Indiana Family and Social Services Administration

Renewal Request for the
Healthy Indiana Plan (HIP)
Section 1115 Waiver
(Project Number 11-W-00296/5)
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Section 1: Summary of HIP Renewal Request

The Healthy Indiana Plan (HIP) has been a feature of Indiana’s Medicaid program since 2008. The current approval to operate HIP expires December 31st, 2020. This document requests to renew the HIP program with no substantive changes. Based on the long-tenure and demonstrated success of HIP, the State requests renewal for a ten-year period through December 2030.¹

This 1115 waiver renewal requests authority to continue to operate HIP, as approved and operating in Indiana today, and to incorporate the HIP Workforce Bridge amendment into the renewed program.

Today, HIP provides coverage each year to approximately 570,000 non-disabled Hoosier adults age 19 to 64 who have income at or below 133 percent of the federal poverty level.² HIP enrollees have access to different benefits and cost-sharing based on factors such as income, health status, and eligibility as a low-income parent and caretaker, as described below:³

- Every HIP enrollee has a $2,500 **POWER Account** to fund the $2,500 deductible. Members and the State contribute to this account.
- **HIP Plus** offers a commercial coverage package including vision, dental and chiropractic services. To receive HIP Plus benefits, HIP members make contributions to their POWER Account. Member contributions to the POWER Account are refunded if a member leaves the program without spending the funds on health care services. HIP Plus is an option for coverage for all HIP enrollees. For members who have income over the poverty level, HIP Plus is the only benefit option. Members can lose coverage for HIP Plus if they fail to pay, and those with income over the poverty level are subject to a 6-month coverage exclusion for non-payment. HIP Plus also incorporates a surcharge for members who continue to use tobacco following a year of cessation opportunities.
- **HIP Basic** members have copayments instead of POWER Account contributions. HIP Basic offers a commercial coverage package that includes all of the essential health benefits but does not include vision, dental, or chiropractic services. Additionally, there are some service limits that are lower than those available under HIP Plus. Members with income at or below the poverty level who do not contribute to their POWER Accounts receive HIP Basic benefits.
- **HIP State Plan** benefits are available to members who are (1) pregnant, (2) medically frail, or (3) low-income parents and caretakers. Pregnant members have no cost sharing. Medically frail and low-income parents and caretakers receive the full Medicaid benefit

¹ The renewal incorporates the inclusion of the HIP Workforce Bridge Amendment as proposed to be effective in the final year of the demonstration.
² $17,422 per year for an individual, or $35,860 for a family of four in 2019, inclusive of the 5% of income disregard.
³ All HIP benefits are approved Alternative Benefit Plans (ABPs) in the Medicaid State Plan. HIP Basic copayments are within the federally allowable limits. All HIP cost-sharing is subject to a maximum 5% of income quarterly limit.
package but may choose to make contributions to the POWER Account or have HIP Basic copayments.4

- **Gateway to Work** started in 2015 as a voluntary referral of HIP members to employment services. In 2019, the program expanded with the goal of increasing community engagement and connecting members to gainful employment. The program is designed to improve physical and mental health, and overall enrollee financial stability and well-being.

- **HIP Workforce Bridge** will support individuals who transition off HIP coverage to enroll in and maintain commercial coverage. If approved as requested in the amendment, beginning in 2020, qualified individuals will access the HIP Workforce Bridge Account. This account leverages unspent POWER Account dollars to fund up to $1,000 of health care costs following disenrollment from HIP and helps ensure individuals disenrolling from HIP have sufficient time to enroll into other coverage.

This renewal requests to continue the existing HIP program with the incorporation of the HIP Workforce Bridge amendment, without substantial changes to policy. The primary modification requested is the extended renewal period of ten years. The State is committed to scientific and evidence-based approaches to program oversight, monitoring and evaluation, and to continued involvement and meaningful consultation with stakeholders on program policy and operations. The ongoing cycle of three-year renewals creates unnecessary administrative burdens for the State and federal government, and does not meaningfully enhance the oversight or transparency of the demonstration. The STCs allow for withdrawal of waiver authority at any time that it is determined that the approved waiver or portions of the waiver are not meeting the objectives of the Medicaid program. In addition, the State solicits public comment prior to submitting any proposed amendment for any need change, meaning that frequent renewal requirements do not provide an enhancement to federal authority over the demonstration.5

With this request to renew HIP, Indiana continues its commitment to providing innovations in the provision of public health care coverage. A ten-year renewal will give HIP members confidence that HIP will continue to be a resource for accessing quality health care, and will also allow state and federal staff to dedicate resources to continually improving HIP and ensuring the program meets its ongoing goals.

### Section 2: Historical Narrative

HIP first passed the Indiana General Assembly in 2007 with bipartisan support. Indiana pioneered the concept of medical savings accounts in the commercial market and became the first state to apply the consumer-driven model to a Medicaid population. Provided by private health insurance carriers, HIP offers its members a high-deductible health plan paired with the POWER Account, which operates similarly to a health savings account. Following CMS approval, HIP began enrolling working-age, uninsured adults in coverage on January 1, 2008.

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4 As discussed in the HIP program components section, a minority of medically frail individuals that have income over the poverty level may have copayments and required contributions.

5 Healthy Indian Plan Special Terms and Conditions, III -12.
In 2011, with the passage of the Patient Protection and Affordable Care Act (ACA), the Indiana General Assembly reinforced its support for the program by calling for HIP to be the coverage vehicle for Medicaid expansion in the State. The legislature passed Senate Enrolled Act 461 (codified at Indiana Code §12-15-44.2), to codify this requirement as well as to make several conforming changes to the HIP program related to the ACA.

In 2014, following several one-year extensions of the original HIP waiver, Governor Mike Pence opted to seek expansion of Indiana’s successful HIP program to cover individuals in the new adult group. Following a historic agreement with the Indiana hospitals that secured funding for the costs of expansion beyond the existing cigarette tax revenue, the State submitted a fiscally sustainable waiver to expand its existing HIP demonstration waiver. The HIP 2.0 waiver built on the early HIP experiences and outcomes to improve the program and strengthen the core values of personal responsibility and consumer driven healthcare. In January 2015, CMS approved the HIP 2.0 program through a three-year waiver expiring in January 2018. Following implementation of HIP 2.0 on February 1, 2015, the Indiana General Assembly codified HIP 2.0 at Indiana Code §12-15-44.5. Through the 2016 codification efforts, the state legislature once again reinforced its support of HIP by expressly prohibiting the continuation of Medicaid expansion in the State except through HIP, operated in a manner consistent with the statutory provisions.

Immediately upon receiving a three-year approval for HIP on January 27, 2015, the State began accepting applications for the program. Services began just days later, as the enhanced HIP program launched on February 1, 2015. In addition to processing new program applications, the launch of HIP 2.0 included the conversion of members previously enrolled in the original HIP program as well as all non-pregnant adults enrolled in Hoosier Healthwise—Indiana’s traditional Medicaid managed care program. Over 222,000 individuals were enrolled in HIP by the end of the first quarter of operations. Program enrollment stabilized with approximately 400,000 enrollees in the program on a month-to-month basis.

HIP 2.0 enhancements included the fast track prepayment option, which allows individuals to pre-pay their POWER Account contribution either by credit card on their application or an invoice received during application processing. The State also rolled out enhancements to presumptive eligibility for HIP, adding new providers that can make presumptive eligibility determinations, including county health departments, federally qualified health centers, rural health centers, and community mental health centers. In addition, at the direction of the Indiana General Assembly, the State implemented a program to provide presumptive eligibility to prison inmates who are being treated in inpatient settings while incarcerated. The State has leveraged this program to ensure that HIP applications are filed for inmates prior to release in order to improve continuity of care and continued access to prescriptions in order to reduce recidivism. A program called HIP Link, which helped individuals connect with and enroll in their employer insurance, was also established during the initial three-year approval period.

In January 2017, after two-years of program operations and 12-months prior to the expiration of the initial three-year approval, Indiana submitted the required request to renew the HIP program. This request was to renew the existing program, incorporate additional, eligible populations, and
implement new policies. Specifically, under the request, pregnant women were proposed to be included in HIP to prevent confusing coverage transitions during pregnancy. Additionally, a tobacco surcharge was proposed to support the State’s initiatives around decreasing tobacco use, and the State proposed to reestablish the non-eligibility period for failure to renew coverage. The renewal request also documented State policy initiatives around encouraging MCEs to develop member incentive and engagement programs, enhancing HIP Plus benefits with chiropractic services, and technical changes requested to the STCs. In addition, the renewal included the request to add a substance use disorder (SUD) component, to ensure access to comprehensive SUD services for all Indiana Medicaid enrollees.

Prior to the renewal request being approved, in July 2017, an amendment was submitted to the original renewal application. This amendment requested additional changes to the preceding renewal request. First, the State requested to change the HIP Plus contribution schedule from two percent of income each month, to one of five set amounts which are approximately two percent of household income. This change allowed for more consistent POWER Account contribution amounts for individuals with variable income. Second, the State requested to enhance the existing voluntary Gateway to Work initiative to include a requirement that individuals who do not have an exemption, already work at least 20 hours per week, are enrolled as a full-time student, or participate in Gateway to Work for eight out of 12 months of the calendar year. The amendment to the pending renewal request also included technical corrections and the request to phase out the HIP Link program due to low enrollment.

HIP was authorized for an additional, three-year approval period on February 1, 2018. The authorization included approval for ongoing program operations and provided authority to implement the requested program changes. The change to the tiered POWER Account contribution was implemented in January 2018, following written guidance from CMS. The remaining waiver changes were implemented over the course of 2018, with Gateway to Work and the tobacco surcharge first taking effect in January 2019. Gateway to Work operates on a calendar-year basis. The program has member community engagement hours that gradually increase over the first 18-months post-implementation; the requirement will be fully phased in at the 20-hour per week level in July 2020. Effective October 2019, the enrollment penalty for not complying with Gateway to Work was temporarily suspended pending results of a lawsuit filed in federal court.

In May 2019, the state posted for public comment the HIP Workforce Bridge Amendment. This amendment proposes to add in the final year of the demonstration program components to help individuals who are no longer eligible for HIP due to increasing income successfully transition to commercial market coverage. The HIP Workforce Bridge Amendment includes a $1,000 account, funded with remaining POWER Account dollars, that helps support the cost of commercial coverage following HIP disenrollment and modifications to Gateway to Work exemptions. Following public comment, this request was submitted to CMS in July 2019.

This renewal request is to continue the HIP program as established, with the incorporation of HIP Bridge Amendment.
2.1 Historical and Current and Program Objectives
Since the initial approval in 2008, HIP has included three different sets of program objectives. The program objectives from 2008 to 2018 were relatively consistent, and progress towards these objectives has been summarized in prior waiver submissions, monitoring, and evaluation reports (see Figure 1). The objectives stipulated by the approval for the current program include a focus around (1) determining the impact of changes to the HIP Plus contribution amounts from a two percent of income amount for each individual to one of five set amounts based on income; (2) the impact of implementing a community engagement initiative; and (3) the impact of implementing the tobacco surcharge. In addition, the evaluation plan for the current demonstration period includes alignment where possible with the CMS 1115 evaluation guidance and includes three additional objectives. First, to improve health care access, appropriate utilization, and health outcomes among HIP members; and second, to evaluate member experience with the program and ensure that HIP policies approximately align with commercial market policies and promote a positive member experience; and finally, to assess the costs of implementing and operating the HIP demonstration aligned the CMS guidance around evaluating program sustainability.  

Figure 1: Objectives of the HIP program, 2008 to 2020

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Approved HIP Evaluation goals for 2018 to 2020 include: (1) Improve health care access, appropriate utilization, and health outcomes among HIP members; (2) Increase community engagement leading to sustainable employment and improved health outcomes among HIP members; (3) Discourage tobacco use among HIP members through a premium surcharge and the utilization of tobacco cessation benefits; (4) Promote member understanding and increase compliance with payment requirements by changing the monthly POWER account payment requirement to a tiered structure; (5) Ensure HIP program policies align with commercial policies, encourage members understanding, and promote positive member experience; and (6) Assess the costs to implement and operate HIP and other non-cost outcomes of the demonstration.
2.1.1 Tiered POWER Account Contributions
Effective January 1, 2018, member POWER Account contribution amounts changed from a two percent of income amount to one of five tiered amounts. The current tiered amounts are seen in Table 1.

Table 1: POWER Account Tiers Effective 1-1-2018

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;22%</td>
<td>$1.00</td>
<td>$1.00</td>
</tr>
<tr>
<td>23-50%</td>
<td>$5.00</td>
<td>$2.50</td>
</tr>
<tr>
<td>51-75%</td>
<td>$10.00</td>
<td>$5.00</td>
</tr>
<tr>
<td>75%-100%</td>
<td>$15</td>
<td>$7.50</td>
</tr>
<tr>
<td>101-133%*</td>
<td>$20.00</td>
<td>$10.00</td>
</tr>
</tbody>
</table>

*With 5% of income disregard

This change is expected to have reduced the number of times a member’s payment amount might change during the year and increase compliance with payments. Preliminary data for 2018 shows that this may be the case. In December 2017, 66 percent of individuals made contributions for HIP Plus coverage, and by December 2018, this had increased to 75 percent. This increase may be due to the change in the contribution policy; however, other factors such as members taking advantage of rollover incentives could also be a factor. Analysis of this objective is a focus of the independent interim evaluation report, included with this renewal request.

2.1.2 Community Engagement
The 2018 HIP renewal provided authority to enhance the existing Gateway to Work program, which provided referrals to employment and job training opportunities. The changes require up to 80 hours of work or community engagement activities per month for non-exempt individuals. The Gateway to Work program rolled out in January 2019 and will be fully phased in July 2020 in alignment with the schedule seen in Table 2.

Table 2: Gateway to Work Phase In Schedule

<table>
<thead>
<tr>
<th>Date Range</th>
<th>Required Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 1, 2019 – June 30, 2019</td>
<td>0 hours per month (0 hours per week)</td>
</tr>
<tr>
<td>July 1, 2019 – September 30, 2019</td>
<td>20 hours per month (5 hours per week)</td>
</tr>
<tr>
<td>October 1, 2019 – December 31, 2019</td>
<td>40 hours per month (10 hours per week)</td>
</tr>
<tr>
<td>January 1, 2020 – June 30, 2020</td>
<td>60 hours per month (15 hours per week)</td>
</tr>
<tr>
<td>July 1, 2020 – Ongoing</td>
<td>80 hours per month (20 hours per week)</td>
</tr>
</tbody>
</table>

The program is implemented on a calendar-year basis, with the requirement applying to individuals for eight out of 12 months of the calendar year. Processes to act on non-compliant individuals will occur for the first time in December 2019. Due to the recent

program implementation, preliminary data is available on Gateway to Work as reported in the independent interim evaluation posted and submitted concurrently with this request.

2.1.3 Tobacco Surcharge
The tobacco surcharge was authorized in 2018 and was implemented through a phased-in approach. Starting in 2019, individuals that had reported smoking and continued to smoke after 12 months were subject to an increased HIP Plus contribution amount.

The independent interim evaluation provides an overview of use of tobacco and use of cessation services in HIP and a preliminary look at the individuals assessed a tobacco surcharge in 2019.

2.2 Independent Interim Program Evaluation
In addition to the three goals above, the interim program evaluation analyzes member service utilization, access to services, and health outcomes in addition to preliminary analysis on member’s experiences and satisfaction with HIP. The interim evaluation also incorporates CMS evaluation guidance around assessing enrollment impacts and costs of operating the demonstration. This evaluation report is available concurrent with this renewal request. The final evaluation for the current three-year renewal period (through December 2020) will be submitted in July 2022 as required in the current program STCs.
2.3 Renewal Program Goals
Under this renewal request, HIP will continue to operate under goals that are in alignment with the prior goals of the demonstration. These goals are targeted to the following realms: Health Care, Economic and Social, Public Health, and improved Policy and Process.

<table>
<thead>
<tr>
<th>Realm</th>
<th>Factor</th>
<th>Policy</th>
<th>Program Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care</td>
<td>Access</td>
<td>HIP members are able to see a doctor in a timely manner without traveling too far to seek care.</td>
<td>Provide timely and geographically appropriate access to healthcare services.</td>
</tr>
<tr>
<td></td>
<td>Utilization</td>
<td>HIP members get the care they need from the most appropriate setting. Access and appropriate utilization support positive health outcomes. HIP members are able to control chronic conditions, receive needed care, and have an overall increase in health and wellbeing.</td>
<td>Promote appropriate utilization of healthcare by maintaining low inappropriate use of the emergency department and supporting utilization of needed services from qualified non-emergency providers.</td>
</tr>
<tr>
<td></td>
<td>Outcomes</td>
<td></td>
<td>Promote control of chronic conditions, delivery of needed care, and increase in member health and wellbeing.</td>
</tr>
<tr>
<td>Economic and Social</td>
<td>Work and community engagement</td>
<td>Through increased educational attainment, connection with community resources, and promotion of sustainable employment community engagement will increase income and self-sufficiency of HIP members.</td>
<td>Increase community engagement leading to increased educational attainment, sustainable employment and member self-sufficiency.</td>
</tr>
<tr>
<td><strong>Insurance rates; Coverage gaps</strong></td>
<td><strong>HIP members may have gaps in coverage when they leave HIP for having income over the HIP limit. HIP promotes increased uptake of commercial insurance when HIP coverage is lost and support individuals in their ability to maintain HIP coverage while they remain eligible.</strong></td>
<td><strong>Reduce the number of uninsured Hoosiers, decrease gaps in coverage, and promote uptake of commercial insurance when leaving HIP.</strong></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td><strong>Public Health</strong></td>
<td>Tobacco use</td>
<td>HIP should encourage access of tobacco cessation services and decrease member tobacco use.</td>
<td>Meaningfully increase use of tobacco cessation services and meaningfully decrease tobacco use status for HIP members.</td>
</tr>
<tr>
<td></td>
<td>Prevention and wellness</td>
<td>HIP members should use preventive services and adopt healthy behaviors.</td>
<td>Encourage healthy behaviors and appropriate care, including early intervention, prevention, and wellness</td>
</tr>
<tr>
<td><strong>Policy and Process</strong></td>
<td>HIP Policy</td>
<td>HIP policies ensure continuous coverage and promote health care access, utilization, and improved health outcomes.</td>
<td>HIP policies support the goals of HIP by promoting continuous coverage and improved health outcomes.</td>
</tr>
<tr>
<td></td>
<td>Social determinants of health</td>
<td>Barriers prevent HIP members from achieving health and financial stability. To support ongoing innovation in HIP, member barriers and needs will be identified.</td>
<td>Generate actionable information on social determinants of health needs.</td>
</tr>
</tbody>
</table>
Section 3: HIP Eligibility, Benefits, and Cost Sharing

HIP coverage is targeted to non-disabled adults between 19 and 64 years of age and encompasses the following eligibility groups: (1) the adult group, (2) low-income parents and caretakers, (3) transitional medical assistance, (4) pregnant women with income that would otherwise make them eligible for HIP, and (5) for limited benefit HIP Bridge coverage starting in 2020, specified former HIP enrollees that lost coverage due to increases in income over the HIP income limit.

Table 4: HIP Eligibility

<table>
<thead>
<tr>
<th>#</th>
<th>Eligibility Group</th>
<th>Social Security Act and CFR Citations</th>
<th>Income Level</th>
<th>Waiver Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Adult group</td>
<td>1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119 including individuals who meet the definition of medically frail consistent with 42 CFR Section 440.315(f).</td>
<td>133 percent of the FPL including a 5 percent of income disregard</td>
<td>Non-medically frail individuals over 100% FPL are eligible for HIP Plus enrollment only</td>
</tr>
<tr>
<td>2</td>
<td>Parents &amp; caretaker relatives</td>
<td>42 CFR 435.110</td>
<td>Parents and caretakers with income under the State’s AFDC payment standard in effect as of July 16, 1996 (section 1931 parents and caretaker relatives), converted to a MAGI-equivalent amount by household</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Adult Transitional Medical Assistance beneficiaries</td>
<td>1902(a)(52) and 1925 of the Act including individuals who are medically frail</td>
<td>No income limit for first 6 months of eligibility. 185% FPL for the second 6 months of eligibility</td>
<td>Individuals with household income over the adult group income level are designated as TMA</td>
</tr>
<tr>
<td>4</td>
<td>Pregnant women, age 19 and older</td>
<td>42 CFR 435.116</td>
<td>133 percent of FPL</td>
<td>Waiver of retroactive coverage does not apply.</td>
</tr>
</tbody>
</table>
Enrolled HIP members qualify for one of three cost-sharing models based on eligibility factors and whether they buy into the HIP Plus package. These cost sharing packages are as follows:

1. HIP Plus cost-sharing which allows individuals to make a monthly contribution to their POWER Account. For those who make a monthly contribution, there are no copayments, with the exception of non-emergency use of the emergency room. A waiver to offer the contribution option for HIP-enrolled individuals is provided; the copayment for non-emergency use of the emergency room is within Medicaid allowable limits. Monthly contributions are a set amount for specified income levels, and with the exception of some individuals with a tobacco surcharge, the amounts are below two percent of enrollee income, with a minimum amount of $1 per month.

2. HIP Basic cost sharing which assesses copayments on most services within the Medicaid allowable limits. The copayment model only applies to eligible individuals who do not contribute to their POWER Account.

3. For pregnant HIP members, all cost sharing is suspended.

In addition to the three cost-sharing models in HIP, there are four separate benefit options. HIP Plus, HIP Basic, the HIP State Plan benefits, and the limited HIP Workforce Bridge benefit that will begin in 2020 based on authorization of the HIP Workforce Bridge amendment. All individuals who are medically frail or low-income parents and caretakers receive the Medicaid State Plan benefits. HIP Plus and HIP Basic benefits are available to newly eligible adults, and individuals eligible for Transitional Medical Assistance. HIP Plus and HIP Basic are based on commercial market benefit packages and are approved Alternative Benefit Plans in the Medicaid state plan and both offer all of the essential health benefits. Aligned with commercial market benefits, neither HIP Plus nor HIP Basic offer coverage for non-emergency medical transportation. HIP Plus has additional enhanced services such as vision, dental, and chiropractic services. Individuals receive HIP Plus and HIP Basic benefits based on income and payment of monthly POWER Account contributions.

Table 5: HIP Benefit and Cost Sharing Options

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Cost Sharing</th>
<th>HIP Eligible Member Characteristics</th>
<th>Members Enrolled Jul 2019&lt;sup&gt;8&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Indiana State Plan Benefits</td>
<td>No cost sharing</td>
<td>Pregnant</td>
<td>18,283</td>
</tr>
<tr>
<td></td>
<td>Monthly Contributions</td>
<td>Low-income parents and caretakers, the medically frail, and individuals</td>
<td>123,578</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th></th>
<th>eligible for Transitional Medical Assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility Criteria</td>
<td></td>
</tr>
<tr>
<td>Copayments</td>
<td>Low-income parents and caretakers and the medically frail at or below the poverty level who do not make monthly contributions</td>
</tr>
<tr>
<td>Contributions and Copayments</td>
<td>The medically frail with income over the poverty level who are 60 days past-due on their monthly contribution</td>
</tr>
<tr>
<td><strong>HIP Plus-ABP</strong></td>
<td></td>
</tr>
<tr>
<td>Monthly Contributions</td>
<td>Able-bodied adults</td>
</tr>
<tr>
<td>Copayment for non-emergency ED use</td>
<td></td>
</tr>
<tr>
<td><strong>HIP Basic-ABP</strong></td>
<td></td>
</tr>
<tr>
<td>Copayments</td>
<td>Able-bodied adults with income at or below the poverty level</td>
</tr>
<tr>
<td><strong>HIP Bridge-Limited $1,000 Benefit</strong></td>
<td>Contribution deducted from premium reimbursement</td>
</tr>
</tbody>
</table>

| Total fully eligible HIP members | 386,240 |

Every enrolled HIP member has a $2,500 POWER Account which is used to cover the $2,500 deductible that applies to all HIP enrollees. For all plans, maternity services and preventive services, such as annual examinations, smoking cessation programs, and mammograms, are covered without charge to the members and are not included in the deductible amount of $2,500. After the plan deductible is met and covered by the $2,500 POWER Account, all benefits in the applicable benefit package continue to be covered for HIP members.

**Section 4: HIP Components and Operations**

HIP is composed of distinct program elements that integrate to achieve the program goals. Many of these elements were established in the initial HIP implementation in 2008 or incorporated when HIP expanded coverage in 2015 to all non-disabled adults with income below 133 percent of the poverty level. The HIP program continues to innovate and since 2018 has designed, developed and implemented changes such as a calendar year period for MCE enrollment, deductibles, and POWER Accounts, a tobacco surcharge, and the Gateway to Work community engagement initiative. The HIP Workforce Bridge initiative incorporated in the waiver amendment request is the most recent example of the evolution in ongoing program innovation.
4.1 POWER Accounts
HIP leverages innovations from the commercial market. Unlike traditional Medicaid, HIP coverage is based on a high-deductible model. HIP enrollees by definition are low-income, and this high-deductible plan pairs with a unique health savings-like account, the POWER Account, to fund the cost of the deductible. The POWER Account has been the central component of the HIP design since program initiation in 2008. In 2019, the POWER Account operates in alignment with original design, and provides a health-savings ‘like’ account that funds member deductibles. The POWER Account provides funding for the first $2,500 in health care services and holds both state and member contributions. The State contributes all dollars that are beyond the member contribution amount, up to the full $2,500, to the account.

The POWER Account promotes transparency around the costs of care and provides members incentives to engage with the health care system to help to control health care costs. As an incentive to receive preventive care, the cost of preventive services is fully covered outside of the POWER Account. Members receive monthly account statements showing account debits and credits, and members who do not use their entire account during the year may earn rollover incentives that reduce the costs of future enrollment. Receipt of preventive services can increase the member’s rollover incentive.

Over 10 years of member experience with POWER Accounts has been documented by quarterly and annual reporting, independent evaluations, and required additional POWER Account reports.

The first HIP member survey, conducted in 2010, found that 95 percent of members were satisfied with the program, 97 percent of members knew their monthly contribution amount; over half (63 percent) of members knew their POWER Account balance; and nearly half (44 percent) of members checked their POWER Account balances at least once a month.⁹

The most recent HIP member survey, conducted in 2016, found that 86 percent of contributing members were satisfied with the program, with 95 percent reporting that they would re-enroll in HIP if they left and became eligible again, and 42 percent reporting that they are checking their POWER Account balances at least once a month.¹⁰ FSSA internal monitoring has found that high member satisfaction with HIP continues through the current demonstration year.

The most recent POWER Account data indicate that 65 percent of members used less than half of their POWER Account balances while 44 percent of members qualified for rollover. Of the members who qualified for the State discount percent (HIP Basic members eligible for HIP Plus), the vast majority (79 percent) qualified for the maximum rollover rate of 50 percent.¹¹

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⁹ 2010 Mathematica Survey of HIP members
¹⁰ 2016 Lewin Survey of HIP members
¹¹ 2018 FSSA Member Data
There is no specific waiver granted to operate the POWER Account under the HIP approval, and reporting on accounts is incorporated into the required CMS-64 reporting in alignment with the current HIP approval. This HIP renewal does not request any changes to the POWER Account, and solely seeks authorization to continue POWER Account operations for the requested renewal period through 2030.

4.2 Member Contributions

Members make monthly payment deposits to the POWER Account. When service costs are deducted from the POWER Account, the payment is deducted proportionally from the state and member funds in the account. In this way, for all services that are applied to the deductible, HIP member contributions are paying a portion of the cost. Members who do not spend their full account on health care during the year get to keep contributions as a rollover towards the next year of enrollment. For members who leave the program, their remaining contributions can be refunded. This design, where all services applied to the deductible are paid with member and state contributions, and where members can count on their contributions rolling over or being returned to them, gives members “skin in the game.” Members engage as consumers with financial incentives to avoid unnecessary care and make value-based healthcare choices.

In the initial HIP program, the contribution was up to 4.5 percent of member annual income. The 2015 approval set contributions at two percent of income with a minimum contribution of one dollar. Starting in 2018, member contributions changed from a certain percent of income to one of five set amounts. The change to the set amount reduces the changes in contribution amounts that a member might experience during the benefit year if they have slight changes in income. Contribution amounts established for the current program are below.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;22%</td>
<td>&lt;$229</td>
<td>&lt;$472</td>
<td>$1.00</td>
<td>$1.00</td>
</tr>
<tr>
<td>23-50%</td>
<td>$229-$520</td>
<td>$472-$1,073</td>
<td>$5.00</td>
<td>$2.50</td>
</tr>
<tr>
<td>50-75%</td>
<td>$521-$780</td>
<td>$1,074-$1,609</td>
<td>$10.00</td>
<td>$5.00</td>
</tr>
<tr>
<td>75%-100%</td>
<td>$781-$1,041</td>
<td>$1,610-$2,146</td>
<td>$15.00</td>
<td>$7.50</td>
</tr>
<tr>
<td>100-133%*</td>
<td>$1,042-$1,453</td>
<td>$2,147-$2,996</td>
<td>$20.00</td>
<td>$10.00</td>
</tr>
</tbody>
</table>

*With 5% of income disregard

Since 2008, initial enrollment in the program has been contingent on making a payment. In the 2015 approval, this requirement continued with HIP Plus enrollment requiring an individual to make an initial contribution, and then an ongoing monthly contribution to maintain enrollment. Individuals have 60 days to make their initial and ongoing monthly payments.
Following application, the start date for coverage is the first of the month in which a member makes their initial contribution to their POWER Account.

Members may make an initial contribution, or fast track pre-payment, towards HIP Plus when they file their application or during application processing. If the member completes the eligibility process and is found eligible, the fast track payment is put towards the required contribution amount. When applicants are found ineligible, the fast track contribution is refunded.

In HIP, the majority of enrollees, across all income levels, have made their required contributions; since the first quarter following the expansion of HIP in 2015, 65 to 75 percent of members have enrolled in HIP Plus in any given month, meaning these members are making regular contributions. The first HIP member survey, conducted in 2010, found 75% of members indicating that POWER Account contributions were affordable; this was when contributions were up to 4.5 percent of income. In the most recent HIP member survey, conducted in 2016, 80% of members indicated that they would pay more to stay in the program.

In this renewal, no substantial changes are requested to the member contribution component of the HIP program. To allow the State flexibility to adjust contributions, Indiana requests that a ceiling based on three percent of household income be established for POWER Account contribution amounts, and that any variation from the current amounts but below this threshold require member and CMS notice, but no formal waiver amendment. This flexibility would allow for adjustments to the contribution tier amounts without requiring an amendment submission and approval process with CMS.

4.2.1 Tobacco Surcharge
The 2018 approval incorporated a tobacco surcharge component where members who report tobacco use and continue to use after a full year of enrollment are assessed a surcharge. The tobacco surcharge increases the member POWER account contribution amount by 50 percent.

In this renewal, no changes are requested to the tobacco surcharge.

4.3 HIP Plus and HIP Basic
Members who make an initial POWER Account contribution enroll into HIP Plus with coverage effective the first day of the month in which their contribution is made. Other than the monthly contribution, the members in HIP Plus have no additional cost sharing responsibility except for a copayment for non-emergency use of the emergency room. The copayment for non-emergency use of the emergency room is within the Medicaid allowable limits and is currently set at $8.00. Members who pay their contribution receive the full Medicaid benefit package if they qualify as a Section 1931 low-income parent and caretaker,

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12 2010 Mathematica Survey of HIP members
13 2016 Lewin Survey of HIP members
or if they are medically frail. They receive the HIP Plus alternative benefit plan, which includes all the essential health benefits and adds vision, dental and chiropractic coverage.

In the initial HIP program established in 2008, individuals that did not make their required contribution were not enrolled. Beginning in 2015, the HIP Basic plan was implemented for individuals with income below the poverty level who do not make their required contribution. Like HIP Plus, HIP Basic is both a benefit package and a cost-sharing schedule. The HIP Basic benefit package is an approved, alternative benefit plan that includes all of the essential health benefits but does not have coverage for vision, dental, or chiropractic services. HIP Basic benefits are available to adults with income under the poverty level who do not complete enrollment into HIP Plus and are not otherwise qualified for the Medicaid State Plan benefits. The HIP Basic cost-sharing schedule includes copays within the Medicaid allowable limits for most services as outlined in Table ##. All HIP-enrolled individuals who do not complete enrollment into HIP Plus and who are not otherwise exempt from cost sharing pay the HIP Basic copayment amounts when accessing care.

**Table 7: HIP Plus and HIP Basic Contribution and Copayment Amounts**

<table>
<thead>
<tr>
<th>Category</th>
<th>HIP Plus</th>
<th>HIP Basic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Contribution</td>
<td>$1-$20</td>
<td>$0</td>
</tr>
<tr>
<td>Copayment- Outpatient services -</td>
<td></td>
<td></td>
</tr>
<tr>
<td>including office visits</td>
<td>$0</td>
<td>$4</td>
</tr>
<tr>
<td>Copayment- Inpatient services -</td>
<td></td>
<td></td>
</tr>
<tr>
<td>including hospital stays</td>
<td>$0</td>
<td>$75</td>
</tr>
<tr>
<td>Copayment- Preferred drugs</td>
<td>$0</td>
<td>$4</td>
</tr>
<tr>
<td>Copayment- Non-preferred drugs</td>
<td>$0</td>
<td>$8</td>
</tr>
<tr>
<td>Copayment- Non-emergency ER visit</td>
<td>$8</td>
<td>$8</td>
</tr>
</tbody>
</table>

Members enroll into HIP Basic when they do not pay for HIP Plus within 60 days and the member income is under the poverty level. At initial application, members’ enrollment into HIP Basic is effective the first of the month in which their 60 days to pay for HIP Plus expire. For members enrolled in HIP Plus who stop making monthly payments for 60 days, HIP Basic enrollment starts the month following the end of the 60-day payment period following notification to the member of the change from HIP Plus to HIP Basic.

Regardless of income level, all members enrolled in other Medicaid categories who transfer to HIP, including those moving from presumptive eligibility, enroll directly into HIP Basic. This ensures that members who currently have Medicaid coverage do not experience coverage gaps while waiting to enroll in HIP Plus. For these initial enrollments in HIP Basic, members have a 60-day payment period while in HIP Basic to make a payment and move to HIP Plus. For members who make a payment, HIP Plus coverage begins the first of the month in which the payment is made.

Members who have income over the poverty level are not eligible for ongoing HIP Basic coverage. A member with income over the poverty level may be enrolled in HIP Basic when (1) the member transitions from another Medicaid category as noted in table 8 below, or (2)
the member had income at or below the poverty level and enrolled in HIP Basic, and income then increased over the poverty level. Members with income over the poverty level enrolled in HIP Basic have a 60-day period to transition to HIP Plus. Following this 60-day period, these members are disenrolled from HIP since HIP Basic is not available as an ongoing coverage option for individuals with income over the poverty level.

On an annual basis, all ongoing HIP Basic enrollees receive an opportunity to move to HIP Plus by making their required contribution. This occurs following the individual’s annual renewal of HIP coverage. HIP Basic members that receive preventive services and have a balance remaining in their POWER Account receive an additional opportunity to transfer to HIP Plus by a rollover incentive which provides a discount off the member’s required HIP Plus contribution. Members enrolled in HIP Plus always have any of their remaining member contributions rollover, and these contributions are matched by the state when the member received preventive care. Since 2015, approximately 40 to 45 percent of HIP members who complete a full benefit period have qualified for a rollover incentive to reduce the ongoing cost of HIP Plus coverage, and in 2018 the average amount rolled over was approximately $50.

In this renewal, no substantial changes are requested to HIP Basic or HIP Plus or the rollover incentive. In the waiver approval, Indiana requests flexibility to vary HIP Basic copayment amounts within the Medicaid limits with proper notification to CMS, members and stakeholders, but without requiring a waiver amendment.

4.4 Non-Payment
Not paying monthly contributions within 60 days results either in enrollment in HIP Basic, disenrollment from HIP Plus, or failure to complete enrollment into HIP Plus. Members who complete enrollment into HIP Plus and have income over the poverty level are subject to a six-month, non-eligibility/lockout period where they may not reenroll into HIP unless the member experiences a qualifying event.

<table>
<thead>
<tr>
<th>Member Characteristics</th>
<th>Action after 60-days with no payment</th>
<th>Subject to Non-eligibility period?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approved applicant below the poverty level</td>
<td>Enrolled in HIP Basic.</td>
<td>No</td>
</tr>
<tr>
<td>Approved applicant above the poverty level</td>
<td>Not enrolled in HIP. No lockout applied, may reapply.</td>
<td>No</td>
</tr>
<tr>
<td>HIP Basic member with income above the poverty level</td>
<td>Disenrolled from HIP. No lockout applied, may reapply.</td>
<td>No</td>
</tr>
<tr>
<td>HIP Plus member with income below the poverty level</td>
<td>Enrolled in HIP Basic.</td>
<td>No</td>
</tr>
</tbody>
</table>
HIP members disenrolled from HIP Plus for non-payment and subject to the six-month coverage lockout may not reenroll in HIP until the six-month period expires, or the member has a qualifying event. Qualifying events include:

- Obtained and subsequently lost private insurance coverage
- Had a loss of income after disqualification due to increased income
- Took up residence in another state and later returned
- Is a victim of domestic violence
- 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 60 calendar days prior to date of member termination for non-payment
- Is medically frail

HIP has incorporated a lockout period for non-payment since initial implementation in 2008. The initial lockout period was for 12 months. This period was decreased to six months in 2015. The HIP lockout period is aligned with commercial market coverage policies, where individuals who fail to maintain coverage during the year must wait to re-enroll unless they have a special enrollment event or until the annual open enrollment opportunity.

In 2018, 5,130 members were subject to a HIP lockout for non-payment. Since the initiation of the program, the rates for applying the non-payment as a proportion of individuals that could be subject to the lockout have remained relatively low and stable on an annual basis ranging from a low of three percent to a high of 8.5 percent.

In this renewal request, no changes are requested the non-payment policy.

### 4.5 Retroactive Coverage
Since initiation in 2008, HIP has included a waiver of retroactive coverage. As discussed in the proceeding sections, following application, HIP benefits do not become effective until the first of the month in which payment is made, or the 60-day payment period expires. This requirement to make a payment to initiate coverage, or to wait for 60-days for coverage to start is aligned with commercial market enrollment policies. In HIP, pregnant women that are under the HIP income level are eligible for coverage that is retroactive up to three months from the date of application. All other populations covered by HIP are not eligible for coverage prior to the month of application, and have a coverage start date in accordance with the payment date or the expiration of the 60-day payment period.
In this renewal request, no changes are requested to the retroactive coverage policy.

4.6 Gateway to Work
Gateway to Work began in 2015 to promote the connection between employment and health by integrating the State’s various work-training and job-search programs with HIP. Through this initiative, all eligible HIP members who were unemployed or working less than 20 hours per week were referred to available employment, job search and training programs to assist in securing gainful employment. This voluntary referral program had few members take advantage of the job search and training opportunity; only 580 Gateway to Work orientations were attended during the first 15 months of the voluntary program.

One of the goals of the HIP demonstration as approved in 2015 was to provide HIP members with opportunities to seek job training and stable employment to reduce dependence on public assistance. To meet this goal, the Gateway to Work program was modified from a voluntary to a mandatory initiative in the 2018 approval.

Beginning in 2019, members that are not exempt and not currently working at least 20 hours per week must complete qualified activities for eight out of 12 months of the calendar year to maintain their benefits. The required hours phase in from zero to 20 hours over the course of 18-months, following the below schedule.

*Table 9: Gateway to Work Phase In Schedule*

<table>
<thead>
<tr>
<th>Date Range</th>
<th>Required Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 1, 2019 – June 30, 2019</td>
<td>0 hours per month (0 hours per week)</td>
</tr>
<tr>
<td>July 1, 2019 – September 30, 2019</td>
<td>20 hours per month (5 hours per week)</td>
</tr>
<tr>
<td>October 1, 2019 – December 31, 2019</td>
<td>40 hours per month (10 hours per week)</td>
</tr>
<tr>
<td>January 1, 2020 – June 30, 2020</td>
<td>60 hours per month (15 hours per week)</td>
</tr>
<tr>
<td>July 1, 2020 – Ongoing</td>
<td>80 hours per month (20 hours per week)</td>
</tr>
</tbody>
</table>

Compliance with the Gateway to Work requirement is designed to be checked at the end of the calendar year. To be compliant, members must have eight out of 12 months of the year where they are exempt from the requirement or have completed qualifying activities. Months in which members are not enrolled in HIP count compliant months. Effective October 2019, eligibility suspension for failure to complete the requirement was temporarily removed pending the resolution of a lawsuit challenging the approval of the Gateway to Work program.
4.6.1 Exemptions
All HIP members may participate in Gateway to Work, but members that have an exemption do not have any requirement to participate. Members meeting the following criteria are considered exempt from the Gateway to Work requirement:

- Pregnant
- Primary Caregiver of Children under 13
- Medically Frail
- Full- or Part-Time Student
- Homeless
- Recently Incarcerated or Institutionalized
- Temporary Certified Illness or Incapacity
- Participating in Substance Use Disorder (SUD) treatment
- Kinship Caregivers of Abused or Neglected Children
- Primary Caregiver of Disabled Dependent
- SNAP and TANF Recipients
- Age 60 or older
- Exemptions for Good Cause
- Member of Federally Recognized Tribe

Member exemptions are applied prospectively where the exemption is already known to the State; for example, SNAP and TANF recipients. For exemptions that are not applied prospectively, members may report any exemptions for past, current and future months. Member requested exemptions are reported to MCEs and documented in the Gateway to Work tracking system.

4.6.2 Qualified Activities
Members that have a requirement for Gateway to Work may meet the requirement by completing any of the following qualified activities:

- Employment and self-employment
- Homeschooling
- Job search activities
- Education related to employment
- College education
- English as a second language
- General education
- High school equivalency
- Job skills training and vocational education
- Caregiving services
- Community and public service
- Volunteer work

14 In the HIP Workforce Bridge Amendment submitted in July 2019, the dependent age for caretakers was increased from under 7 to under 13 and the exemption for federally recognized tribes was added.
• Other miscellaneous non-prohibited activities

Activities that do not count for Gateway to Work include:
• Illegal activities
• Medical treatment, such as doctor’s appointments, medical tests or treatment
• Taking care of own pets
• Behavioral health counseling or case management, such as therapy appointments or time billed by an entity providing case management services
• Support groups (anger management, behavior awareness, PTSD, cancer support group)
• Activities directly related to the health improvement of the member rather than their community engagement
  o Examples: swimming classes, participating in a 5k, exercise classes and smoking cessation classes

Members that have verified employment of at least 20 hours per week, for the purposes of HIP eligibility, are considered to meet the Gateway to Work requirement; these enrollees are not required to report community engagement hours. For members required to report activities, multiple modes of reporting are available, including online or by phone via the MCEs. All online tools and resources are designed to be mobile device compatible. Members may report activities for the current month or any past month during the calendar year. Member activity reports are accepted based on member self-attestation. Both MCEs and OMPP review a sample of the reported activities to verify that the member attestation is reasonable and compatible with known information about the member using a reasonable compatibility methodology.

4.6.3 Member Supports
Gateway to Work is designed to ensure member success. All members receive notification of their requirements for completing Gateway to Work. Specifically, on a monthly basis, along with the POWER Account statement, members receive an update of their status towards meeting their requirements. Gateway to Work status is also documented in FSSA’s online benefits portal. Additionally, multiple options are available for members that need help understanding the requirement, identifying if they are exempt, or finding activities.

For example, members may complete an initial online assessment. This assessment will inform members if they may be exempt or are already completing activities that meet the requirement. Referrals to Gateway to Work partner resources are also provided through this process. Members who cannot complete the assessment online may call their MCE and complete the same assessment telephonically with an MCE representative.

Additionally, members who need support beyond referrals and general information have the option of completing a more in-depth assessment with their MCE. This process builds off the information provided in the initial assessment to help support identification of a more concrete plan to meet the Gateway to Work requirements. Further, members that need additional help beyond completing assessments, may receive ongoing Gateway to Work
assistance through their MCE. This ongoing assistance will support members in development and monitoring of a plan to achieve Gateway to Work compliance.

In addition to MCE supports, organizations across the state have stepped up as Gateway to Work partners. Gateway to Work partners may provide many levels of support including: computer terminals where members can log their information, access state-funded job training and adult education classes, comprehensive education and support in meeting the requirements, or volunteer opportunities where members can complete activities.

4.6.4 Eligibility Suspensions
Effective October 2019, eligibility suspensions for Gateway to Work are not active pending resolution of a federal lawsuit. As designed, members that have a requirement to report but are non-compliant will have their benefits suspended if they do not meet the Gateway to Work requirement eight out of 12 months of the calendar year. Members that are not on track to meet the annual requirement by October of the calendar year will have the opportunity to go back and report earned hours for previous months and/or complete pre-suspension courses that will help count towards member compliance with the requirement. Members are evaluated for suspension in December and all existing information, including member reported hours and exemptions during the calendar year, will be considered. Members that are not exempt and do not meet the requirement to complete Gateway to Work activities for eight out of 12-months of the calendar year, inclusive of participation in pre-suspension courses, will be suspended from HIP benefits effective January 1\textsuperscript{st} of the subsequent calendar year. All suspended members can have their benefits restored quickly without having to reapply. After January 1\textsuperscript{st}, all suspended members will work directly with the Gateway to Work Unit to resolve their suspension. Suspension resolution can occur by the member reporting hours and meeting the current month’s hours requirements, gaining an exemption, gaining full or part-time work, or enrolling in full or part-time post-secondary training.

4.6.5 Current Gateway to Work Operations
The Gateway to Work requirement began in January 2019. Members were not required to report activities until July 2019. In July 2019, out of approximately 380,000 fully enrolled HIP members 73 percent of members were exempt, 8 percent who are not exempt meet the requirement with current reporting of employment, and the remaining 19 percent were required to report either hours or an exemption.\textsuperscript{15} Since initial implementation, members have been reporting exemptions and hours by calling their MCEs and by accessing the online reporting tool. More detailed description of the first six months of Gateway to Work is included in the Interim Program Evaluation available concurrent with this renewal request.

Effective October 2019, the enrollment suspension for not meeting the requirement was temporarily removed pending the resolution of a lawsuit. In this renewal no changes are requested to the existing Gateway to Work approval.

\textsuperscript{15} FSSA Data provided August 15\textsuperscript{th}, 2019 via e-mail. Gateway to Work allows for retroactive reporting of exemptions, so exemption percentage for July 2019 may increase throughout the year.
4.7 HIP Workforce Bridge Account
The State requests the HIP Workforce Bridge Account be authorized as a component of the renewal, consistent with the waiver amendment submitted in July 2019.\textsuperscript{16}

The HIP Workforce Bridge Account will provide $1,000 to pay for health care expenses that occur during a transition to commercial coverage. This will include payment for premiums, deductible costs, copayments, and co-insurance incurred through enrollment on the commercial plan. HIP members who lose eligibility for HIP due to increased income will be qualified for the Account. This Account will help to bridge the gap between the costs of HIP and costs of commercial insurance.

The HIP Workforce Bridge Account is targeted for implementation in Spring of 2020, the final year of the current HIP demonstration. It is estimated that approximately 27,000 HIP members will qualify for the account on an annual basis.

4.8 Managed Care Entity Selection Periods
In HIP a member’s MCE is the main point of contact for coverage. Beyond coordinating access and payment for health care services, HIP MCEs monitor the member deductible and POWER Account, provide member incentives, and, starting in 2019, support members with Gateway to Work. Similar to selection of coverage during commercial market enrollment periods, HIP members have an opportunity to select their plan prior to making their initial POWER Account contribution payment. Following enrollment into an MCE, members receive an opportunity to change plans once per year, during the annual open enrollment period. The open enrollment period occurs each fall, with the selection of the new MCE taking effect on January 1 of the following calendar year. Members continue to have the opportunity to change plans for cause, in accordance with 42 CFR §438.56.

In this waiver request no changes are requested to the current process for selecting, maintaining and changing enrollment in MCEs.

4.9 HIP Maternity Coverage
Beginning in 2018, all HIP members who become pregnant and any new applicants who are pregnant and are within the HIP income level are enrolled in HIP Maternity coverage. HIP Maternity coverage provides the HIP State Plan benefit package and has no cost sharing. Pregnant women remain eligible for retroactive coverage when enrolled in HIP. All pregnancy services are considered to be covered outside of the member POWER Account, and pregnant women that complete preventive care, including prenatal visits, can qualify for rollover and reduce their costs of future enrollment in HIP Plus. In addition to the ability to earn rollover incentives while pregnant, continued enrollment in HIP during pregnancy eliminates the coverage transition between HIP and Hoosier Healthwise at pregnancy onset and the end of the 60 day post-partum period. This provides greater coverage continuity for members.

\textsuperscript{16} The HIP Workforce Bridge Account Amendment is available at: https://www.in.gov/fssa/hip/files/BridgeAmendmentRequest2019_SubmissionFINAL.PDF
No changes are requested to the HIP Maternity policy applicable to pregnant women with income under the HIP income limit.

4.10 Non-emergency Transportation
The HIP Basic and HIP Plus alternative benefit plans are based on commercial market benefits and do not include coverage for non-emergency transportation. A waiver of non-emergency transportation has been a component of HIP since initial implementation in 2008. Pregnant members, medically frail members, and members who qualify as Section 1931 low-income parents and caretakers qualify for the full Medicaid benefit package and receive non-emergency transportation.

In this waiver renewal, no changes are requested to the non-emergency transportation policy.

4.11 Eligibility Renewal Requirements
Similar to commercial market coverage, HIP incorporates requirements that encourage members to maintain coverage. These requirements include the HIP POWER Account contribution policy, as well as the policy around HIP renewals. In the 2008 implementation, HIP excluded individuals who did not renew their HIP coverage from reenrolling in coverage for a set period of time. This policy to require renewal of HIP coverage and to exclude individuals who do not renew coverage for a period of up to six months was reauthorized in the 2018 approval and also exists in Indiana Code at 12-15-44.5-4.9(b). Individuals who fail to complete their HIP coverage renewal on time have a grace period of three months where they can complete the renewal without a penalty. Following the grace period, there is a three-month period where members are excluded from HIP enrollment. Members who do not successfully complete a renewal during enrollment, or in the grace period, are eligible to reenroll after six months from the expiration of their HIP coverage. Members who are medically frail, pregnant, or Section 1931 low-income parents and caretakers are exempt from the exclusion period for failure to renew coverage.

While authorized in the current approval, this policy is not currently in effect.

4.12 Presumptive Eligibility
The HIP waiver currently includes the authorization for additional provider types, including Federally Qualified Health Centers, Rural Health Centers, Community Mental Health Centers and Health Department sites, to complete presumptive eligibility (PE) for HIP members. Through 2017, HIP has received over 340,000 PE applications, and has enrolled over 265,000 individuals in coverage through PE since 2015. (HIP Annual Reports, 2015 – 2017). No changes to this waiver component are requested.

4.13 Medically Frail with Income Above the Poverty Level
Members in HIP who are medically frail but who have income over the poverty level are not subject to disenrollment from HIP if they fail to make their POWER Account contribution within 60 days. Medically frail members with income over the poverty level continue to owe POWER Account contributions, but also become subject to copayments when they fail to pay the required monthly POWER Account contribution. As with all HIP members, total cost sharing is limited to five percent of quarterly income. Medically frail members subject to
copayments and contributions have an annual opportunity at eligibility renewal to eliminate their copayments by making a required contribution.

In this waiver renewal request, no changes are requested for the medically frail with income over the poverty level.

4.14 Transitional Medical Assistance
In the 2018 approval, Transitional Medical Assistance (TMA) was authorized as continued coverage for Section 1931 low-income parents and caretakers who had income increase over the HIP eligibility threshold. Individuals who have income that increases over the Section 1931 low-income parent and caretaker limit, but remain under the HIP income level, maintain their HIP enrollment but are not designated as TMA, as HIP provides continued comprehensive coverage. Low-income parent and caretakers who earn income over the HIP limit and designated as TMA. For these individuals, coverage is provided for six months for all income levels, regardless of the individual’s payment of the HIP Plus monthly contribution. Individuals designated as TMA receive the full Medicaid benefit package with HIP Plus cost sharing. For the first six months of enrollment, TMA individuals are not disenrolled for failure to pay for HIP Plus in alignment with TMA rules. Following the initial six-month TMA period, TMA members are eligible for an additional six months of enrollment where income is below 185 percent of the federal poverty level, and the TMA member maintains HIP Plus enrollment through making the required contribution amount. TMA members who do not make their POWER account payments in the second six months of enrollment will be disenrolled for non-payment.

In this waiver renewal request, no changes are requested to the TMA policy.

4.13 Substance Use Disorder
The 2018 approval included a waiver to implement enhanced benefits for substance use disorders. The request to renew the SUD waiver and the corresponding SMI amendment is included as part of this renewal request and detailed further in the document.

Section 5: Summary of Requested HIP Program Changes
No substantive changes are requested, with the exception of the request to incorporate the HIP Workforce Bridge Amendment requested in 2019 into the approved waiver renewal. A summary of requested non-substantive changes to the approved waiver include:

- The State requests the flexibility to modify the POWER Account contribution tiers below average limit of three percent\(^{17}\) of member income, with appropriate notice to members, stakeholders and CMS, but without requiring the submission of a waiver amendment. Modifications could include increasing or decreasing the amounts of the base contribution or the tobacco surcharge or introducing POWER Account

\(^{17}\) In the CMS Approval of Kentucky Health, a member contribution ceiling of 4 percent of income was established. Kentucky also plans to assess contributions in a tiered approach as implemented in HIP.
contribution waivers such as a waiver of the contribution requirement for individuals that are also enrolled in employer sponsored coverage.

- The State requests the flexibility to modify the HIP Basic copayment amounts within the Medicaid allowable limits, with appropriate notice to members, stakeholders and CMS, but without requiring the submission of a waiver amendment. These modifications may include increases in copayment amounts within limits allowed for cost of living increases, decreases in copayment amounts, or implementation of copayment waivers on target services.

While not a change to the content approval, the substantive request of this renewal is to allow the program to be reauthorized in entirety for a period of 10 years.

5.1 10-year Approval Request

HIP is established as the Indiana program that provides coverage to low-income, non-disabled adult Hoosiers. The foundation of the HIP program, providing consumer directed coverage options that leverage commercial market policies for a Medicaid program, have been operational since 2008. When initially approved and subsequently authorized as the vehicle to cover the Medicaid expansion population in 2015, HIP pioneered innovations in Medicaid including POWER Accounts, member contributions, benefit-plan and cost-sharing variations, and commercial market policies around required monthly payment and eligibility renewals. Today, these policy innovations have been approved and implemented in Medicaid demonstration programs across the country.
The CMCS Informational Bulletin from November 6, 2017 covering 1115 Demonstration process improvements acknowledges that the 1115 demonstration approval process can be cumbersome and time consuming. The opportunity to renew routine and successful demonstrations for a period of up to 10 years is proposed as a solution to increase efficiency and reduce the burden associated with operating demonstrations.

From its long-term experience with HIP, Indiana knows that short approval periods requiring waiver renewal every three years do not serve to further the goals of the Medicaid program, or meaningfully enhance transparency, stakeholder input, or the federal oversight process.

As part of standard program operations, there are monthly, quarterly, and annual program reports as well as extensive program evaluation reporting completed for the 1115 demonstration. In addition, a public forum discussing the demonstration with stakeholders is held annually, and input is documented in program reporting. Further, the waiver STCs require amendments and public comment for any substantial changes to the waiver, and allow for CMS to withdraw approval for the entire demonstration or for any component of the demonstration at any time, negating the need for short approval periods. All of these activities are opportunities for meaningful transparency and stakeholder input.
Three-year renewal cycles create administrative complexity. A program may only be in effect for 12–18 months before drafting of the renewal must begin. Because renewal applications are due one year before the waiver authority expiration, a state must begin waiver drafting and public notice at least 18–24 months before submission. In Indiana, this means that our Gateway to Work program, which started phase-in January 2019, will have almost no real operational experience before we started drafting a renewal.

Indiana is committed to transparency around the demonstration, continual improvement, and support of scientifically rigorous methods to evaluate the demonstrations impacts. Renewing the long-term, core components of HIP for a 10-year period through 2030 relieves the State and CMS from the administrative requirements associated with supporting the renewal cycle, and allows for resources to focus on understanding the impacts of the demonstration, and continually improve demonstration operations. This longer approval period will also give HIP members confidence that HIP coverage is here to stay; and it will allow the State to reallocate resources from supporting the ongoing renewal process to focusing on making HIP the best program possible, and continuing to develop cutting-edge program innovations.

Section 6: HIP Program Evaluation

The Lewin Group was selected via Indiana’s procurement process to complete the interim and summative independent evaluation reports for the current demonstration period (2018 to 2020). The Lewin Group and FSSA have coordinated with CMS in development of a comprehensive evaluation plan for this demonstration period. The current draft of this evaluation plan is available for review with this renewal request and incorporates the 2019 CMS 1115 evaluation guidance. The interim evaluation report is posted and submitted with this renewal request. The summative evaluation will be available by July 2022, in alignment with federal requirements in the current STCs.

For this renewal request, the State proposes that, in addition to comprehensive quarterly and annual monitoring, three separate evaluation reports be submitted covering the 10-year approval period.

- First, an initial report on the first three years of the demonstration expected to be complete in 2025
- Second, an interim report on the first eight years of the demonstration, expected to be complete in 2029 and
- Third, a final report covering the full 10-year demonstration period submitted 18-months following the expiration of the waiver in 2032. For the 10-year approval period, the state proposes to continue the currently approved evaluation design, with modifications as necessary to ensure alignment of program operations and the current program objectives detailed in Section 2.2.
Section 7: HIP Quality Reporting

Indiana has a robust quality oversight plan for continually monitoring the performance of the MCEs serving the HIP population: Anthem, CareSource, MDwise, and MHS. The Office of Medicaid Policy and Planning’s (OMPP) Quality and Outcomes section is responsible for oversight of the MCEs, including managing compliance with contract requirements, monitoring program data, and reviewing required reporting documents from each MCE.

The State conducts numerous monitoring activities to assure quality and consistent delivery of healthcare services to Medicaid and HIP members. Specifically, the monitoring activities include quality management and improvement program work plans (QMIPs); data analysis; enrollee hotlines operated by the State’s enrollment broker; geographic mapping for provider networks; external quality review (EQR); network adequacy assurance submissions; monthly on-site monitoring reviews; recognized performance measure reports; and surveys.

7.1 Managed Care and State Quality Assurance Monitoring

Each year, OMPP prospectively identifies priorities for improving the delivery of healthcare to Medicaid and HIP members and improving operations. These priorities are included in the State’s Quality Strategy Plan (QSP). The State's QSP includes an overall framework for continuous quality improvement that utilizes several quality committees related to key agency priorities. Representation on these committees includes state agencies, including the Indiana State Department of Health, MCE staff, and other health industry experts. The 2017 and 2018 QSPs\textsuperscript{18} contained the HIP-specific objectives and goals for quality improvement in the tables below.

<table>
<thead>
<tr>
<th>Table 10: 2017 QSP HIP-Specific Goals and Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective</strong></td>
</tr>
<tr>
<td>1. HIP members shall have access to primary care within a maximum of 30 miles of the member’s residence and at least two providers of each specialty type within 60 miles of member’s residence.</td>
</tr>
<tr>
<td>2. HIP members shall have access to dental and vision care within a maximum of 60 miles of the member’s residence and at least two providers of each specialty type within 60 miles of the member’s residence.</td>
</tr>
<tr>
<td>3. HIP members who obtain a preventive exam during the measurement year receive power account roll-over.</td>
</tr>
</tbody>
</table>

\textsuperscript{18} The 2019 QSP has been posted for public comment and is in the process of being finalized. Please see https://www.in.gov/fssa/files/2019%20QSP%20Plan%20-%20public%20comment%20draft%20.pdf
4. ER admissions per 1000-member months | Achieve at or below 75 visits per 1000-member months.
---|---
5. Percentage of members who received follow-up within 7 days of discharge from hospitalization for mental health disorders | Achieve at or above the 90th percentile for members who receive follow-up within 7 days of discharge from hospitalization for mental health disorders.
6. Number of outpatient and emergency department visits per member months | Achieve at or above the 90% percentile of outpatient visits (HEDIS) Achieve at or below the 10th percentile of emergency department visits (HEDIS)
7. Increase the referral of pregnant women who smoke to the Indiana Tobacco Quitline for smoking cessation services. | Achieve an increase in the percentage who are referred to and have one contact with the Indiana Tobacco Quitline.
8. Right Choices Program (RCP) | A minimum of 90% of the findings of appeals filed by members to be removed from RCP will be upheld because the member was correctly assessed as requiring RCP services.
9. Provide quality health care to members identified as medically frail. | Identify individuals who meet the medically frail criteria and offer access to enhanced services.

Table 11: 2018 QSP HIP-Specific Goals and Objectives

<table>
<thead>
<tr>
<th>Objective</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. HIP members shall have access to primary care within a maximum of 30 miles of the member’s residence and at least two providers of each specialty type within 60 miles of member’s residence.</td>
<td>90% of all HIP members shall have access to primary care within a minimum of 30 miles of member’s residence and at least two providers of each specialty type within 60 miles of member’s residence.</td>
</tr>
<tr>
<td>2. HIP members shall have access to dental care within a maximum of 30 miles of the member’s residence and vision care within a maximum of 60 miles of the member’s residence.</td>
<td>90% of all HIP members shall have access to dental care within a maximum of 30 miles of the member’s residence and vision care within a maximum of 60 miles of member’s residence.</td>
</tr>
<tr>
<td>3. HIP members who obtain a preventive exam during the measurement year receive power account roll-over.</td>
<td>Achieve at or above 85% of the number of members who receive a preventive exam during the year.</td>
</tr>
<tr>
<td>4. ER Admissions per 1000-member months</td>
<td>Achieve at or below 75 visits per 1000-member months.</td>
</tr>
<tr>
<td>5. Percentage of members who received follow-up within 7 days of discharge from hospitalization for mental health disorders</td>
<td>Achieve at or above the 90th percentile for members who receive follow-up within 7 days of discharge from hospitalization for mental health disorders.</td>
</tr>
</tbody>
</table>
6. Percentage of members who had a preventive care visit
   Achieve at or above the 90th percentile for the percentage of members who had a preventive care visit.

7. Frequency of prenatal and post-partum care
   Achieve at or above the 90th percentile for the frequency of prenatal care and at or above the 90th percentile for the frequency of post-partum care.

8. Increase the referral of pregnant women who smoke to the Indiana Tobacco Quitline for smoking cessation services.
   Achieve an increase in the percentage who are referred to and have one contact with the Indiana Tobacco Quitline.

9. Right Choices Program
   A minimum of 90% of the findings of appeals filed by members to be removed from RCP will be upheld because the member was correctly assessed as requiring RCP services.

The QSP framework also includes MCE-led quality improvement projects (QIPs) that promote innovation and health outcomes improvement. These QIPs are submitted to OMPP and reviewed for performance.

Additionally, each of the contracted health plans are required to develop and maintain a QMIP that incorporates and addresses data from the plans’ Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys and quality metrics obtained from the Healthcare Effectiveness Data and Information Set (HEDIS) collected by the National Committee for Quality Assurance (NCQA). The QMIPs also must address any opportunities for improvement identified in the EQR, which is further discussed below.

The MCEs serving the HIP population are required to submit reports to OMPP on a monthly and quarterly basis, which are reviewed by staff for compliance with contractual requirements. Additionally, OMPP also conducts a monthly on-site meeting at each of the MCEs’ offices to discuss focus areas, observe process demonstrations, and address concerns from the monthly and quarterly reports. The contracted plans report on various operational and programmatic factors, including member access to primary medical providers, dentists, behavioral health providers, and specialists. The reports for 2017 indicated the following HIP access statistics for Indiana’s 92 counties:

- Primary medical providers: HIP members statewide largely resided in counties in which the average mileage from a member’s home address to an available primary medical provider is fewer than 30 miles. The MCEs ranged from a low of 25 counties where the distance from a member to an available provider was more than 30 miles to a high of 37 counties.19
- Dentists: HIP members statewide largely resided in counties in which the average mileage from a member’s home address to an available dentist is fewer than 30 miles.

19 [https://www.in.gov/fssa/files/Website_Report_4A_Primary_Care%5b1%5d.pdf](https://www.in.gov/fssa/files/Website_Report_4A_Primary_Care%5b1%5d.pdf)
The MCEs ranged from a low of seven counties where the distance from a member to an available provider was more than 30 miles to a high of 16 counties.  

- Behavioral health providers: HIP members statewide largely resided in counties in which the average mileage from a member’s home address to an available behavioral health provider is fewer than 45 miles. The MCEs ranged from a low of six counties where the distance from a member to an available provider was more than 45 miles to a high of 10 counties.  

- Specialists: HIP members statewide largely resided in counties in which two providers in each identified specialist category were within 60 miles of the member’s home address. Category-specific details are available on OMPP’s website at https://www.in.gov/fssa/files/Website_Report_4E_Specialists_HIP%5b1%5d.pdf.

In addition to monitoring of member access to healthcare services, the State strives to ensure that the care provided to HIP members is of the highest quality. CAHPS surveys of members in 2017 and 2018 indicate that across all MCEs, an average of 79.7 percent of members were satisfied with their personal doctor in 2017 and 80.4 percent of members were satisfied with their personal doctor in 2018, as indicated by a ranking of 8-10 on a 1-10 scale. Additionally, 75.7 percent and 77.1 percent of members were satisfied with their personal healthcare in 2017 and 2018, respectively.

7.2 External Quality Review

The State utilizes Burns & Associates, Inc. to conduct an annual EQR of each of the MCEs. The EQR includes all of Indiana’s Medicaid managed care programs, including HIP, Hoosier Healthwise, and Hoosier Care Connect. In addition to validating general performance measures and the performance improvement projects, the 2017 EQR for the 2016 calendar year (CY) focused on validation of performance measures, validation of performance improvement projects, and focus studies on lead testing and related outreach efforts, medication adherence, potentially preventable readmissions, and claims processing. Of note specific to HIP, the EQR includes an evaluation of the rate of potentially preventable readmissions (PPRs). This evaluation found that the PPR rate for HIP dropped from 8.8 percent in CY 2014 to 6.7 percent in CY 2016. EQR reports can be reviewed online at: https://www.in.gov/fssa/ompp/5533.htm

20 https://www.in.gov/fssa/files/Website_Report_4B_Dentist%5b1%5d.pdf
21 https://www.in.gov/fssa/files/Website_Report_4C_Behavioral_Health%5b1%5d.pdf
22 https://www.in.gov/fssa/files/Website_Report_6D_HIP_CAHPS%5b1%5d.pdf
23 Id.
24 Id.
25 https://www.in.gov/fssa/files/FINAL%20REPORT%20External%20Quality%20Review%20of%20Indiana%20Health%20Coverage%20Programs%20Year%202016.pdf
Section 8: Requested Waivers

The State requests a renewal of all currently approved waivers with minor, non-substantive changes. The state also requests incorporation of the waivers granted for the HIP Workforce Bridge Amendment in the renewal. The waivers requested for the renewal period include the below.

1. Health Plan Enrollment

Expenditures under contracts with managed care entities that do not meet the requirements in section 1903(m)(2)(A) of the Act specified below. Indiana's managed care organizations (MCO) participating in the demonstration will have to meet all the requirements of section 1903(m) except the following:

a. Section 1903(m)(2)(A)(vi) of the Act insofar as it requires compliance with requirements in section 1932(a)(4) of the Act and 42 CFR 438.56(c)(2)(i) that enrollees be permitted an initial period to disenroll without cause, except as described in the terms and conditions.

b. Section 1903(m)(2)(A)(vi) of the Act insofar as it requires compliance with requirements in section 1932(a)(4) of the Act and 42 CFR 438.56(g) that automatic MCO reenrollment occur only if the beneficiary’s disenrollment was due to a Medicaid eligibility lapse of two months or less, as described in the terms and conditions.

2. Premiums Section 1902(a)(14) insofar as it incorporates Section 1916 and 1916A

To enable the state to charge monthly contributions for HIP Plus at a minimum amount of one-dollar per month and not to exceed a maximum amount of three-percent of member income.

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

To enable enrollment in HIP Plus on the first day of the month in which an individual makes their initial contribution to the POWER Account, or, for individuals with incomes at or below 100 percent FPL who fail to make an initial POWER Account payment within 60-days following the date of invoice, the first day of the month in which the 60-day payment period expires, except for individuals who are found eligible through presumptive eligibility.

4. Provision of Medical Assistance Section 1902(a)(8) and 1902(a)(10)

To the extent necessary to enable Indiana to suspend eligibility for, and not make medical assistance available to, beneficiaries who fail to comply with community engagement requirements, unless the beneficiary is exempted.

5. Eligibility Section 1902(a)(10) and 1902(a)(52)

To the extent necessary to enable Indiana to prohibit reenrollment, and deny eligibility, for up to six months, for individuals with income over 100 percent of the FPL who are disenrolled for failure to make POWER Account premium contributions within 60 days of the date of invoice, subject to the exceptions and qualifying events.

To the extent necessary to enable Indiana to prohibit reenrollment, and deny eligibility, for up to three months following the end of the 90-day reconsideration period for individuals who are
disenrolled for failure to provide the necessary information for the state to complete an annual redetermination, subject to the exceptions and qualifying events.

To the extent necessary to enable Indiana to make a determination of ineligibility, and terminate eligibility for, beneficiaries who are in a suspension of coverage for failure to meet the approved community engagement requirements on their redetermination date, unless the beneficiary meets the requirement or is exempted as described in the STCs during the month of redetermination.

6. **Methods of Administration Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53**

To the extent necessary to relieve Indiana of the requirement to assure transportation to and from medical providers for HIP demonstration populations. No waiver of methods of administration is authorized for pregnant women, individuals determined to be medically frail, and section 1931 parents and caretaker relatives.

7. **Comparability and Amount, Duration and Scope of Services Sections 1902(a)(17) and 1902(a)(10)(B)**

To the extent necessary to enable the state to vary cost sharing requirements for beneficiaries for cost sharing to which they otherwise would be subject under the state plan, such that beneficiaries who are in HIP Plus will be charged only one copayment (for non-emergency use of the emergency department) and individuals who are in HIP Basic will be subject to copayments within Medicaid permissible levels.

To the extent necessary to enable Indiana to vary contribution requirements, for different HIP Plus program beneficiaries based on income and on tobacco use, and in a manner consistent with all otherwise applicable law. To allow for variations or waivers of POWER Account contribution requirements, within established limits, based on target initiatives such as encouraging uptake of employer insurance.

To allow the HIP Workforce Bridge Account to be available solely to defined eligible individuals that are disenrolled from HIP due to an increase in income.

To allow the state to provide only a limited defined benefit via the HIP Bridge Account, that is limited to cost-sharing assistance up to an amount of $1,000, regardless of health care costs incurred by the member. To allow any balance payable in excess of $1,000, to be assigned to member responsibility without regard to cost-sharing limitations.

8. **Retroactivity Section 1902(a)(34)**

To enable the state not to provide three months of retroactive eligibility for beneficiaries receiving coverage through the HIP program as described in the STCs, except for pregnant women.
**Section 9: Demonstration Financing and Budget Neutrality**
The HIP component of the demonstration does not include Budget Neutrality Component. Budget Neutrality is incorporated in the SUD/SMI waiver renewal request posted concurrently with this waiver.

**Section 10: Public Notice and Comment**
Public notice of the HIP and SUD Renewal request was provided November 6th, 2019 and can be accessed at [https://www.in.gov/fssa/hip/](https://www.in.gov/fssa/hip/). Public hearings are scheduled for:

1) Tuesday November 19th at 2:00 pm at the Indiana State Library, History Reference Room 211, 315 W. Ohio St., Indianapolis, IN 46202. This hearing will be a special session of the Medical Advisory Commission.
2) Wednesday November 20th at 10 am at Indiana Government Center South, Conference Room 18, 302 W Washington St, Indianapolis, IN 46204. This hearing will be accessible via web conference at [https://Indiana.AdobeConnect.com/indiana](https://Indiana.AdobeConnect.com/indiana).

Written comments may be sent to the FSSA via mail at 402 West Washington Street, Room W374, Indianapolis, Indiana 46204, Attention: Natalie Angel or via electronic mail at [hip@fssa.in.gov](mailto:hip@fssa.in.gov) through December 6th, 2019.

Copies of the public notice documents are provided in Attachment A.

**Section 10.1 Summary of Public Comments**
Following conclusion of the comment period a summary of comments received will be provided in the request submitted to CMS.

**Section 10.2 Changes Made to Request as a Result of Public Comment**
Following conclusion of the comment period, any changes made to the waiver request as a result of public comment will be summarized in the request submitted to CMS.

**Section 11: Tribal Notice**
Notice of the waiver renewal request was provided to Indiana’s federally recognized tribe, the Pokagon Band of Potawatomi Indians, on November 1, 2010. The notice and opportunity for consultation was provided in accordance with 42 CFR 431.408(b).

**Section 12: HIP Demonstration Administration**
Name and Title: Natalie Angel, Healthy Indiana Plan Director
Telephone: (317) 234-5547
Email Address: Natalie.Angel@fssa.in.gov
ATTACHMENT A: Public Notices

OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES ADMINISTRATION
NOTICE OF PUBLIC HEARING

In accordance with 42 CFR §431.408(a)(2)(ii), the Indiana Family and Social Services Administration (FSSA) will be holding public hearings on a proposed extension of the Healthy Indiana Plan Section 1115 demonstration waiver (HIP Waiver) that will be submitted to the Centers for Medicare and Medicaid Services (CMS). Through this The Healthy Indiana Plan (HIP) has been a feature of Indiana’s Medicaid program since 2008. The current approval to operate HIP expires December 31, 2020. FSSA is seeking a ten year extension of the HIP Waiver with no substantive changes. The extension request includes incorporation of the HIP Bridge Account amendment, which was submitted to CMS on July 25, 2019. FSSA will be requesting the following non-substantive, technical changes through the extension request:

- Flexibility to modify the POWER Account contribution tiers below average limit of three percent of member income, with appropriate notice to members, stakeholders and CMS, but without requiring the submission of a waiver amendment. Modifications are not currently proposed but could, for example, include increasing or decreasing the amounts of the POWER Account base contribution or the tobacco surcharge.
- Flexibility to modify the HIP Basic copayment amounts within the Medicaid allowable limits, with appropriate notice to members, stakeholders and CMS, but without requiring the submission of a waiver amendment. Modifications are not currently proposed but these modifications may include increases in copayment amounts within limits allowed for cost of living increases, decreases in copayment amounts, or implementation of copayment waivers on target services.

Additionally, through this waiver extension application, FSSA is seeking federal approval for a five-year extension of the substance use disorder (SUD) and requested serious mental illness (SMI) components of the HIP Waiver. This includes authority to reimburse institutions for mental disease (IMDs) for short term stays for individuals diagnosed with SMI or SUD.

Hearings will be held as follows:
1) Tuesday November 19th at 2:00 pm at the Indiana State Library, History Reference Room 211, 315 W. Ohio St., Indianapolis, IN 46202. This hearing will be a special session of the Medical Advisory Commission.
2) Wednesday November 20th at 10 am at Indiana Government Center South, Conference Room 18, 302 W Washington St, Indianapolis, IN 46204. This hearing will be also be accessible via web conference at https://Indiana.AdobeConnect.com/indiana.

All information regarding the submission, including the public notice, the HIP Waiver extension, and other documentation regarding the proposal are available for public review at the FSSA, Office of General Counsel, 402 W. Washington Street, Room W451, Indianapolis, Indiana 46204. The full Public Notice and HIP Waiver documents are also available to be viewed online at https://www.in.gov/fssa/hip/.

Written comments may be sent to the FSSA via mail at 402 West Washington Street, Room W374, Indianapolis, Indiana 46204, Attention: Natalie Angel or via electronic mail at hip@fssa.in.gov through December 6th, 2019.
OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES ADMINISTRATION

NOTICE OF PUBLIC COMMENT PERIOD TO EXTEND THE HEALTHY INDIANA PLAN 1115 DEMONSTRATION

Pursuant to 42 CFR § 431.408(a), notice is hereby given that the Indiana Family and Social Services Administration (FSSA) will provide the public the opportunity to review and provide input on a proposed extension of the Healthy Indiana Plan Section 1115 demonstration waiver (HIP Waiver). This notice provides details about the waiver amendment submission and serves to open the 30-day public comment period, which closes on December 6, 2019.

In addition to the 30-day public comment period in which the public will be able to provide written comments to the FSSA via US postal service or electronic mail, the FSSA will host two public hearings in which the public may provide verbal comments. Hearings will be held at the following dates, times, and locations:

1) Tuesday, November 19th at 2:00 pm at the Indiana State Library, History Reference Room 211, 315 W. Ohio St., Indianapolis, IN 46202. This hearing will be a special session of the Medical Advisory Commission.

2) Wednesday, November 20th at 10:00 am at the Indiana Government Center South, Conference Room 18, 302 W. Washington St., Indianapolis, IN 46204. This hearing will be also be accessible via web conference at https://Indiana.AdobeConnect.com/indiana.

Prior to finalizing the proposed HIP Waiver extension, the FSSA will consider all the written and verbal public comments received. The comments will be summarized and addressed in the final version to be submitted to the Centers for Medicare and Medicaid Services (CMS).

EXTENSION PROPOSAL SUMMARY AND OBJECTIVES

The Healthy Indiana Plan (HIP) has been a feature of Indiana’s Medicaid program since 2008. The current approval to operate HIP expires December 31, 2020. Based on the long-tenure and demonstrated success of HIP, FSSA is seeking a ten year extension of the HIP Waiver with no substantive changes. The extension request includes incorporation of the HIP Bridge Account amendment, which was submitted to CMS on July 25, 2019. FSSA will be requesting the following non-substantive, technical changes through the extension request:

- Flexibility to modify the POWER Account contribution tiers below average limit of three percent of member income, with appropriate notice to members, stakeholders and CMS, but without requiring the submission of a waiver amendment. Modifications are not currently proposed but could, for example, include increasing or decreasing the amounts of the POWER Account base contribution or the tobacco surcharge.

- Flexibility to modify the HIP Basic copayment amounts within the Medicaid allowable limits, with appropriate notice to members, stakeholders and CMS, but without requiring the submission of a waiver amendment. Modifications are not currently proposed but these modifications may include increases in copayment amounts within limits allowed for cost of living increases, decreases in copayment amounts, or implementation of copayment waivers on target services.
Additionally, through this waiver extension application, FSSA is seeking federal approval for a five-year extension of the approved substance use disorder (SUD) and requested serious mental illness (SMI) components of the HIP Waiver. This includes authority to reimburse institutions for mental disease (IMDs) for short term stays for individuals diagnosed with SMI or SUD.

**BENEFICIARIES & ELIGIBILITY**

All current HIP eligibility limits and requirements will remain unchanged. HIP continues to target non-disabled adults between the ages of 19 and 64 with a household income less than 133% of the federal poverty level (FPL) with a 5% of income disregard, including individuals eligible for the adult group, low-income parents and caretakers eligible under Section 1931 of the Social Security Act (Section 1931), pregnant women with income within the HIP limit, and individuals eligible for transitional medical assistance.

HIP includes Gateway to Work a community engagement initiative that connects HIP members with ways to look for work, train for jobs, finish school and volunteer. While eligibility suspensions for not completing Gateway to Work are on hold, this HIP Waiver extension requests the ability to continue the Gateway to Work program.

Additionally, all Medicaid enrollees ages 21-64, eligible for full Medicaid benefits, and with a SMI or SUD diagnosis would be eligible for short term stays in an IMD under the SUD and requested SMI component of the waiver extension.

The HIP Waiver extension includes incorporation of the HIP Bridge Account amendment, currently under review by CMS, under which Indiana will adopt limited coverage for the group of adults who have income over the income eligibility level for the new adult group identified in § 1902(a)(10)(A)(ii)(XX) of the Social Security Act and in 42 CFR § 435.218. Individuals with MAGI-based income above 133 percent of the federal poverty level (FPL) who have lost HIP coverage solely due to an increase in income will be eligible for the defined benefit HIP Bridge Account for 12-months following HIP disenrollment. There will be no income limits on eligibility for the account.

**ENROLLMENT & FISCAL PROJECTIONS**

The HIP Waiver extension will have no impact on expected annual Medicaid enrollment as HIP is requested to be continued with no substantial changes. Further, it is expected to be budget neutral as outlined in the table below.

**Without-Waiver Total Expenditures**

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<tr>
<th></th>
<th>DEMONSTRATION YEARS (DY)</th>
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<tr>
<td></td>
<td>2021</td>
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<tr>
<td>IMD Services MEG 1</td>
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<td>(Managed Care)</td>
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With-Waiver Total Expenditures

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<td>IMD Services MEG 3 (Managed Care)</td>
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<td>$31,695,8</td>
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<tr>
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BENEFITS, COST SHARING, AND DELIVERY SYSTEM

The HIP Waiver extension does not propose any changes to benefits, cost sharing, or delivery system. However, it does incorporate the changes requested specific to the HIP Bridge Account amendment, currently under review by CMS, under which HIP members who qualify for the HIP Bridge Account will receive the benefits and cost sharing applicable to the HIP Bridge Account.

All HIP members will continue to receive a comprehensive benefit package, consistent with private market plans and compliant with all mandated essential health benefits as required by the Patient Protection and Affordable Care Act (ACA). The HIP benefit package does not include non-emergency transportation. Notwithstanding the foregoing, low-income parents and caretakers eligible under Section 1931, pregnant women, low-income 19 and 20-year-old dependents, individuals eligible for transitional medical assistance, and individuals identified as medically frail receive the same benefits as the Medicaid State Plan, including non-emergency transportation and other services not otherwise available to HIP members. Except for members receiving these HIP State Plan benefits, vision and dental services are only available through the HIP Plus plan. Participation in HIP Plus requires members to regularly contribute to their POWER account. The HIP Basic plan is only available to members below the federal poverty level who fail to make their monthly POWER account contributions. The HIP Basic plan does not cover vision and dental services and includes Medicaid allowable copayment amounts.

For all plans, preventive services, such as annual examinations, smoking cessation programs, and mammograms, are covered without charge to the members and are not included in the deductible amount. After the plan deductible is met by way of the $2,500 POWER account, the HIP program includes a comprehensive health plan benefits package.
All HIP medical benefits are currently provided through four (4) MCEs: Anthem, MDwise, Managed Health Services (MHS), and CareSource. Once an MCE has been selected, the member must remain in the MCE for 12 months, with limited exceptions. Members who do not select an MCE will be auto-assigned to an MCE and have the opportunity to change the assigned MCE before the first POWER account contribution is made.

Enrollees receiving services under the SUD and requested SMI component of the waiver extension will continue to receive services through their current delivery system.

**HYPOTHESES & EVALUATION**

The HIP Waiver extension will not propose any changes to the evaluation design or hypotheses. Enhanced program goals, which include the below and will be incorporated into the existing evaluation design posted with the extension documentation, are proposed in the extension request. The enhanced program goals for the HIP extension include period the following:

- Provide timely and geographically appropriate access to healthcare services.
- Promote appropriate utilization of healthcare by maintaining low inappropriate use of the emergency department and supporting utilization of needed services from qualified non-emergency providers.
- Promote control of chronic conditions, delivery of needed care, and increase in member health and wellbeing.
- Increase community engagement leading to increased educational attainment, sustainable employment and member self-sufficiency.
- Reduce the number of uninsured Hoosiers, decrease gaps in coverage, and promote uptake of commercial insurance when leaving HIP.
- Meaningfully increase use of tobacco cessation services and meaningfully decrease tobacco use status for HIP members.
- Encourage healthy behaviors and appropriate care, including early intervention, prevention, and wellness.
- Leverage HIP policies to support the goals of HIP by promoting continuous coverage and improved health outcomes.
- Generate actionable information on social determinants of health.

**WAIVER & EXPENDITURE AUTHORITY**

FSSA requests an extension of all currently approved waivers and the waiver authority currently under review with CMS for the HIP Workforce Bridge amendment. As specified in the HIP Waiver extension, the requested waivers include:

1. **Premiums**  
   *Section 1902(a)(14) insofar as it incorporates Section 1916 and 1916A*  
   To enable the State to charge monthly contributions for HIP Plus at a minimum amount of one-dollar per month and not to exceed a maximum amount of three-percent of member income.

2. **Reasonable Promptness**  
   *Section 1902(a)(8)*  
   To the extent necessary to enable enrollment in HIP Plus on the first day of the month in which an individual makes their initial contribution to the POWER Account, or, for individuals with incomes at or below 100 percent FPL who fail to make an initial POWER Account payment within 60 days following
3. **Provision of Medical Assistance**  
Sections 1902(a)(8) and 1902(a)(10)  
To the extent necessary to enable Indiana to suspend eligibility for, and not make medical assistance available to, beneficiaries who fail to comply with community engagement requirements, unless the beneficiary is exempted.

4. **Eligibility**  
Sections 1902(a)(10) and 1902(a)(52)  
To the extent necessary to enable Indiana to make a determination of ineligibility, and terminate eligibility for, beneficiaries who are in a suspension of coverage for failure to meet the approved community engagement requirements, unless the beneficiary meets the requirement or is exempted as described in the STCs.

To the extent necessary to enable Indiana to prohibit reenrollment, and deny eligibility, for up to six months, for individuals with income over 100 percent of the FPL who are disenrolled for failure to make POWER Account premium contributions within 60 days of the date of invoice, subject to the exceptions and qualifying events.

To the extent necessary to enable Indiana to prohibit reenrollment, and deny eligibility, for up to three months following the end of the 90-day reconsideration period for individuals who are disenrolled for failure to provide the necessary information for the state to complete an annual redetermination, subject to the exceptions and qualifying events.

5. **Methods of Administration**  
Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53  
To the extent necessary to relieve Indiana of the requirement to assure transportation to and from medical providers for HIP demonstration populations. No waiver of methods of administration is authorized for pregnant women, individuals determined to be medically frail, and section 1931 parents and caretaker relatives.

6. **Comparability and Amount, Duration and Scope of Services**  
Sections 1902(a)(17) and 1902(a)(10)(B)  
To the extent necessary to enable the State to vary cost sharing requirements for beneficiaries for cost sharing to which they otherwise would be subject under the state plan, such that beneficiaries who are in HIP Plus will be charged only one copayment (for non-emergency use of the emergency department) and individuals who are in HIP Basic will be subject to copayments within Medicaid permissible levels.

To the extent necessary to enable Indiana to vary contribution requirements, for different HIP Plus program beneficiaries based on income and on tobacco use, and in a manner consistent with all otherwise applicable law. To allow for variations or waivers of POWER Account contribution requirements, within established limits, based on target initiatives such as encouraging uptake of employer insurance.

To allow the HIP Workforce Bridge Account to be available solely to defined eligible individuals that are disenrolled from HIP due to an increase in income.

To allow the State to provide only a limited defined benefit via the HIP Bridge Account, that is limited to cost sharing assistance up to an amount of $1,000, regardless of health care costs incurred by the
To allow any balance payable in excess of $1,000, to be assigned to member responsibility without regard to cost-sharing limitations.

7. **Retroactivity**

To enable the State not to provide three months of retroactive eligibility for beneficiaries receiving coverage through the HIP program as described in the STCs, except for pregnant women.

FSSA also requests extension of the following expenditure authorities that are currently approved or pending approval by CMS:

1. Expenditures under contracts with managed care entities that do not meet the requirements in section 1903(m)(2)(A) of the Act specified below. Indiana's managed care organizations (MCO) participating in the demonstration will have to meet all the requirements of section 1903(m) except the following:

   a. Section 1903(m)(2)(A)(vi) of the Act insofar as it requires compliance with requirements in section 1932(a)(4) of the Act and 42 CFR 438.56(c)(2)(i) that enrollees be permitted an initial period to disenroll without cause, except as described in the terms and conditions.

   b. Section 1903(m)(2)(A)(vi) of the Act insofar as it requires compliance with requirements in section 1932(a)(4) of the Act and 42 CFR 438.56(g) that automatic MCO reenrollment occur only if the beneficiary’s disenrollment was due to a Medicaid eligibility lapse of two months or less, as described in the terms and conditions.

2. Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental disease (IMD) and expenditures for otherwise covered services furnished to otherwise eligible individuals for short term stays for acute care in a psychiatric hospital that qualifies as an IMD.

**REVIEW OF DOCUMENTS & SUBMISSION OF COMMENTS**

All information regarding the submission, including the public notice, the HIP Waiver extension, and other documentation regarding the proposal are available for public review at the FSSA, Office of General Counsel, 402 W. Washington Street, Room W451, Indianapolis, Indiana 46204. The full Public Notice and HIP Waiver documents are also available to be viewed online at [https://www.in.gov/fssa/hip/](https://www.in.gov/fssa/hip/).

Written comments may be sent to the FSSA via mail at 402 West Washington Street, Room W374, Indianapolis, Indiana 46204, Attention: Natalie Angel or via electronic mail at [hip@fssa.in.gov](mailto:hip@fssa.in.gov) through December 6, 2019.