



FEB - 1 2018

Deputy Administrator

Washington, DC 20201

Allison Taylor
Medicaid Director
Indiana Family and Social Services Administration
402 W. Washington Street, Room W461, MS25
Indianapolis, IN 46204

Dear Ms. Taylor:

The Centers for Medicare & Medicaid Services (CMS) is approving Indiana's request for CMS approval of its Medicaid demonstration entitled, "Healthy Indiana Plan (HIP)" (Project Number 11-W-00296/5) in accordance with section 1115(a) of the Social Security Act (the Act).

This approval is effective February 1, 2018, through December 31, 2020, upon which date, unless reauthorized or otherwise noted, all authorities granted to operate this demonstration will expire. CMS's approval is subject to the limitations specified in the attached expenditure authorities, waivers, and special terms and conditions (STC). The state may deviate from Medicaid state plan requirements only to the extent those requirements have been listed as waived or as not applicable to expenditures.

Extent and Scope of Demonstration

The current HIP section 1115 demonstration was implemented by the State of Indiana ("state") on February 1, 2015. The HIP program provides beneficiaries with a consumer-driven plan with required monthly contributions, supported by the Personal Wellness and Responsibility ("POWER") account, which is similar to a health savings account. With this approval, the state is authorized to make several changes to HIP, which the state has indicated are designed to improve member outcomes by targeting tobacco cessation, substance use disorder (SUD), chronic disease management, and community engagement. HIP also aims to help prepare beneficiaries for participation in the commercial insurance marketplace. The state's approach is designed to prepare beneficiaries for the personal responsibility required to maintain coverage and continuity of care they will experience when they seek commercial insurance coverage.

Indiana is making a change to how HIP Plus beneficiaries will be charged premiums. The state will apply a premium surcharge for HIP Plus beneficiaries who use tobacco, and who do not participate in tobacco cessation activities. This increased premium will be applied after the first year of enrollment, during which beneficiaries are encouraged to use the various state plan options available to cease tobacco use. By charging beneficiaries a surcharge related to a specific behavior (i.e., tobacco use), the state will test whether incentivizing beneficiaries to change behavior and engage in their own healthcare will achieve better health outcomes.

In addition, the state will be moving from charging HIP Plus beneficiaries a premium that is exactly two percent of household income to assessing premiums based on income bands, in which most beneficiaries will pay no more than two percent of household income.

In addition, beginning in 2019, Indiana will implement a community engagement requirement as a condition of continued coverage and eligibility for adult beneficiaries enrolled in HIP who are not exempt. The terms and conditions of Indiana's community engagement requirement that accompany this approval are aligned with the guidance provided to states through State Medicaid Director's Letter (SMD 18-0002), Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries, issued on January 11, 2018.

Certain groups, including pregnant women, beneficiaries identified as medically frail, students, some caregivers of dependents, and beneficiaries in active SUD treatment will be exempt from this requirement. To maintain coverage, non-exempt members will be required to participate in community engagement activities that may include (but are not limited to) employment, education, job skills training, or volunteer work for a weekly hours requirement that will phase in over the life of the demonstration to eventually become a requirement of 20 hours per week. Compliance will be required for eight months of the 12-month calendar year (for a non-exempt beneficiary that participates for the full year). Beneficiaries will have four months (within a 12-month calendar year) in which they do not have to meet the community engagement requirement. Beneficiaries who fail to meet their required community engagement hours in the preceding calendar year will have their eligibility suspended in the new calendar year until the month following notification to the state that they have completed a calendar month of required hours. If a suspended beneficiary does not complete the one month of community engagement hours to reactivate coverage by their redetermination date, and does not qualify for an exemption, or qualify for another eligibility category that is not subject to the community engagement requirement in the month of redetermination, the individual will be disenrolled from Medicaid at that time, and will have to reapply to reenroll in Medicaid. When an individual whose enrollment was terminated during redetermination reapplies, their previous noncompliance with the community engagement requirement will not be factored into the state's determination of their eligibility for reenrollment into HIP. Indiana will allow good cause exemptions in certain circumstances for beneficiaries who cannot meet their requirement. With this policy, the state will test whether requiring some beneficiaries to engage in community engagement requirements will lead to improved health outcomes.

HIP enrollees have their eligibility reconfirmed through a redetermination period, which begins 45 days prior to the end of the beneficiary's eligibility period. Beneficiaries who do not provide requested information to confirm eligibility during this period will be subject to disenrollment, unless otherwise exempted. However, beneficiaries subject to disenrollment will have an "on-ramp" back into coverage during an additional 90-day reconsideration period, consistent with Medicaid regulations. During the 45-day redetermination period, the state and plans will conduct outreach to ensure understanding of paperwork requirements and encourage compliance. If an individual subject to disenrollment does not take advantage of the on-ramp and cannot show good cause for non-compliance, he or she will not be able to re-enroll in HIP for three months following the reconsideration period. With this policy, the state will test whether

incentivizing beneficiaries to follow established procedures and engage in maintaining their healthcare coverage will lead to improved health outcomes.

This HIP demonstration will also include a SUD program to ensure that a broad continuum of care is available to Indiana Medicaid beneficiaries with a SUD, which will help improve the quality, care, and health outcomes for those Medicaid beneficiaries. The SUD program contributes to a comprehensive statewide strategy to combat prescription drug abuse and opioid use disorders, and expands the SUD benefits package to cover short-term residential services for all Medicaid enrollees.

Determination that the demonstration project is likely to assist in promoting Medicaid's objectives

Demonstration projects under section 1115 of the Act offer a way to give states more freedom to test and evaluate innovative solutions to improve quality, accessibility and health outcomes in a budget-neutral manner, provided that, in the judgment of the Secretary, the demonstrations are likely to assist in promoting the objectives of Medicaid.

While CMS believes that states are in the best position to design solutions that address the unique needs of their Medicaid-eligible populations, the agency has an obligation to ensure that proposed demonstration programs are likely to better enable states to serve their low-income populations, through measures designed to improve health and wellness and help individuals and families attain or retain capability for independence or self-care. Medicaid programs are complex and shaped by a diverse set of interconnected policies and components, including eligibility standards, benefit designs, reimbursement and payment policies, information technology (IT) systems, and more. Therefore, in making this determination, CMS considers the proposed demonstration as a whole.

In its consideration of the proposed changes to HIP, CMS examined whether the demonstration was likely to assist in improving health outcomes; whether it would improve access to high-quality, person-centered services; whether it would address behavioral and social factors that influence health outcomes; whether it would incentivize beneficiaries to engage in their own healthcare and achieve better health outcomes; and whether it would familiarize beneficiaries with a benefit design that is typical of what they may encounter in the commercial market and thereby facilitate smoother beneficiary transition to commercial coverage. CMS has determined that the HIP demonstration is likely to promote Medicaid objectives, and that the waivers and expenditure authorities sought are appropriate to carry out the demonstration.

1. The demonstration is likely to assist in improving health outcomes through strategies that promote community engagement and address certain health determinants.

HIP is a consumer-driven health plan that provides a combination of complementary incentives and disincentives that are intended to address certain health determinants, and promote increased upward mobility, greater independence, and improved quality of life. Indiana's community engagement requirement, an evolution of the state's existing Gateway to Work program, is an

incentive for beneficiaries to obtain employment or engage in other community activities that are correlated with improved health and wellness. As Indiana informed CMS in the request for approval of the community engagement program, Gateway to Work, the state's work referral program, did not prove to provide a sufficient incentive to influence many Medicaid beneficiaries to participate in employment. Despite the fact that around 244,000 HIP beneficiaries were unemployed and an additional 58,000 worked fewer than 20 hours per week, only 580 beneficiaries attended Gateway to Work orientations during the first 15 months of the program. By making participation in community engagement a requirement to receive benefits for most non-pregnant, non-medically frail beneficiaries who are not eligible for Medicaid on the basis of a disability, Indiana is incentivizing certain beneficiaries to participate in employment, volunteer work, education, or training. As noted in CMS' SMDL: 18-002, these activities have been shown to lead to healthier individuals.

Approving a range of community engagement incentive structures in various states is likely to give CMS and the states helpful information about how different incentive structures function; the evidence generated by a range of incentive structures designed around work and community engagement requirements will inform future agency decisions about which program features best promote the objectives of Medicaid. CMS has determined that the Indiana demonstration includes a meaningful incentive by requiring affected beneficiaries to demonstrate compliance with the community engagement requirements during the prior calendar year, or face a suspension in the next calendar year. CMS considered Indiana's experience in the existing Gateway to Work program and has determined that the proposal has been informed by this experience as the state seeks to strengthen the incentives for community engagement. Indiana has tailored the incentive structure to include beneficiary protections, such as the opportunity to reactivate suspended eligibility in the month following notification to the state that the beneficiary has completed a calendar month of required hours, as well as the opportunity to begin a new period of eligibility at the beneficiary's next redetermination date. The impact of this incentive, as well as other aspects of the demonstration, will be assessed through an evaluation designed to measure how the demonstration affects eligibility, behavior, and health outcomes over time for persons subject to the demonstration's policies.

2. The demonstration is likely to improve health outcomes for beneficiaries with substance use disorder.

The SUD program directly supports Medicaid's objectives by improving access to high-quality services, and it is critical to addressing Indiana's substance use epidemic. All Medicaid beneficiaries in Indiana will continue to have access to all current mental health and SUD benefits. In addition, all beneficiaries, ages 21 through 64, will have access to expanded covered services provided while residing in an Institution for Mental Diseases (IMD) for SUD short-term residential stays. The SUD program will allow beneficiaries with SUD to access benefits that include SUD residential treatment, crisis stabilization and withdrawal management services provided in IMDs, which would otherwise be excluded from federal reimbursement.

3. The demonstration is expected to strengthen beneficiary engagement in their personal health care, and provide incentives for responsible decision-making.

Indiana expects that requirements related to redetermination and reporting will also strengthen beneficiary engagement in their personal health care plan, and provide an incentive structure to support responsible consumer decision-making.

Indiana's previous HIP evaluation has indicated that some of the demonstration's prior features had a positive impact on beneficiary behavior.¹ For example, a majority of HIP beneficiaries opt into paying premiums in order to receive an enhanced benefit package. Therefore, the state is retaining this requirement, but adjusting the premium structure for administrative simplification so any slight fluctuation in a beneficiary's income will no longer always change the amount of the premium due. In a program enhancement, to encourage individuals to take advantage of the tobacco cessation options available through the state plan, beneficiaries who do not use tobacco will be charged a lower premium; beneficiaries who do identify as tobacco users will be given a year to stop using tobacco before paying the surcharge.

The waiver of retroactive eligibility encourages beneficiaries to obtain and maintain health coverage, even when healthy. This demonstration is intended to increase continuity of care by reducing gaps in coverage when beneficiaries churn on and off Medicaid or sign up for Medicaid only when sick.

Imposition of a non-eligibility period for failing to complete timely redetermination encourages individuals to maintain compliance with longstanding beneficiary responsibilities, as described in regulation, and helps to ensure Medicaid is covering only those individuals who are eligible for the program.

4. The demonstration will remove potential obstacles to a successful beneficiary transition to commercial coverage.

Indiana anticipates many Medicaid beneficiaries will transition to commercial health insurance since the demonstration seeks to provide members the tools to successfully utilize commercial market health insurance, thereby removing potential obstacles to a successful transition from Medicaid to commercial coverage. The demonstration includes several features that align with common features of commercial market plans. For instance, the demonstration includes premium payment requirements (with a non-eligibility period for non-payment for certain populations), limited managed care enrollment windows, and limited time periods to switch between managed care plans. The HIP Plus benefit package also provides enhanced medical benefits (e.g., vision and dental) above Medicaid state plan benefits, requires monthly member premiums, and initiates benefits prospectively from the initial premium payment.

This approval also gives Indiana additional tools to encourage HIP beneficiaries to complete the annual redetermination process (with a non-eligibility period for non-compliance for certain populations), which will help educate beneficiaries on the need to timely complete enrollment requirements. CMS notes that in the state's HIP 1.0 demonstration, Indiana successfully applied

¹ https://www.in.gov/fssa/files/Lewin_IN%20HIP%202%200%20Interim%20Evaluation%20Report_FINAL.pdf

a policy of non-eligibility for a small population of individuals who were in the expansion group who did not complete the redetermination process. CMS later did not allow the state to impose this policy on the new adult population as part of HIP 2.0, in part due to concerns about the impact of the policy on access to affordable coverage. CMS has reconsidered its earlier position and believes the state should be given the opportunity to test the efficacy of this policy in HIP , with the appropriate assurances of safeguards for individuals who may need an exception for good cause (such as hospitalization, domestic violence, or the death of a family member) or who have a disability. The state expects this policy will build on the successes of the redetermination and open enrollment policy in the original HIP program and, with continued beneficiary outreach efforts by the state and managed care entities, will result in improved compliance with redetermination requirements. CMS is approving the state's request to apply this policy to non-pregnant and non-medically frail HIP beneficiaries. Incentivizing beneficiaries to complete the annual redetermination process is likely to help educate beneficiaries on the need to timely complete enrollment requirements because of limited opportunities to enroll in coverage. Thus, in addition to the opportunity to enhance program integrity noted above, approval of this policy is likely to support the objectives of Medicaid to the extent that it prepares individuals for a smooth transition to commercial health insurance coverage and ensures that resources are preserved for individuals who meet eligibility requirements.

Similar to how commercial coverage operates, coverage eligibility will continue to be impacted under this approval for certain HIP Plus beneficiaries with income over 100 percent of the FPL for non-payment of premiums. Unless exempt, such beneficiaries will be disenrolled and have a six month non-eligibility period. The demonstration includes special exemptions for those that lose private insurance coverage or are the victim of domestic violence. CMS also notes that Indiana has taken steps to minimize beneficiary harm by exempting certain vulnerable populations, such as pregnant women and individuals who are medically frail, from disenrollment for non-payment of premiums.

Overall, CMS believes that HIP has been designed to empower individuals to improve their health and well-being. If successful in its objectives, HIP will improve health outcomes, promote increased upward mobility and improve quality of life, increase individual engagement in health care decisions, and prepare individuals who transition to commercial health insurance coverage to be successful in this transition. At the same time, HIP ensures vulnerable individuals, like people with disabilities and pregnant women, continue to receive medical assistance.

Consideration of Public Comments

Both Indiana and CMS received a large volume of comments during the state and federal public comment periods. Consistent with federal transparency requirements, CMS reviewed all of the materials submitted by the state, as well as all the public comments it received, when evaluating whether the demonstration project as a whole was likely to promote the objectives of the Medicaid program, and whether the waiver and expenditure authorities sought were necessary and appropriate to implement the demonstration. In addition, CMS took public comments submitted during the federal comment period into account as it worked with Indiana to develop the STCs that accompany this approval, and that will bolster beneficiary protections, including specific state assurances around these protections to further support beneficiaries.

In both the state and federal comment periods, there were comments in support of the application, specifically the state's efforts to promote beneficiary responsibility and accountability, and enhance sustainability of the program in the long-term. Supporters noted that the demonstration has provided them with affordable, accessible, and comprehensive health coverage, while others agreed with the state's move to realigning POWER account contributions to a simpler income-band approach. Some supporters also noted their agreement with the principle that working-age adults who are not eligible for Medicaid on the basis of a disability must meet community engagement requirements as a condition of eligibility. Many commenters supported the state's efforts to expand services for substance use disorder by requesting expenditure authority for residential SUD services in an IMD and by incentivizing tobacco cessation.

In the state and federal comment periods, opposing commenters expressed general disagreement with the continued efforts of the state to utilize non-traditional means to expand Medicaid. Commenters indicated they would rather the state expand through the state plan, without an accompanying section 1115 demonstration, because they found the enrollment process confusing and a barrier to care. Some offered more specific feedback regarding individual elements of the demonstrations or the impact of certain provisions on distinct populations. In addition, some commenters were concerned that the qualifying activities and list of exemptions were not broad enough.

Some commenters asserted that the premium provisions in the HIP 2.0 demonstration had resulted in a higher rate of disenrollment due to nonpayment, citing the state's independent evaluation on this project. We continue to believe that the demonstration's premium provisions are appropriate to prepare beneficiaries to participate in the commercial market. We note that the independent evaluation has reported several positive impacts from the demonstration to date, namely that HIP 2.0 has reduced the number of uninsured low-income Indiana residents, many of whom were previously uninsured or underinsured, and that at least a portion of those who disenrolled showed the primary reason was a change in income or having secured insurance from another source.

Other commenters expressed concerns that the community engagement requirements, or that the requirements for beneficiaries to cooperate with the redetermination process, would be burdensome on families or create barriers to coverage for non-exempt people who might have trouble accessing care. We believe that the community engagement requirements create appropriate incentives for beneficiaries to gain employment. Given that employment is positively correlated with health outcomes, it serves the purposes of the Medicaid statute to impose these requirements, both to improve beneficiaries' health and to encourage beneficiaries to gain independence and to transition to private coverage.

Additional comments characterized the provisions to lock beneficiaries out of coverage for failure to participate in the redetermination process as "punitive," and characterized the state's paperwork requirements as confusing and complicated. We disagree with these characterizations. We believe that it is appropriate to protect the integrity of the program by expecting beneficiaries to cooperate with the state in providing necessary documentation to determine their eligibility. Far from a "punitive" process, the demonstration calls for the state to

assist individuals over a 45-day period in completing redetermination, and an individual is disenrolled, for a limited three-month period, only if that individual has not cooperated with the state before the end of the expiration of the reconsideration period.

In response to the comments submitted to the state, the state added participation in accredited English as a Second Language courses to the list of qualifying activities; beneficiaries who meet the Supplemental Nutrition Assistance Program (SNAP) work requirements were added to the list of those who would be considered to have met the community engagement requirement. Responding to the comments to expand the list of exemptions for community engagement requirements, the state added beneficiaries who are homeless or receiving Temporary Assistance for Needy Families (TANF) to the exemption list. Some commenters requested that the state exclude former foster care youth under age 26 from the community engagement requirement; however, this population is not covered under the demonstration and therefore, not subject to the community engagement requirement. The state also assures that it will make good faith efforts to connect beneficiaries to existing community supports that are available to assist beneficiaries in meeting community engagement requirements, such as available non-Medicaid assistance with transportation and child care.

To help determine whether the demonstration is meeting its goals of improving quality, accessibility, and health outcomes, Indiana will submit, for CMS comment and approval, a draft evaluation design with implementation timeline, no later than 180 days after demonstration approval. CMS will work with Indiana to ensure that the comments received also inform the monitoring and evaluation design and the necessary oversight is in place to provide for program adjustments when necessary.

The CMS' approval of this demonstration is conditioned upon compliance with the enclosed list of waiver and expenditure authorities and STCs defining the nature, character and extent of anticipated federal involvement in the project. The award is subject to our receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter.

Your project officer for this demonstration is Ms. Shanna Janu. She is available to answer any questions concerning your section 1115 demonstration. Ms. Janu's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-03-17
7500 Security Boulevard
Baltimore, MD 21244-1850
E-mail: Shanna.Janu@cms.hhs.gov

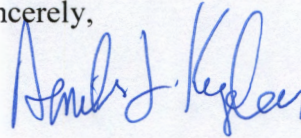
Official communications regarding program matters should be sent simultaneously to your project officer and Ms. Ruth Hughes, Associate Regional Administrator in our Chicago Regional Office. Ms. Hughes's contact information is as follows:

Ms. Ruth Hughes
Associate Regional Administrator
Centers for Medicare & Medicaid Services
Division of Medicaid and Children Health Operations
233 N. Michigan Avenue, Suite 600
Chicago, IL 60601-5519
Email: Ruth.Hughes@cms.hhs.gov

If you have questions regarding this approval, please contact Ms. Judith Cash, Acting Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.

Thank you for all your work with us, as well as stakeholders in Indiana, over the past months to reach approval.

Sincerely,



Demetrios Kouzoukas
Principal Deputy Administrator

Enclosures