DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

July 26, 2022

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

Dear Ms. Taylor:

On March 13, 2020, the President of the United States issued a proclamation that the Coronavirus Disease 2019 (COVID-19) outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (the Act) as amended (42 U.S.C. 1320b-5). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences of the COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6:00 PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. We note that the emergency period will terminate upon termination of the public health emergency (PHE), including any extensions.

In response to the section 1115(a) demonstration opportunity announced to states on March 22, 2020, in State Medicaid Director Letter (SMDL) #20-002, on January 28, 2022, Indiana submitted a request for an amendment to the "Healthy Indiana Plan (HIP)" section 1115(a) demonstration (Project Number 11-W-00296/5) to the COVID-19 PHE. CMS has determined that the state's application is complete, consistent with the exemptions and flexibilities outlined in 42 CFR § 431.416(e)(2) and 431.416(g). CMS expects that states will offer, in good faith and in a prudent manner, a post-submission public notice process, including tribal consultation as applicable, to the extent circumstances permit. This letter serves as a time-limited approval of the state's request, which will be approved as an amendment under the HIP demonstration and which is hereby authorized retroactively from January 1, 2021, and applies for the full duration of rating periods that begin or end during the COVID-PHE and up to six months post COVID-

PHE, but will not extend beyond December 31, 2023.

This expenditure authority would test whether, in the sole context of the current COVID-19 PHE, an exemption from the regulatory prohibition in 42 CFR 438.4(b)(1) on Medicaid Managed Care Organization (MCO) payment arrangements employed by the state, that the state is unable to change without a transition period, promotes the objectives of Medicaid. To that end, the expenditure authority is expected to support Indiana with making payments during the PHE to help maintain beneficiary access to care.

The expenditure authority, outlined below, provides the state a transition period to comply with 42 CFR 438.4(b)(1) which was revised as part of the 2020 Medicaid and Children's Health Insurance Program Managed Care Rule (CMS-2408-F) published on November 13, 2020 and took effect on December 14, 2020. Because every other state was already complying with the prohibition on differential payment rates at issue, only Indiana was put on notice in the November 13, 2020 final rule that it was required to comply with the rule beginning with payment rates effective January 1, 2021, only 48 days after the final rule was published. Although Indiana theoretically could have obtained legislation necessary to do so, and implemented compliant rates retroactive to January 1, CMS believes the additional timeframe approved under this demonstration is reasonable given the unique and unprecedented circumstances that would be specific to the state of Indiana, which would have uniquely been required to combined the disruption of changing its MCO rate structure with addressing some of the unexpectedly worst months of the COVID-19 pandemic. For example, the Final Rule was released 8 months into this PHE at a time the state was focused on key health policy priorities directly related to this PHE, including provider reimbursement that is critical to the state's pandemic response. At the time this Final Rule was released, it was not anticipated this PHE declaration would be as long-standing in this unprecedented manner. Additionally, the COVID-19 PHE has had a profound and all-consuming impact on the entire health care delivery system in the state, including hospitals, physicians and ancillary services. Implementing this regulatory change requires the state to equalize reimbursement across all Medicaid managed care programs where currently there are different payment rates for physician and ancillary services among the three Medicaid managed care programs. Maintaining provider reimbursement is critical to ensure a robust provider network to serve vulnerable Hoosiers in the health and economic crisis of COVID-19 and that a disruptive loss of associated federal funds for all Medicaid managed care programs given a failure to comply with this federal requirement or making provider reimbursement cuts likely necessary to comply would substantially and detrimentally impair the state's ability to provide critically needed care to Medicaid beneficiaries during the PHE. The state has also indicated that there are necessary state administrative and policy changes that must occur to comply with this regulatory change, including state legislative and contractual changes that were unable to be made during this unprecedented, long-standing PHE. Therefore, the state requested that the demonstration amendment be in place through December 31, 2023 to give the state a transition period to implement all the steps necessary to comply with this new regulatory requirement. CMS believes this request by the state is reasonable in these combined unique circumstances only. Therefore, CMS is approving this request subject to the requirements and limitations outlined in Attachment L.

Due to the uniquely limited scope of the changes under the amendment to the HIP

demonstration, CMS is incorporating this amendment as Attachment L to the HIP special terms and conditions (STC), which is also affixed with this Letter. CMS has determined that this amendment – including the expenditure authority detailed below and in Attachment L – promotes the objectives of Medicaid because it is necessary to maintain access to services during the COVID-19 PHE, and it assists the state in delivering the most effective care to its beneficiaries in light of the COVID-19 PHE as outlined further in the previous paragraph. To that end, the amendment is expected to help the state furnish medical assistance in a manner intended and providers who may be affected by the COVID-19 PHE.

In addition, in light of the unprecedented emergency circumstances associated with the COVID-19 pandemic and consistent with the President's declaration detailed above – and in consequence the time-limited nature of this demonstration amendment – CMS did not require the state to submit budget neutrality calculations for this COVID-19 PHE amendment to HIP. In general, CMS has determined that the costs to the federal government are likely to have been otherwise incurred and allowable. Indiana will be required to track the expenditures and conduct a cost-assessment of this expenditure authority, and will be expected to evaluate the connection between those expenditures and the state's response to the PHE.

Expenditure Authority

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act, shall, for the period from January 1, 2021 through the full duration of rating periods that begin or end during the COVID PHE and up to six months post COVID-PHE but will not extend beyond December 31, 2023be regarded as expenditures under the state's title XIX plan.

CMS is approving this expenditure authority to allow the state and its managed care organizations to vary reimbursement rates for physician and ancillary services in the HIP in comparison to other Medicaid managed care programs to maintain capacity during the COVID-PHE. This expenditure authority is effective January 1, 2021 and applies for the full duration of rating periods that begin or end during the COVID-19 PHE and up to six months post COVID-PHE but will not extend beyond December 31, 2023. The authority would exempt, when necessary, the state from compliance with the current requirements in 42 CFR 438.4(b)(1). This authority is effective only as the state maintains compliance with the requirements described in Attachment L.

Monitoring and Evaluation Requirements

Consistent with CMS requirements for monitoring and evaluation of section 1115 demonstrations, the state is required to develop an Evaluation Design and a Final Report, which will consolidate the monitoring and evaluation requirements for this demonstration amendment. The draft Evaluation Design will be due to CMS no later than 60 calendar days after the approval of this expenditure authority. The draft Final Report will be due to CMS no later than 18 months after either the expiration of the approval period of this expenditure authority or the end of the latest rating period covered under the state's approved expenditure authority, whichever comes

later.

CMS will provide technical assistance to help the state fulfill the monitoring and evaluation requirements, including in developing the Evaluation Design. Given the specific circumstances and time-limited nature of this demonstration amendment, CMS expects Indiana to undertake data collection or analyses that are meaningful, but not unduly burdensome for the state. Specifically, the state can focus on qualitative methods and descriptive data to address evaluation questions that will support understanding the successes, challenges, and lessons learned in implementing the demonstration amendment. The state is also expected to review 42 CFR 431.428 to ensure that the Final Report captures all applicable requirements stipulated for an annual report (e.g., incidence and results of any audits, investigations or lawsuits, or any state legislative developments that may impact the demonstration). The Evaluation Design and the Final Report shall cover all rating periods under the scope of the demonstration.

Once approved, in accordance with 42 CFR 431.424(e), the state is required to post the Evaluation Design to its Medicaid agency website within 30 calendar days of CMS approval. Likewise, per the HIP section 1115 demonstration STCs, specifically, Section XV STC #10 on Public Access pertaining to demonstration deliverables, the state shall post the CMS-approved Final Report to its website within 30 calendar days of CMS approval.

Per 42 CFR 431.420(f), the state shall comply with any requests for data from CMS and/or its federal evaluation contractors.

In addition to the section 1115 monitoring and evaluation requirements outlined above, the state shall separately comply with the applicable managed care reporting requirements per 42 CFR 438.66 and section 1936(b) of the Act.

Other Information

Approval of this demonstration amendment is subject to the expenditure authority and limitations specified in the enclosed Attachment L to the STCs. The state may deviate from its Medicaid state plan requirements only to the extent specified in the approved expenditure authority and the enclosed STCs for the demonstration. This approval is conditioned upon continued compliance with the previously approved STCs, which set forth in detail the nature, character, and extent of anticipated federal involvement in the project.

CMS reminds the state that failure to comply with 42 CFR 438.4(b)(1) for the entire managed care program, as of January 1, 2024, will jeopardize all federal financial participation for the Healthy Indiana Program, Hoosier Healthwise, and Hoosier Care Connect as CMS will be unable to consider the associated managed care plan contracts and rates nor associated state directed payment(s) for approval.

The award is subject to CMS receiving written acceptance of this award within 15 days of the date of this approval letter. Your project officer is Rachel Nichols. Ms. Nichols is available to answer any questions concerning implementation of the state's section 1115(a) demonstration amendment and her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, Maryland 21244-1850
Email: Rachel.Nichols@cms.hhs.gov

We appreciate your state's commitment to addressing the significant challenges posed by the COVID-19 pandemic, and we look forward to our continued partnership on the HIP section 1115(a) demonstration. If you have any questions regarding this approval, please contact Ms. Judith Cash, Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.

Sincerely,

Daniel Tsai
Deputy Administrator and Director

cc: Mai Le-Yuen, State Monitoring Lead, Medicaid and CHIP Operations Group

Attachment L

Time-limited Expenditure Authority and Associated Program Requirements for the COVID-19 Public Health Emergency (PHE) Demonstration Amendment

Expenditure Authority

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act, shall, for the period from January 1, 2021 through the full duration of rating periods that begin or end during the COVID PHE and up to six months post COVID-PHE but will not extend beyond December 31, 2023 be regarded as expenditures under the State's title XIX plan.

> Expenditure authority to allow the state and its managed care organizations to vary reimbursement rates for physician and ancillary services in the HIP in comparison to other Medicaid managed care programs to maintain capacity during the emergency. This expenditure authority is effective January 1, 2021 and applies for the full duration of rating periods that begin or end during the COVID-19 PHE and up to six months post COVID-PHE but will not extend beyond December 31, 2023. The authority would exempt, when necessary, the state from compliance with the current requirements in 42 CFR 438.4(b)(1). This authority is effective only as the state maintains compliance with the requirements described in the program requirements below.

Program Requirements

By no later than January 1, 2024, Indiana must comply with 42 CFR 438.4(b)(1) and equalize the reimbursement rates for all Medicaid managed care services across all Medicaid managed care populations in all Medicaid managed care programs to ensure that reimbursement does not vary based on the rate of federal financial participation associated with the covered populations in a manner that increases federal costs. The state is required to maintain at a minimum the Medicaid managed care reimbursement methodologies in effect as of December 31, 2020 and not utilize the section 1115 authority to further differentiate reimbursement rates for Medicaid managed care services across the Medicaid managed care programs. In order to demonstrate the state is working toward compliance, the state must complete the key action steps within CMS's required timelines outlined below. If the state does not maintain the required maintenance of effort or misses one of the required timelines, the related section 1115 expenditure authority will cease immediately. If the state faces unforeseen circumstances in meeting a required timeline for a key action step, it may formally request an extension to one of the required timelines subject to CMS approval. The state's extension request must include the required components outlined below and be submitted to CMS no later than 60 days prior to the required timeline (e.g., a request to revise a January 31, 2023 timeline must be formally submitted to CMS no later than December 2, 2022). Additionally, with an extension request, the state must: (1) provide a description of the unforeseen circumstance impacting the state's ability to meet a key action step within the required timeline; (2) propose a new timeline for meeting the required action step, including a description of why this requested new timeline is reasonable and appropriate; and (3) submit a Corrective Action Plan detailing the activities the state will undertake to ensure no further delays in completing key action steps within the required timelines to ensure compliance with 42 CFR

438.4(b)(1) no later than January 1, 2024. In no event, shall the expenditure authority extend beyond December 31, 2023. CMS reserves the right to ask for additional supporting documentation or request a revised timeline related to the state's extension request. An approved extension becomes a component of the 1115 and CMS will publish the extension, including all components outlined above, as an Attachment to the 1115.

- By October 1, 2022, the state must complete a public notice process on the proposed changes including issuing public notice, establishing a comment period, holding public hearings, and summarizing and submitting comments to CMS.
- By December 1, 2022, the state must submit to CMS a draft of the proposed rate methodology for physician and ancillary services for Medicaid managed care.
- By January 31, 2023, the state must provide CMS with draft legislation to revise current state requirements to pay differential reimbursement rates between the Healthy Indiana Plan and all other Medicaid managed care programs and populations.
- By July 1, 2023, the state must have in effect a biennium budget approved by the state legislature that includes the appropriation necessary to implement the programmatic changes to comply with 42 CFR 438.4(b)(1) and equalize the reimbursement rates for all Medicaid managed care services across all Medicaid managed care populations and all Medicaid managed care programs to ensure that reimbursement does not vary based on the rate of Federal financial participation associated with the covered populations in a manner that increases Federal costs.
- The state must also notify CMS no later than July 1, 2023 if the state intends to utilize a state directed payment(s) to direct the expenditures of its managed care plans, such as by requiring a minimum fee schedule or other payment arrangement, beginning January 1, 2024.
- The state must also provide draft contract language to CMS no later than July 1, 2023 that describes the state's intended payment arrangements for calendar year 2024.
- If CMS determines that prior approval by CMS is required for the state directed payment(s), in accordance with 42 CFR 438.6(c), the state must submit a complete preprint(s) for the calendar year 2024 rating period by no later than September 1, 2023.
- By October 1, 2023, the state must establish an equitable fee schedule for all Medicaid managed care services, including physician and ancillary services across all Medicaid managed care programs beginning no later than January 1, 2024, and submit this fee schedule.
- The state is also required to submit calendar year 2024 rate certifications for all Medicaid managed care programs (i.e. Healthy Indiana Plan, Hoosier Care Connect and Hoosier Healthwise) and related executed managed care plan contract actions by no later than October 1, 2023. The rate certifications must include all necessary documentation outlined in the Medicaid Managed Care Rate Development Guide, including but not limited to, an assurance from the state's actuary that rate development complies with 42 CFR 438.4(b)(1) and documentation of all applicable state directed payments.

Monitoring and Evaluation Requirements

1. **Evaluation Design.** The state must submit an Evaluation Design to CMS within 60 days of the demonstration amendment approval. CMS will provide technical assistance on developing the Evaluation Design, in alignment with guidance developed specifically for

the expenditure authorities approved for the COVID-19 PHE. For this demonstration amendment, the state will test whether and how the approved expenditure authority facilitated the state's response to the COVID-19 PHE, and helped promote the objectives of Medicaid. To that end, the evaluation for this amendment will address thoughtful evaluation questions that support understanding the successes and challenges in implementing the expenditure authority. The state is required to post its Evaluation Design to the state's website within 30 days of CMS approval of the Evaluation Design, per 42 CFR 431.424(e).

2. **Final Report.** The state is required to submit a Final Report, which will consolidate the monitoring and evaluation reporting requirements for this expenditure authority. The state must submit the draft Final Report no later than 18 months after either the expiration of the demonstration approval period or the end of the latest rating period covered under this approved expenditure authority, whichever comes later. The Final Report should include a background description of the scope and objectives of the amendment, and in alignment with proposed evaluation questions and approaches in the approved Evaluation Design, an assessment of the implementation of the demonstration amendment, lessons learned thereof, and best practices for similar situations. The state will be required to track expenditures associated with this amendment, including but not limited to, administrative costs and program expenditures. The Final Report shall include an assessment of the linkage between those expenditures and the state's response to the PHE. For each year of the amendment, to satisfy the requirements set in 42 CFR 431.428(a), the state may submit any applicable information as part of the Final Report. CMS's section 1115 demonstration evaluation guidance "Preparing the Evaluation Report"[1] provides pertinent instructions that would be helpful in preparing the consolidated Final Report. The state should customize the content of the Final Report to align with the specific scope of the demonstration amendment. CMS will provide additional technical assistance on the structure and content of the Final Report.

[1] Available at https://www.medicaid.gov/sites/default/files/2020-02/preparing-the-evaluation-report.pdf.