payment within the sixty (60) day payment period, the beneficiary shall --

1. Maintain their existing benefit package; and
2. Be required to pay copayments as required under the HIP Basic.

d. **Qualifying Events.** Any beneficiary with income above 100 percent of the FPL who has been terminated from the HIP 2.0 program for failure to pay POWER account contributions after exhausting the 60-day grace period may be reinstated to HIP 2.0 prior to the expiration of the 6-month lockout, if a new application is filed and the individual can provide verification of non-payment due to the following:

- i. Obtained and subsequently lost private insurance coverage;
- ii. Had a loss of income after disqualification due to increased income;
- iii. Took up residence in another state and later returned;
- iv. Is a victim of domestic violence;
- v. Was residing in a county subject to a disaster declaration made in accordance with IC 10-14-3-12 at the time the member was terminated for non-payment or at any time in the sixty (60) calendar days prior to date of member termination for non-payment; or
- vi. Is medically frail.

The state may add additional circumstances for granting exceptions, as it deems

necessary. If any of the above criteria are met, the individual may return to HIP Plus prior to the expiration of the 6-month lockout provided the individual resumes making POWER account contributions. The state shall ensure that payment of any debt plus new POWER account contributions do not exceed 5 percent of the family's household income on a quarterly basis.

13. Ineligibility and POWER Account Contributions. If a beneficiary is determined ineligible, the beneficiary will be dis-enrolled from HIP 2.0. As such time, the beneficiary may be owed a refund by the state for contributions made or may be required to pay a debt to the MCO as described in the operational protocol (see Attachment B).

14. POWER Account Balance Transfers. If a beneficiary transfers to a new MCO during the benefit period, the new MCO will be informed of the beneficiary's POWER account balance within 30 days of transfer. POWER account reconciliation with the original MCO will occur no later than 120 days after the individual transfers plans. After the 120 day reconciliation period, the remaining POWER account balance will be transferred from the prior MCO to the new MCO as will information on beneficiary receipt of preventive services.

For a transfer at annual redetermination, the current MCO remains responsible for determining the amount of the beneficiary's POWER account that may be carried over. This amount will be forwarded to the state through the POWER account reconciliation process and the state will provide the information to the new MCO.

15. POWER Account Reporting to State. Each MCO must submit a report to the state each month that provides the following for each terminated or ineligible beneficiary:

- a. Demographic information on the beneficiary;
- b. The balance remaining in the beneficiary's POWER account; and
- c. After 120 days after the termination, the MCE shall report the amount to be returned to the state.

VIII. HIP 2.0 Cost Sharing

1. Co-payments. Beneficiaries with income at or below 100 percent of the FPL, medically frail beneficiaries, and section 1931 parents and caregivers, and low-income 19 and 20 year old dependent beneficiaries who do not pay their monthly POWER account contributions within the sixty (60) day grace period will be enrolled in HIP Basic and will be subject to co-payments. These amounts are described below in Table 3. These co-payments shall be charged consistent with Medicaid cost sharing rules at 42 CFR 447.50 – 447.56, including automated tracking of the 5 percent monthly or quarterly aggregate cap.

Table 3. HIP Basic Plan Co-Pay Schedule	
Preventive Care Services (including family planning and maternity services)	\$0
Outpatient Services	\$4
Inpatient Services	\$75
Preferred Drugs	\$4
Non-Preferred Drugs	\$8

2. Emergency Room Co-pay. All beneficiaries in HIP 2.0 are required to pay a copayment for non-emergency use of the emergency room (ER). However, this copayment will be waived for any HIP 2.0 beneficiary who contacts their health plan's 24-hour nurse hotline prior to utilizing the hospital emergency department. This copayment shall be charged consistent with 1916A(e)(1) of the Act and 42 CFR 447.54 with the exception of the amount, \$25, for recurrent non-emergent visits.

- a. Under the provisions of section 1916(f) of the Act, the state has the authority to test a graduated co-pay for non-emergency use of the ER. The test shall examine whether use of a \$25 copay for recurrent non-emergent use of the emergency department reduces unnecessary ER use without any meaningful harm to beneficiary health. This provision will expire on or before January 31, 2017.
 - i. The amount of this co-pay will be \$8 for the first non-emergent visit in a twelve month period and \$25 for any other non-emergent visits in that period.
 - ii. The state must submit a protocol as described in paragraph 6 of this section and conduct an evaluation as indicated in section XIII paragraph 6.
 - iii. The individual must receive an appropriate medical screening examination under section 1867—the Emergency Medical Treatment and Labor Act, or EMTALA provision of the Act.
 - iv. The co-payment for HIP 2.0 beneficiaries must be refunded if the person is found to have an emergency condition, as defined in section 1867(e)(1)(A) of the Act, or if the person is admitted to the hospital on the same day as the visit.
- b. The State assumes liability, and will not claim federal matching funding, for costs associated with any claims for damage to the health of a beneficiary resulting from establishment of a \$25 copay for non-emergency services in the ER that would have been prevented had the co-pay been \$8.

3. Alternative ER Co-pay. As required by provisions under 1916(f), the state shall have a control group for testing the graduated ER co-pay established by May 1st, 2015. Beneficiaries participating in the control group will have an \$8 co-pay for each visit categorized as non-emergency use of the emergency room and shall not be charged \$25. This co-pay will be waived for any beneficiary participating in the control group who contacts their health plan's 24-hour nurse hotline prior to utilizing the hospital emergency department. All conditions specified under paragraph 2(a)(iii)-(iv) of this section would also apply to beneficiaries participating in the control group.

The control group shall include a minimum of 5,000 beneficiaries. A detailed description of the selection of beneficiaries must be provided as part of the protocol required in paragraph 6 of this section.

4. POWER Account Contributions and Copayments Infrastructure Operational Protocol. (Attachment B) Within 30 days after approval of this demonstration, the state must submit a POWER Account and Copayments Infrastructure Operational Protocol to CMS describing the process to be used under the state plan for collecting POWER account contributions and copayments from beneficiaries. The protocol should include the following items:

- a. A description of how the POWER account and roll-over incentive will work for beneficiaries in HIP 2.0 and HIP Link with specific examples and scenarios for different household sizes.
- b. A description of how the state will collect data from the plans regarding the amount of POWER account contributions and copayments due.
- c. The process by which the state will identify individuals who are exempt or meet qualifying event criteria with respect to the POWER account contributions and copayment requirements. Before any beneficiary with income above 100 percent of the FPL can be terminated from the HIP 2.0 program for failure to pay POWER account contributions, the state shall have this procedure in place.
- d. The state's operational plan to ensure that the beneficiaries with the option of paying nominal co-pays will only be charged a nominal copay by a Medicaid healthcare provider when covered benefits are provided.
- e. The state's operational plan to ensure that POWER account contributions and copayment liability (on a per visit basis) will be accurately tracked, as well as monthly statements will be provided to the beneficiary.
- f. The process by which the state will determine any debts owed by the beneficiary or refunds that would be sent to the beneficiary upon early termination from HIP 2.0.
- g. The process by which the MCO will collect past due POWER account contributions

including how the MCOs will collect the debt , which beneficiaries will be subject to collection, and the timeframe for which the debt collection must occur.

- h. The process by which renewals will occur under HIP 2.0.
- i. The process by which beneficiaries will be able to remit POWER Account contributions, including ways individuals who cannot pay by check will be accommodated.
- j. The state's process for acting on changes in income as it relates to the POWER account contributions.
- k. The state's implementation plan for the beneficiary education and assistance process including copies of beneficiary notices, a description of beneficiaries' rights and responsibilities, appeal rights and processes and instructions for beneficiaries about how to interact with state officials for discrepancies or other issues that arise regarding the beneficiaries' cost sharing obligations.
- l. Materials for use in educating beneficiaries about the difference between HIP Plus and HIP Basic.
- m. The state's strategy for educating beneficiaries on how to use the POWER account statements, and understand that their health care expenditures will be covered.
- n. The state's strategy for educating beneficiaries on how to self-report changes in income and the importance of doing so.
- o. The state's strategy for educating beneficiaries and employers on the HIP Link program.

5. Power Account Contributions and Copayments Monitoring Protocol. Within 180 days after approval of this demonstration, the state must submit criteria by which the state shall monitor required beneficiary contributions (both POWER account contributions and copayments). As part of monitoring, the state shall engage an independent entity to, each year, survey individuals enrolled in HIP 2.0, individuals who are eligible but not enrolled, and individuals who have disenrolled for nonpayment of contributions. The state must include a list of the data it will report to CMS in quarterly reports and actual data where it is available. Such data must include but is not limited to the number of:

- a. Individuals subject to POWER account contributions and copayment requirements;
- b. Individuals whose required POWER account contributions have been reduced or have benefited from the roll-over incentive due to preventive care;

- c. The number of individuals who received POWER account contributions from employers and not-for-profit entities and the average total amounts by income level;
- d. Individuals with overdue POWER account contributions including those with POWER account contributions past due less than and greater than 60 days;
- e. The number of beneficiaries subjected to a 6-month lockout, number exempted and meeting qualifying event criteria, and the reasons for non-payment as reported in the survey;
- f. Information about the MCO's collection activities including the number of beneficiaries subject to collection, amounts due, and amounts paid;
- g. The number of individuals who are obligated to make POWER account contributions, POWER account debts;
- h. The number of individuals who have reached the 5 percent threshold on a monthly or quarterly basis;
- i. The number of individuals in the differing co-payment structures for non-emergency use of the ER;
- j. The number of individuals who have called the nurse hotline and the number who subsequently visited the ER;
- k. The number of individuals charged the \$8 non-emergency use of the ER copayment; and
- l. The number of individuals charged the \$25 non-emergency use of the ER copayment.

6. Emergency Room Co-pay Protocol. Within 90 days after approval of this demonstration, the state must submit for approval the design and process for implementing the co-pay for non-emergency use of the ER provisions and documentation that the state meets all of the requirements under 1916(f) and 42 CFR 447.54 including, but not limited to:

- a. The method by which beneficiaries will be assigned to participate in the emergency room co-pay structure test group as described in paragraph 2 of this section (\$8 for the first visit and \$25 for each subsequent visit) and control group as described in paragraph 3 of this section (\$8 for each visit);
- b. Baseline data related to ambulatory care sensitive conditions and any other health outcomes the state proposes to examine;
- c. The method by which providers will identify those in the test and control groups;

- d. The strategy for educating beneficiaries on their assigned group including any beneficiary materials such as member handbooks;
 - e. The strategy for working with health plans on implementing the copay structure;
 - f. The strategy for a grievance and appeals process for beneficiaries;
 - g. The number of individuals who were determined to have an emergent condition;
 - h. How the State/MCOs defines non-emergency services for purposes of imposing cost sharing;
 - i. Any MCO guidelines for ER staff in determining what is and is not a condition that requires emergency treatment;
 - j. The plan to operationalize a process to ensure hospitals meet the requirements at 447.54(d);
 - k. A description of the network of providers available to accommodate after hours and next day appointments as an alternative to the ED;
 - l. Description of appeal rights, how those are made available and including in member education, if an individual feels as though it was indeed an emergency, and shouldn't have been charged cost sharing; and
 - m. The estimated state savings with implementing this co-pay.
- 7. CMS Review of the Protocols.** Once reviewed by CMS, the POWER Account Contributions and Copayment Protocols and the approved ER Co-pay protocol will become Attachments B, C, and D of these STCs, and will be binding upon the state. The state may request changes to the Power Account Contributions and Copayments Monitoring Protocol, and which will be effective prospectively. Changes may be subject to an amendment to the STCs in accordance with paragraph 7 of section III, depending upon the nature of the proposed change. A delay in submitting such protocols could subject the state to penalties described in paragraph 16 of section III.

IX. DELIVERY SYSTEM

- 1. Managed Care Requirements.** The state must comply with the managed care regulations published at 42 CFR 438. Capitation rates shall be developed and certified as actuarially sound, in accordance with 42 CFR 438.6.
- 2. Public Contracts.** Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).

- 3. Network Requirements.** The state must deliver all covered benefits, ensuring high quality care. Services must be delivered in a culturally competent manner, and the MCO network must be sufficient to provide access to covered services. In addition, the MCO must coordinate health care services for demonstration populations. The following requirements must be included in the state's MCO contracts:
- a. **Special Health Care Needs.** Beneficiaries with special health care needs must have direct access to a specialist, as appropriate for the individual's health care condition, as specified in 42 CFR 438.208(c)(4).
 - b. **Out of Network Requirements.** The state, through its contracts with the HIP 2.0 MCOs, will require the MCOs to provide out of network benefits in the following situations:
 - i. Each MCO must allow access to non-network providers, when services cannot be provided consistent with the timeliness standards required by the state.
 - ii. During the transition of beneficiaries into HIP 2.0 MCOs, for any provider seen by the beneficiary during the month in which enrollment is effectuated, MCOs will honor previous care authorizations for a minimum of 30 calendar days from the member's date of enrollment with the MCO, or date the member paid their contribution (whichever is later) even on a non-network basis.
- 4. HIP 2.0 Managed Care Organizations (MCO).** All HIP 2.0 beneficiaries shall be enrolled to receive service through an MCO under contract to the state. The MCOs are subject to the federal laws and regulations as specified in 42 CFR Part 438. The HIP 2.0 beneficiary will be given an opportunity to select an MCO at the time of application. A HIP 2.0 beneficiary who does not make an MCO selection at the time of application may be auto-assigned to a HIP 2.0 MCO by the state. Except in cases of presumptive eligibility, auto-assignment may occur after the date in which the state determined their eligibility.

The state may adjust the auto-assignment methodology. The state may consider assignment to the lowest-cost MCO, or to the MCOs that demonstrate higher quality scores or better health outcomes, or to MCOs on a rotating basis. Any change to the auto-assignment methodology must be approved by CMS before implementation.

Beneficiaries will be advised both at the time of application, and upon receiving an initial invoice, of the auto-assignment and their right to change MCOs prior to the first POWER account contribution payment. The notice to beneficiaries shall include information on the process to change MCOs.

- 5. MCO Information and Selection.** The state shall contract with an enrollment broker to assist interested applicants with their MCO selection so they can make an informed decision. The enrollment broker will provide the applicant with appropriate counseling

on the full spectrum of available MCO choices and will address any questions the applicant may have. Once an MCO has been selected and after the beneficiary has made either their fast-track pre-payment or first POWER account contribution, or has begun coverage in HIP Basic after non-payment, the beneficiary is required to remain in that MCO for 12 months, with exceptions specified in paragraph 6 of this section.

6. Beneficiary's Right to Change MCOs.

- a. A beneficiary may change HIP 2.0 MCOs without cause if the change is requested prior to (i) the date the beneficiary pays their initial POWER account contribution or fast track POWER account prepayment, or (ii) has defaulted into HIP Basic for non-payment of fast-track prepayment or POWER Account contribution whichever comes first.

During a beneficiary's redetermination, the state shall notify HIP 2.0 beneficiaries that they may change plans without cause during their redetermination period. Beneficiaries may seek assistance from the enrollment broker in choosing an MCO.

- b. **For Cause.** A beneficiary may change MCOs for cause at any time and will include this information in all communications about POWER account contributions. "Cause" is defined in 42 CFR 438.56(d)(2). Other reasons as described in 42 CFR 438.56(d)(2)(iv), includes, but is not limited to, the following:
 - i. Receiving poor quality care;
 - ii. Failure of the Insurer to provide covered services;
 - iii. Failure of the Insurer to comply with established standards of medical care administration;
 - iv. lack of access to providers experienced in dealing with the enrollee's health care needs;
 - v. Significant language or cultural barriers;
 - vi. Corrective Action levied against the Insurer by the Family and Social Services Administration (FSSA);
 - vii. Limited access to a primary care clinic or other health services within reasonable proximity to a beneficiary's residence;
 - viii. A determination that another MCO's formulary is more consistent with a new beneficiary's existing health care needs; or
 - ix. Other circumstances determined by FSSA or its designee to constitute poor quality of health care coverage.

- c. The beneficiary must submit his or her request for change to the enrollment broker either orally or in writing. The beneficiary shall still have access to the state's normal grievance and appeals process required under the managed care regulations.
- d. If the state fails to make a determination by the first day of the second month following the month in which the beneficiary files the request, the request for change will be considered approved and the beneficiary will be transferred into the new MCO.
- e. If a beneficiary is transferred from the MCO, the MCO must disable the beneficiary's POWER account card immediately, and return the remaining balance of the individual's POWER account to the state within 120 days of the last date of participation with the MCO. The state shall then provide the entire POWER account balance to the new MCO with the information needed to properly track the individual's contribution.
- f. The state shall ensure that all transferring individuals receive coverage from their new MCO promptly, without any interruption in care.

7. Withhold and Incentive Payments. Any capitation withhold arrangements or incentive payments, to MCOs under 42 CFR 438.6(c) shall only be based on quality measures or demonstrated improved health outcomes.

8. Provider Payment Rates. No later than the January 1, 2018 – December 31, 2018 rating period, the state shall equalize the MCO provider payment rates between the HIP 2.0 program and the Hoosier Health Wise (HHW) program. Before January 1, 2018 the state shall:

- a. Submit an annual report by December 30th in DY 1 and September 30th of each subsequent DY that:
 - i. Evaluates whether the differential in MCO provider payment rates between the HIP 2.0 program and the Hoosier Health Wise (HHW) program has resulted in unequal access to health care services, either in the number of providers available to beneficiaries, the number of providers accepting new beneficiaries, or in the time required to access care. Beneficiary access shall be assessed for routine care and urgent care in the following provider groups: primary care providers, OB\GYNs, and the most commonly used adult specialty providers;
 - ii. Describes corrective actions implemented if evaluation shows access between programs is not equal;
 - iii. Describes any incremental changes to the provider payment rates in either the HHW and/or HIP 2.0 programs the state will be making for the upcoming rating period; and

- b. Include the changes reported in subparagraph a of this paragraph in the

annual actuarial rate certification for the rating period.

X. THE GENERAL REPORTING REQUIREMENTS

1. **General Financial Requirements.** The state must comply with all general financial requirements under Title XIX outlined in Section XI of these STCs.
2. **Monthly Monitoring Calls.** CMS will convene periodic conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration; including planning for future changes in the program or intent to further implement HIP 2.0 beyond January 31, 2018. CMS will provide updates on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration. The State and CMS will jointly develop the agenda for the calls. Areas to be addressed may include, but are not limited to:
 - a. Transition and implementation activities,
 - b. Stakeholder concerns,
 - c. HIP 2.0 operations and performance,
 - d. Enrollment,
 - e. Cost sharing including operation of the 1916(f) test and control group,
 - f. Quality of care,
 - g. Access,
 - h. The benefit packages,
 - i. Audits,
 - j. Lawsuits,
 - k. Financial reporting issues,
 - l. Progress on evaluations,
 - m. Legislative developments, and
 - n. Any demonstration amendments the state is considering submitting.
3. **Quarterly Progress Reports.** The state shall submit progress reports in a format agreed upon by CMS and the state no later than 60 days following the end of each quarter. The intent of these reports is to present the state's analysis and the status of the various operational areas. These quarterly reports shall include, but not be

limited to:

- a. A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, enrollment, quality of care, access, health plan financial performance that is relevant to the demonstration, the benefit package, and other operational issues;
- b. A discussion of key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed;
- c. Enrollment figures for the quarter including enrollment figures for individuals by income level and benefit plan;
- d. Data related to POWER account including the number and average amount of contributions to POWER accounts from third parties, by type of entity, and by beneficiary income level, the HIP Plus and HIP Basic rollover numbers and amounts, and the rate of disenrollment for failure to pay POWER Account contributions;
- e. Data related to emergency department use including the number of individuals by income level and a breakdown of the number of visits classified as an emergency vs. non-emergency by income level and benefit plan; the number of people who incurred the \$8 and \$25 copayments.
- f. Reports on speed of eligibility determinations for HIP 2.0 eligible individuals, including the average number of days between the submission of an application and an eligibility determination, and the average number of days between an eligibility determination and HIP 2.0 plan enrollment;
- g. A discussion of the HIP Link program, including but not limited to enrollment, HIP Account balance amounts, grievances, changes in employer contribution levels, participants moving from ESI coverage to HIP Plus or HIP Basic, other operational issues; and evaluation activities.
- h. The status of the NEMT Evaluation and POWER Account Contributions and Copayments Monitoring; and
- i. Reports on data required as part of the Health Incentives Protocol described in Section VIII and POWER Account Contributions and Copayments Monitoring Protocols.
- j. The number of hospitals and other entities participating in Presumptive Eligibility, by type and the number of applications filed by each entity. The number of full applications filed and the number determined eligible, by entity.

4. **Rapid Cycle Assessments.** The state shall specify for CMS approval a set of

performance and outcome metrics, including their specifications, reporting cycles, level of reporting (e.g., the state, health plan and provider level, and segmentation by population) to support rapid cycle assessment in trends and for monitoring and evaluation of the demonstration.

5. **Compliance with Federal Systems Innovation.** As MACBIS or other federal systems continue to evolve and incorporate 1115 demonstration reporting and analytics, the State shall work with CMS to revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems.
6. **Demonstration Annual Report.** The annual report must, at a minimum, include the requirements outlined below. The State shall submit the draft annual report no later than 90 days after the end of each demonstration year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted for the DY to CMS. A delay in submitting the draft or final annual report could subject the state to penalties described in paragraph 16 of section III.
 - a. All items included in the quarterly report must be summarized to reflect the operation/activities throughout the DY;
 - b. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately;
 - c. Yearly enrollment reports for demonstration beneficiaries for each DY (beneficiaries include all individuals enrolled in the demonstration); and
 - d. Data related to the comprehensive quality strategy as described in paragraph 7 of this section.
7. **Final Report.** Within 60 days after the end of the demonstration, the state must submit a draft final report to CMS for comments. The final report should provide a comprehensive presentation of all key components of the demonstration that were addressed in quarterly and annual reports, and reflect the entire demonstration approval period from its inception until the final expiration date. The state must take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 120 days after receipt of CMS' comments. A delay in submitting the draft final report or final report could subject the state to penalties described in paragraph 16 of section III.
8. **Comprehensive State Quality Strategy.** The state shall modify and update its current Medicaid managed care strategy, required by 42 CFR 438.202, to incorporate the HIP 2.0 demonstration.
 - a. The Comprehensive Quality Strategy (CQS) shall meet all the requirements of 42 CFR Part 438, subparts D and E, and address the following elements:

- i. The state's goals for improvement, identified through claims and encounter data, quality metrics and expenditure data. The goals should align with the three part aim and specifically identify pathways for the state to achieve these goals.
 - ii. The specific quality metrics for measuring improvement in the goals and a description of planned interventions for obtaining improvement in the goals. (See November 22, 2013 CMS letter to State Health Official.)
 - iii. Monitoring and evaluation. Describe specific plans for monitoring continuous quality improvement, which includes transparency of performance on metrics and structured learning, and also a rigorous and independent evaluation of the demonstration, as described in paragraph 3 of section XIII. The evaluation should reflect all the programs covered by the CQS as mentioned above.
 - iv. A timeline that considers metric development and specification, contract amendments, data submission and review, incentive disbursement (if available), and the re-basing of performance data.
 - v. The CQS must include state Medicaid agency and any contracted service providers' responsibilities, including managed care entities, and providers enrolled in the state's FFS program. The state Medicaid agency must retain ultimate authority and accountability for ensuring the quality of and overseeing the operations of the program. The CQS must include distinctive components for discovery, remediation, and improvement.
 - vi. As required by 42 CFR 438.360(b)(4), the state must identify in the CQS any standards for which the external quality review organization (EQRO) will use information from private accreditation reviews to complete the compliance review portion of external quality review (EQR) for participating MCOs. The state must, by means of a crosswalk included in the CQS, set forth each standard that the state deems as duplicative to those addressed under private accreditation and explain its rationale for why the standards are duplicative.
- b. The first draft of this CQS is due to CMS no later than 120 days following the approval of the HIP 2.0 demonstration. A delay in submitting the draft CQS could subject the state to penalties described in paragraph 16 of section III. CMS will review this draft and provide feedback to the state. The state must revise and resubmit the CQS to CMS for approval within 45 days of receipt of CMS comment. The state must revise (and submit to CMS for review and approval) their CQS whenever significant changes are made to the associated Medicaid programs or the content of the CQS. Any further revisions must be submitted accordingly:
 - i. Modifications to the CQS due to changes in the Medicaid operating authorities must be submitted concurrent with the proposed changes to the operating authority (e.g., state plan or waiver amendments or waiver

renewals); and/or

- ii. Changes to an existing, approved CQS due to fundamental changes to the CQS must be submitted for review and approval to CMS no later than 60 days prior to the contractual implementation of such changes. If the changes to the CQS do not impact any provider contracts, the revisions to the CQS may be submitted to CMS no later than 60 days following the changes.
- c. The state must solicit for and obtain the input of beneficiaries, the Medical Care Advisory Committee (MCAC), and other stakeholders in the development of its CQS and make the initial CQS, as well as any significant revisions, available for public comment prior to submission to CMS for approval. Pursuant to paragraph 5 of this section, the state must also provide CMS with annual reports on the implementation and effectiveness of their CQS as it impacts the demonstration.
- d. Upon approval by CMS, the state shall publish the CQS on its Medicaid website.

XI. GENERAL FINANCIAL REQUIREMENTS

1. **Quarterly Expenditure Reports.** The state must report quarterly expenditures associated with the populations affected by this demonstration on the Form CMS-64.
2. **Reporting Expenditures under the Demonstration.** The following describes the reporting of expenditures:
 - a. **Tracking Expenditures.** In order to track expenditures under this demonstration, Indiana must report demonstration expenditures through the MBES and state Children's Health Insurance Program Budget and Expenditure System (CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the state Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX of the Act must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS, including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made. For this purpose, DY 1 is defined as the year beginning February 1, 2015, and ending December 31, 2015. DY 2 and subsequent DYs are defined accordingly. All title XIX service expenditures that are not demonstration expenditures and are not part of any other title XIX waiver program should be reported on Forms CMS-64.9 Base/64.9P Base.
 - b. **Reporting of HIP 2.0 POWER Account Contributions.** The state must report HIP plan POWER account contributions as follows:
 - i. HIP 2.0 MCO Contributions. HIP plan contributions must be reported on Forms CMS-64.9 Waiver and CMS-64.9P Waiver, using Line 18A.

- ii. State's Contributions to Participants' POWER Accounts. The state's contributions to participants' POWER accounts must be reported on Forms CMS-64.9 Waiver, using Line 18E. (Because individual participants' POWER account contributions are not subject to federal matching, they are not to be reported on the CMS-64.).
- iii. Recouped State Contributions to Participants' POWER Accounts. In the event that the state recoups state POWER account contributions from HIP MCOs (for example, when a participant disenrolls from HIP; see paragraphs 12 and 13 in section VII), the amounts collected must be reported as a prior period adjustment using Line 10B of the Forms CMS-64.9P Waiver on Line 18E.
- c. **Cost Settlements.** For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlements not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the state Medicaid Manual.
- d. **Use of Waiver Forms.** The following six (6) waiver Forms CMS-64.9 Waiver and/or 64.9P. Waiver must be submitted each quarter (when applicable) to report title XIX expenditures for individuals enrolled in the demonstration. The expressions in quotation marks are the waiver names to be used to designate these waiver forms in the MBES/CBES system.
 - i. "1931 Parents and low-income 19/20 year old dependent" expenditures
 - ii. "New Adult Group" expenditures
 - iii. "HIP Link" expenditures
 - iv. "Medically Frail" expenditures
 - v. "'HIP Presumptive Eligibility" expenditures
 - vi. "Section 1931 Uncompensated Care" expenditures
- e. **Pharmacy Rebates.** The state may propose a methodology for assigning a portion of pharmacy rebates to the demonstration, in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the demonstration population, and which reasonably identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. The portion of pharmacy rebates assigned to the demonstration using the approved methodology will be reported on the appropriate Forms CMS-64.9 Waiver for the demonstration, and not on any other CMS-64.9 form (to avoid double-counting). Each rebate amount must be distributed as state and federal revenue consistent with the federal matching rates under which the claim was paid. Pharmacy rebates are not applicable to the HIP Link program.

- f. **Administrative Costs.** The following provisions govern reporting of administrative costs during the demonstration.
- i. Administrative costs attributable to the demonstration must be reported under waiver name “HIP 2.0.”
 - ii. Administrative costs not related to the demonstration should be reported on the appropriate CMS-64.10 Base or 64.10P Base, or another waiver schedule as appropriate.
- g. **Claiming Period.** All claims for expenditures (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately on the CMS-64 waiver forms the net expenditures related to dates of service during the operation of the section 1115 demonstration, in order to account for these expenditures properly to determine budget neutrality.

3. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and federal share) and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS will reconcile expenditures reported on the Form CMS-64 quarterly with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

4. Extent of FFP for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole as outlined below:

- a. Administrative costs, including those associated with the administration of the demonstration.
- b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved state plan.
- c. Medical Assistance expenditures made under section 1115 demonstration authority, including those made in conjunction with the demonstration, cost sharing, pharmacy rebates, and all other types of third party liability or CMS payment adjustments.

5. Sources of Non-Federal Share. The state must certify that the matching non-federal

share of funds for the demonstration are state/local monies. The state further certifies that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

- a. CMS may review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
- b. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding.
- c. The state assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid state plan.
- d. Under all circumstances, health care providers must retain 100 percent of the HIP reimbursement amounts claimed by the state as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes (including health care provider-related taxes), fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.
- e. FFP will not be available for individual contributions to the POWER accounts. FFP will be available for state contributions to the POWER accounts to the extent that funds are actually transferred to MCOs (net of any such funds returned to the state or other governmental entity), and for capitation payments to MCOs.

6. State Certification of Funding Conditions. The state must certify that the following conditions for non-federal share of demonstration expenditures are met:

- a. Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.
- b. To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for Title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs

eligible under Title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

- c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to fund the non-federal share of demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.
- d. The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of Title XIX payments.
- e. Under all circumstances, health care providers must retain 100 percent of the HIP reimbursement amounts claimed by the state as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes (including health care provider-related taxes), fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

7. **Monitoring the Demonstration.** The state shall provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable timeframe.

XII. BUDGET NEUTRALITY DETERMINATION

1. **Limit on Title XIX Funding.** The state shall be subject to a limit on the amount of federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit will be determined by using a per capita cost method. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. Actual expenditures subject to the budget neutrality expenditure limit shall be reported by the state using the procedures described in Section XI paragraph 2(d). The data supplied by the state to CMS to set the annual limits is subject to review and audit, and, if found to be inaccurate, will result in a modified budget neutrality expenditure limit.
2. **Risk.** Indiana shall be at risk for the per capita cost (as determined by the method described below in this Section) for Medicaid eligibles but not for the number of demonstration eligibles in each of the groups. By providing FFP for HIP enrollees in

these eligibility groups, Indiana shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing Indiana at risk for the per capita costs for HIP enrollees, CMS assures that the federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration.

3. Budget Neutrality Annual Expenditure Limits. For each DY, annual limits are calculated.

- a. **PMPM Costs.** The following table gives the projected PMPM costs for the calculations described above by DY.

Eligibility Group	Trend Rate	DY 1 (2/1/15- 12/31/15)	DY2 (1/1/16- 12/31/16)	DY 3 (1/1/17- 12/31/17)
1931 Adults	5.3%	\$666.15	\$701.46	738.64
New Adults	1.1%	545.14	\$551.14	\$557.20
Medically Frail	4.3%	\$1,662.65	\$1,734.14	\$1808.71
HIP Link	1.1%	\$348.33	\$352.17	\$356.04

- i. If the State’s experience of the take up rate for the new adult group and other factors that affect the costs of this population indicates that the PMPM limit described above in paragraph (a) may underestimate the actual costs of medical assistance for the new adult group, the State may submit an adjustment to paragraph (a), along with detailed expenditure data to justify this, for CMS review without submitting an amendment pursuant to Section 3 paragraph 7. Adjustments to the PMPM limit for a demonstration year must be submitted to CMS by no later than October 1 of the demonstration year for which the adjustment would take effect.
- ii. The budget neutrality cap is calculated by taking the PMPM cost projection for the above group in each DY, times the number of eligible member months for that group and DY, and adding the products together across groups and DYs. The federal share of the budget neutrality cap is obtained by multiplying total computable budget neutrality cap by the federal share.
- iii. The State will not be allowed to obtain budget neutrality “savings” from the New Adults, Medically Frail and HIP Link Groups.

4. Composite Federal Share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the 3-year approval period, as reported on the forms listed in Section XI paragraph 2(d) by total computable demonstration expenditures for the same period as reported on the same forms. Should the demonstration be terminated prior to the end of the 3-year approval period, the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be used.

5. Future Adjustments to the Budget Neutrality Expenditure Limit. CMS reserves the rights to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letter, memoranda, or regulations with respect to the provision of services covered under HIP.

6. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis, by combining the annual limits calculated following this paragraph into lifetime limits for the demonstration. The following describes how budget neutrality will be enforced.

- a. If the demonstration is terminated prior to the end of the budget neutrality agreement, an assessment of the state’s compliance with these requirements shall be based on the time elapsed through the termination date.
- b. **Interim Checks/Corrective Action Plan.** If the state exceeds the calculated cumulative target limit by the percentage identified below for any of the DYs, the state shall submit a corrective action plan to CMS for approval.

DY	Cumulative Target Definition	Percentage
Year 1	Cumulative budget neutrality expenditure cap plus:	3%
Year 2	Cumulative budget neutrality expenditure cap plus:	1.5%
Year 3	Cumulative budget neutrality expenditure cap plus:	0%

XIII. EVALUATION

1. Submission of Draft Evaluation Design. The state must submit to CMS for approval, within 120 days of the approval date of the demonstration a draft evaluation design. A delay in submitting the draft evaluation design could subject the state to penalties described in paragraph 16 of section III. At a minimum, the draft design must include a discussion of the goals, objectives, and specific testable hypotheses, including those that focus specifically on target populations for the demonstration, and more generally on beneficiaries, providers, plans, market areas and public expenditures. The analysis plan must cover all elements in paragraphs 3- 6 of this section. The design should be described in sufficient detail to determine that it is scientifically rigorous. The data strategy must be thoroughly documented.

The design should describe how the evaluation and reporting will be developed and maintained to assure its scientific rigor and completion. In summary, the demonstration evaluation will meet all standards of leading academic institutions and academic journal peer review, as appropriate for each aspect of the evaluation, including standards for the

evaluation design, conduct, interpretation, and reporting of findings. The design must also control for various confounding factors in the demonstration such as the 60-day waiting period for beneficiaries below poverty that choose not to pay a monthly POWER Account contribution. Among the characteristics of rigor that will be met are the use of best available data; controls for and reporting of the limitations of data and their effects on results; and the generalizability of results.

The design must describe the state's process to contract with an independent evaluator, ensuring no conflict of interest.

The design, including the budget and adequacy of approach, to assure the evaluation meets the requirements of paragraph 9 of this section, is subject to CMS approval. The budget and approach must be adequate to support the scale and rigor reflected within paragraphs 3- 6 of this section.

2. Cooperation with Federal Evaluators. Should HHS undertake an evaluation of the demonstration or any component of the demonstration, the state shall cooperate fully with CMS or the evaluator selected by HHS. In addition, the state shall submit the required data to HHS or its contractor in a timely manner and at no cost to CMS or the contractor, unless the state incurs a cost in which case CMS will participate in accordance with regular administrative matching rules.

3. Evaluation Design. The Evaluation Design shall include the following core components to be approved by CMS:

a. **Domains of Focus.** The state must propose at least one research question that it will investigate within each of the domains listed below. The research questions should focus on processes and outcomes that relate to the CMS Three-Part Aim of better care, better health, and reduced costs. The following are among the hypotheses to be considered in the development of the evaluation and design and will be included in the design as appropriate.

- i. HIP 2.0 will reduce the number of uninsured Hoosiers with income under 133 percent FPL by 90 percent over the course of the demonstration.
- ii. HIP 2.0 will increase access to quality health care services for all adults eligible for the program.
- iii. HIP 2.0 will effectively promote beneficiary use of preventive, primary, and chronic disease management care to achieve improved health outcomes.
- iv. HIP Plus beneficiaries will exhibit more cost-conscious healthcare consumption behavior than: a) HIP Basic beneficiaries; and b) traditional Hoosier Healthwise beneficiaries, without harming beneficiary health.
- v. POWER Account contributions for individuals in the HIP Plus plan are affordable and do not create a barrier to health care access.

- vi. Few individuals will experience the lock-out period, because the policy will deter nonpayment of POWER Account contributions policy for HIP Plus beneficiaries.
- vii. Presumptive eligibility and fast-track prepayments will provide the necessary coverage so as not to have gaps in health care coverage.
- viii. HIP policies such as rollovers and healthy behaviors will encourage beneficiaries' compliance with required contributions and provide incentives to actively manage POWER account funds.
- ix. Not assuring non-emergency transportation does not pose a barrier to access to care.
- x. The graduated copayment structure for non-emergency use of the emergency department will decrease inappropriate ED utilization without harming beneficiary health;
- xi. The prior authorization process for hospital emergency department use and efforts to expand access to other urgent care settings will decrease inappropriate ED utilization without harming beneficiary health.
- xii. The HIP Link program will increase the proportion of Hoosiers with income under 138 percent of the FPL covered by employer-sponsored insurance (ESI).

b. **Measures.** The draft evaluation design must discuss the outcome measures that shall be used in evaluating the impact of the demonstration during the period of approval, including:

- i. A description of each outcome measure selected, including clearly defined numerators and denominators, and National Quality Forum (NQF) numbers (as applicable);
- ii. The measure steward;
- iii. The baseline value for each measure; and
- iv. The sampling methodology for assessing these outcomes.

c. **Sources of Measures.** CMS recommends that the state use measures from

nationally- recognized sources and those from national measures sets (including CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, and the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults).

- d. The evaluation design must also discuss the data sources used, including, but not limited to, the use of Medicaid encounter data, enrollment data, EHR data, and consumer and provider surveys. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring in the state. The evaluation designs proposed for each question may include analysis at the beneficiary, provider, and aggregate program level, as appropriate, and include population stratifications to the extent feasible, for further depth and to glean potential non-equivalent effects on different sub-groups.
- 4. NEMT Evaluation.** Indiana must conduct an independent evaluation of NEMT as described in Section V, paragraph 2. The evaluation must be submitted by November 1, 2015, include hypotheses, and address at a minimum the following questions:
- a. What is the effect of no access to NEMT on missed appointments by income level?
 - b. Are there parts of the state that are more affected by no access to NEMT?
 - c. How does not having access to NEMT affect preventive care and overall health outcomes?
 - d. What is the impact of no access to NEMT as viewed by the providers and beneficiaries?

A delay in submitting this report could subject the state to penalties described in paragraph 16 of section III.

- 5. HIP Plus POWER Account Contribution Evaluation.** Indiana must use the results of the contribution monitoring data—including the survey of enrolled and unenrolled individuals— described in Section VIII STC 4—as well as other available data to conduct an independent evaluation that examines POWER Account contributions policy for HIP Plus beneficiaries.
- a. As part of this evaluation, the state shall survey statistically significant groups of individuals who:
 - i. are income eligible but do not enroll in HIP;
 - ii. have been disenrolled for non-payment of POWER account contribution; and

- iii. are in HIP Basic.
- b. The survey shall include questions about the affordability of HIP POWER account contributions.
- c. The interim evaluation report must be submitted within 60 days after DY 2, include hypotheses, and address the effect of the lockout policy on enrollment and reenrollment for HIP Plus beneficiaries broken down by income level and questions including:
 - i. How many individuals were disenrolled by income level?
 - ii. What are the reasons beneficiaries did not make contributions?
 - iii. What health care needs did individuals have while they were in the lockout period and how did they address those needs?
- d. Information provided in this interim evaluation report must also be addressed in the evaluation design, interim evaluation report as described in paragraph 8 of this section, and final evaluation report as described in paragraph 9 of this section. A delay in submitting this report could subject the state to penalties described in paragraph 16 of section III.

6. Emergency Department Co-pay Evaluation. Indiana must conduct an independent evaluation of the emergency room co-pay structure that is authorized under provisions of 1916(f). The draft evaluation design must be submitted within 60 days after approval of the protocol and the draft evaluation report must be submitted 60 days before January 31, 2017. The draft evaluation design must include at a minimum:

- a. The method by which beneficiaries will be randomized to participate in the emergency room co-pay control group (\$8 per visit) and test group (\$8 per visit then \$25 each visit).
- b. Hypotheses and outcome data for the evaluation.

A delay in submitting this draft evaluation design or final evaluation report could subject the state to penalties described in paragraph 16 of section III.

7. Retroactive Coverage Evaluation. Indiana must conduct an independent evaluation of the retroactive coverage waiver and transition uncompensated care program. The state will provide the following data by September 1, 2015, including:

- a. The number of people determined eligible using ex parte
- b. The number of people receiving a prepopulated renewal form
- c. The number of people responding to the prepopulated renewal form

- d. The number of responders determined eligible
- e. The number of people who reapply within 90 days or less, within 6 months, and within one year, following a termination for failure to respond

8. Final Evaluation Design and Implementation. CMS shall provide comments on the draft design and the draft HIP 2.0 evaluation strategy, and the state shall submit a final design within 60 days of receipt of CMS's comments. A delay in submitting the final evaluation design could subject the state to penalties described in paragraph 16 of section III. The state must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports.

9. Interim Evaluation Report. The state must submit an interim evaluation report to CMS as part of any future request to extend the demonstration, or by June 30, 2016, if no extension request has been submitted by that date. The interim evaluation report will discuss evaluation progress and present findings to date as required under paragraph 9 of this section.

10. Final Evaluation Report. The state must submit to CMS a draft of the evaluation final report within 60 days after to the expiration of the demonstration.

The report shall include items as required in the Evaluation Design (Attachment E). The state must take into consideration CMS' comments for incorporation into the final report. The final evaluation report is due to CMS no later than 120 days after receipt of CMS' comments. A delay in submitting the draft of the final evaluation report or final evaluation report could subject the state to penalties described in paragraph 16 of section III.

11. Public Access. The state shall post the final approved Evaluation Design on the state Medicaid website within 30 days of approval by CMS.

12. Electronic Submission of Reports. The state shall submit all required plans and reports using the process stipulated by CMS, if applicable.

XIV. HEALTH INFORMATION TECHNOLOGY

1. Health Information Technology (HIT). The state shall use HIT to link services and core providers across the continuum of care to the greatest extent possible. The state is expected to achieve minimum standards in foundational areas of HIT and to develop its own goals for the transformational areas of HIT use.

- a. Indiana must have plans for health IT adoption for providers. This will include creating a pathway (and/or a plan) to adoption of certified electronic health record (EHR) technology and the ability to exchange data through the state's health information exchanges. If providers do not currently have this technology, there must be a plan in place to encourage adoption, especially for those providers

eligible for the Medicare and Medicaid EHR Incentive Program.

- b. The state must participate in all efforts to ensure that all regions (e.g., counties or other municipalities) have coverage by a health information exchange. Federal funding for developing health information exchange (HIE) infrastructure may be available, per State Medicaid Director letter #11-004, to the extent that allowable costs are properly allocated among payers. The state must ensure that all new systems pathways efficiently prepare for 2014 eligibility and enrollment changes.
- c. All requirements must also align with Indiana’s State Medicaid HIT Plan and other planning efforts such as the Office of National Coordinator HIE Operational Plan.

XV. T-MSIS REQUIREMENTS

On August 23, 2013, a State Medicaid Director Letter entitled, “Transformed Medicaid Statistical Information System (T-MSIS) Data,” was released. It states that all states are expected to demonstrate operational readiness to submit T-MSIS files, transition to T-MSIS, and submit timely T-MSIS data by July 1, 2014. Among other purposes, these data can support monitoring and evaluation of the Medicaid program in Indiana against which the HIP 2.0 demonstration will be compared. Should the MMIS fail to maintain and produce all federally required program management data and information, including the required T-MSIS, eligibility, provider, and managed care encounter data, in accordance with requirements in the SMM Part 11, FFP may be suspended or disallowed as provided for in federal regulations at 42 CFR 433 Subpart C, and 45 CFR Part 95.

XVI. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

The state is held to all reporting requirements outlined in the STCs; this schedule of deliverables should serve only as a tool for informational purposes only.

Per award letter - Within 30 days of the date of award	Confirmation Letter to CMS Accepting Demonstration STCs
Per Section XIII, Paragraph 1	Submit Draft Evaluation Design
Per Section III, Paragraph 8	Submit Demonstration Extension Application
Per Section III,	Post-award Forum
Per Section VIII, Paragraphs 4 & 5	POWER Account Contributions and Copayments Operational and Monitoring Protocols

Per Section VIII, Paragraph 6	ER Co-pay Protocol
Per Section XIII, Paragraph 4	NEMT Evaluation
Quarterly	Deliverable
Per Section X, Paragraph 3	Quarterly Progress Reports
Per Section XI, Paragraph 1	Quarterly Expenditure Reports
Annual	Deliverable
Per Section III, Paragraph 10	Post Award Forum Transparency deliverable
Per Section X, Paragraph 6	Draft Annual Report

Renewal/Close Out	Deliverable
Per Section XIII, Paragraph 9	Draft Final Evaluation
Per Section XIII, Paragraph 9	Final Evaluation

Attachment A – HIP Link Protocol

HIP Link is an optional premium assistance program intended to provide a new choice to HIP 2.1 participants. The program allows individuals to choose to participate in their employer's sponsored health plan as an alternative to participating in HIP 2.0. As discussed in section VI of the STCs, the program is available to any individual who qualifies for HIP 2.0 and has access to a state-certified employer sponsored health plan. The employer must contribute at least 50 percent of the cost of the premium.

Under HIP Link, the state shall establish a POWER account, valued at \$4,000, for each HIP 2.0 qualified individual, which may be utilized by the beneficiary to defray the costs of the employer's health plan, including premiums and other out-of-pocket expenses. The beneficiary shall not be required to contribute to the POWER account, but will be required to pay an amount through payroll deduction towards the employee share of the employer sponsored health plan, as described below. The amount of the POWER account was developed using data on the average employee out-of-pocket expenditures for Indiana's employer health plans. In addition, the current costs of the HIP program were also considered to ensure the state's contribution to the HIP Link POWER account is no more than the cost of providing coverage to the individual through the HIP 2.0 plan. The state shall continue to review and, if needed, adjust the POWER account contribution amount throughout the waiver period to ensure the amount is appropriate. The state shall implement several measures to ensure that the HIP Link program does not result in unfunded health care costs for a beneficiary.

1. The state shall develop a robust process to review employer plans to ensure they meet the requirements for HIP Link. This includes evaluation of adherence to the Alternative Benefit Plans, as well as reviewing the cost sharing obligations, premiums, and/or deductibles applicable to the employer plan that could make HIP Link an unaffordable option for participants. As part of the review process, the state shall assess if the employer provides and/or contributes to a health savings account (HSA) or health reimbursement account (HRA) to help defray deductible costs. The state shall not approve a health plan with deductibles that significantly exceed \$4,000 plus any HSA or HRA contributions made by the employer. . The state may choose not to approve an employer health plan based on other criteria related to out of pocket expenses.
2. The state shall contribute \$4,000 per individual to the POWER account. Therefore, in the case of two adult participants in a family accounts may be combined.
3. During the employer plan certification process, the state shall collect key data on cost-sharing requirements such as, the health plan's deductible, out-of-pocket maximums, co-payments, co-insurance, as well as the presence of an employer funded health savings account or health reimbursement account. This will help the state provide robust counseling to potential participants as they consider their health plan options.
4. While the HIP Link POWER account will be used to pay for both state premium contributions and employee cost-sharing, the state shall bifurcate the POWER account

between state premium contribution amounts and other applicable cost-sharing to ensure the funds will be sufficient pay state premium contributions throughout the entire benefit period. HIP Link POWER account funds will be allocated between the state premium contribution and the out-of-pocket expenses used to pay for medical expenses incurred by the beneficiary.

5. The state shall work with the employer to implement a payroll deduction for the beneficiary that will be contributed to the required employee share of the cost of the employer sponsored health plan, and shall equal the lesser of 2 percent of family income or the required employee share of the cost of coverage.
6. An individual may request to terminate their HIP Link coverage and enroll in HIP Plus during their twelve month benefit period, under the following circumstances:
 - a. A woman becomes pregnant;
 - b. The individual certifies they have one of the conditions specified in the “medically frail” screener contained in the HIP 2.0 application;
 - c. The individual is no longer eligible for the employer sponsored health plan, or the employer sponsored health plan changes and no longer meets the HIP Link requirements and; or
 - d. The POWER account funds designated for non-premiums are significantly diminished and the remaining patient liability is projected to exceed 5% of the individual’s income.
 - i. Since the state is acting as a secondary payer to the employer plan, the state shall be able to track individual cost-sharing from the claims received and will identify when an individual may be close to exceeding their POWER account and/or their 5 percent annual cost-sharing limit.
 - ii. The state shall conduct outreach to the individual and allow them to terminate their employer plan and join HIP through the HIP Plus plan.
 - iii. The state shall develop the threshold standard for the remaining POWER account balance and remaining deductible to determine the actual timing for outreach.
 - iv. In addition to electronic tracking, the state shall also allow individuals to present data (“shoebox” method), outside of the claims process to the state if they have exceeded their 5 percent annual limit.

**Attachment B – POWER Account Contributions and Copayments Infrastructure
Operational Protocol (reserved)**

**Attachment C – POWER Account Contributions and Copayments Monitoring Protocol
(reserved)**

Attachment D – Emergency Room Co-pay Protocol (reserved)

Attachment E - Evaluation Design