UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA
Civil Action No. 1:19-cv-02848-JEB

MONTE A. ROSE, JR.
[redacted]

CHELSEY LANG
[redacted]

EMILY RAMES
[redacted]

Plaintiffs,

v.

XAVIER BECERRA
SECRETARY, UNITED STATES
DEPARTMENT OF HEALTH AND
HUMAN SERVICES
in his official capacity
200 Independence Avenue, S.W.
Washington, DC 20201

CHIQUITA BROOKS-LASURE
ADMINISTRATOR, CENTERS FOR
MEDICARE AND MEDICAID SERVICES
in her official capacity
7500 Security Boulevard
Baltimore, MD 21244

UNITED STATES DEPARTMENT OF
HEALTH AND HUMAN SERVICES
200 Independence Avenue, S.W.
Washington, DC 20201

CENTERS FOR MEDICARE AND
MEDICAID SERVICES
7500 Security Boulevard
Baltimore, MD 21244

Defendants.

SUPPLEMENTAL COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

PRELIMINARY STATEMENT

1. Congress enacted the Medicaid Act to furnish medical assistance on behalf of people whose income and resources are insufficient to meet the costs of necessary care. The Medicaid Act sets out a deal for states that wish to participate. States are guaranteed federal funding for a substantial percentage of the ongoing costs of providing medical assistance to their low-income residents in exchange for their compliance with federal requirements. These requirements include critical protections for low-income people, including prohibiting states from imposing premiums on some population groups, mandating that states provide retroactive coverage, and directing states to ensure that beneficiaries have access to non-emergency medical transportation (NEMT) to and from Medicaid services.

2. Section 1115 of the Social Security Act allows the Secretary of Health and Human Services ("the Secretary" or HHS) to waive certain Medicaid requirements for the period of time needed for a State to carry out an experimental project that is likely to assist in promoting the objectives of the Medicaid Act. Purporting to invoke this authority, the Secretary has permitted Indiana to ignore the premium, retroactive coverage, and NEMT protections for more than 15 years.

3. In 2007, Indiana applied for a Section 1115 project to expand health coverage to adults who, at the time, were not eligible for coverage under the Medicaid Act. In approving the Healthy Indiana Plan (HIP) project for five years, the Secretary allowed Indiana to impose limits on coverage for this not-otherwise-eligible group, including charging monthly premiums and terminating coverage for failure to pay, imposing lockout penalties for noncompliance with certain

features of the project, eliminating retroactive coverage, and eliminating coverage of NEMT. Indiana began implementing the project on January 1, 2008.

4. Between 2012 and 2018, the HIP project was extended several times and rebranded as "HIP 2.0" in 2015. In 2018, the Secretary, acting through the Centers for Medicare & Medicaid Services (CMS), approved another extension of the project for three more years and also allowed Indiana to add work requirements to the existing restrictions on coverage. This lawsuit followed.

5. Between 2018 and 2020, Indiana suspended implementation of the redetermination lockout penalty, work requirements, and premium requirements being challenged by Plaintiffs. Nevertheless, in October 2020, the Secretary approved yet another extension of the HIP 2.0 project, this time conditioning approval of the work requirements, the six-month lockout penalty for failure to pay premiums, and the redetermination lockout penalty on the Supreme Court issuing a decision in *Gresham v. Azar*—a related case challenging approval of Arkansas's Section 1115 project—"that legally authorizes these elements." The Supreme Court did not issue such a decision, so Indiana does not have authority to implement those features of the project.

6. CMS announced in February of 2021 that it was commencing a review of the waiver authorities it had approved only four months earlier. The outcome of that review was announced in a December 22, 2023 decision letter. After extensively discussing the cumulative evidence of the harm caused by premiums, CMS reaffirmed the extension of the project, specifically the premium, retroactive coverage, and NEMT restrictions. CMS justified its decision on the grounds that stopping the premiums would cause administrative chaos for the State. However, the State has not imposed premiums for nearly four years and does not plan to reinstate them until July 2024. Equally confounding, the December 2023 decision was announced just a month after CMS had cited much of the same evidence (including evidence from Indiana) to deny another state's request

to continue imposing premiums through Section 1115, having already denied the requests of two other states for the same reasons. In those decision letters, CMS concluded that premiums are not likely to promote the objectives of the Medicaid Act.

7. The HIP extension has harmed and will continue to harm Plaintiffs and individuals throughout the State who need health care to address a range of health care needs, including Long COVID, inner-ear problems, vision and dental needs, genetic counseling, and ongoing primary care. Without access to Medicaid coverage, Medicaid enrollees will be forced to forgo treatment for their conditions or will incur significant medical debt when they experience medical emergencies or their conditions leave them with no choice but to seek treatment in acute and emergency department settings.

8. In approving the 2020 HIP extension, and in approving the extension for another decade, the Secretary exceeded his authority under Section 1115 and failed to engage in reasoned decision-making in considering whether the project met the criteria for approval under the statute. This failure continued with his December 2023 decision to allow Indiana to proceed with the remainder of the project, including the premiums and associated penalties for failure to pay, despite the decision letter's extensive discussion and repeated recognition of the significant evidence of their detrimental effect on coverage. Accordingly, the approval violated the Administrative Procedure Act and the Social Security Act and should be vacated.

JURISDICTION AND VENUE

9. This case seeks declaratory and injunctive relief for violation of the Administrative Procedure Act and the Social Security Act.

10. The Court has jurisdiction over Plaintiffs' claims pursuant to 28 U.S.C. §§ 1331 and 1361 and 5 U.S.C. §§ 702 to 705. This action and the remedies it seeks are further authorized by 28 U.S.C. §§ 1651, 2201, and 2202, and Federal Rule of Civil Procedure 65.

11. Venue is proper under 28 U.S.C. § 1391(b)(2) and (e).

PARTIES

12. Plaintiff Monte A. Rose, Jr. is a 52-year-old resident of Bloomington, Indiana and is enrolled in HIP.

13. Plaintiff Chelsey Lang is a 30-year-old resident of Indianapolis, Indiana and is enrolled in HIP.

14. Plaintiff Emily Rames is a 29-year-old resident of Lafayette, Indiana and is enrolled in HIP.

15. Defendant Xavier Becerra is Secretary of the United States Department of Health and Human Services (HHS) and is sued in his official capacity. Secretary Becerra ("the Secretary") has overall responsibility for implementation of the Medicaid program, including federal review and approval of state requests for waivers pursuant to Section 1115 of the Social Security Act.

16. Defendant Chiquita Brooks-LaSure is Administrator of the Centers for Medicare & Medicaid Services and is sued in her official capacity. Administrator Brooks-LaSure is responsible for implementing the Medicaid program as required by federal law.

17. Defendant United States Department of Health and Human Services is a federal agency with responsibility for overseeing implementation of provisions of the Social Security Act, of which the Medicaid Act is a part.

18. Defendant Centers for Medicare & Medicaid Services is the agency within HHS with primary responsibility for overseeing federal and state implementation of the Medicaid Act as required by federal law.

STATUTORY AND REGULATORY BACKGROUND

A. The Medicaid Program

19. Title XIX of the Social Security Act establishes the cooperative federal-state medical assistance program known as Medicaid. *See* 42 U.S.C. §§ 1396 to 1396w-7. Medicaid's stated purpose is to enable each state, as far as practicable, "to furnish [ ] medical assistance" to individuals "whose income and resources are insufficient to meet the costs of necessary medical services" and to provide "rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care." *Id*. § 1396-1.

20. The statute defines "medical assistance" to include a range of "care and services" that participating states must cover or are permitted to cover. *Id*. § 1396d(a).

21. Although states do not have to participate in Medicaid, all states do.

22. Each participating state must maintain a comprehensive state Medicaid plan for medical assistance that the Secretary has approved. *Id*. § 1396a.

23. The state Medicaid plan must describe the state's Medicaid program and affirm its commitment to comply with the requirements imposed by the Medicaid Act and its associated regulations.

24. States and the federal government share responsibility for funding Medicaid. Section 1396b requires the Secretary to pay each participating state the federal share of "the total amount expended . . . as medical assistance under the State plan." *Id.* §§ 1396b(a)(1), 1396d(b). In general, the federal reimbursement rate is based on the state's relative per capita income. However, states

receive a 90% federal match for medical assistance provided to the adult population group covered as a result of the Affordable Care Act (ACA). *Id.* § 1396d(y).

B. Medicaid Eligibility and Coverage Requirements

25. Using household income and other specific criteria, the Medicaid Act sets forth who is eligible to receive Medicaid coverage. *Id.* § 1396a(a)(10)(A), (C). The Act identifies required coverage groups as well as options for states to extend Medicaid to additional groups. *Id.*

26. To be eligible for federal Medicaid funding, states must cover, and may not exclude from Medicaid, individuals who: (1) are part of a mandatory population group; (2) meet the minimum financial eligibility criteria applicable to that population group; (3) are residents of the state in which they apply; and (4) are U.S. citizens or certain qualified immigrants. *Id.* § 1396a(a)(10)(A), 1396a(b)(2), (3); 8 U.S.C. §§ 1611, 1641.

27. Before the ACA, mandatory Medicaid population groups included children; parents and other caretaker relatives; pregnant women; and the elderly, blind, and disabled. 42 U.S.C. § 1396a(a)(10)(A)(i). States must also provide at least twelve months of transitional medical assistance (TMA) to certain parents and caretaker relatives when they lose eligibility for Medicaid due to an increase in hours of, or income from, work. *Id.* §§ 1396r-6, 1396u-1(b)(1)(A).

28. In 2010, Congress passed, and the President signed, comprehensive health insurance reform legislation, the Patient Protection and Affordable Care Act. Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029. "The Act aims to increase the number of Americans covered by health insurance and decrease the cost of health care." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 538 (2012).

29. As part of the ACA, Congress amended the Medicaid Act to add a mandatory population group. Effective January 1, 2014, the Medicaid Act requires states to cover adults who are under age 65, are not eligible for Medicare, do not fall within another Medicaid eligibility category, and have household income below 133% of the federal poverty level (FPL). 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII), 1396a(e)(14). This group, often called the "expansion population," includes adults in a variety of family circumstances: parents (whose incomes exceed the state-established limit for the mandatory parent/caretaker population group); parents of older children who have left the home; and adults without children.

30. As noted, states receive enhanced federal reimbursement (90%) for medical assistance provided to the expansion population. *Id.* § 1396d(y).

31. In *National Federation of Independent Business v. Sebelius*, the U.S. Supreme Court held that HHS could not terminate all Medicaid funding to states if they fail to extend Medicaid coverage to the expansion population. 567 U.S. 519 (2012).

32. States that cover the expansion population submit state plan amendments electing this coverage. To date, 41 states (including D.C.) have implemented Medicaid expansion.

33. Indiana has an approved state Medicaid plan that covers the expansion population. State Plan Amendment IN-15-0001-MM1, https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/IN/IN-15-0001-MM1.pdf.

34. Once a state elects to expand coverage to the expansion population, it becomes a mandatory coverage group.

35. As noted above, the Medicaid Act gives states the option to extend Medicaid eligibility to cover additional low-income population groups. 42 U.S.C. § 1396a(a)(10)(A)(ii), 1396a(a)(10)(C) (describing optional population groups).

36. Participating states must extend Medicaid to *all* members of a covered population group and may not cover subsets of a population group described in the Act. *Id.* § 1396a(a)(10)(B). This requirement applies to optional and mandatory population groups. *Id*.

37. States cannot impose additional eligibility requirements that are not explicitly allowed by the Medicaid Act. *Id.* § 1396a(a)(10)(A).

38. In addition to addressing *who* is eligible for medical assistance, the Medicaid Act delineates *how* states must make and implement eligibility determinations to ensure that all eligible people who apply get coverage.

39. States must determine eligibility and provide medical assistance to all eligible individuals with "reasonable promptness." 42 U.S.C. § 1396a(a)(8); 42 C.F.R. § 435.912(c)(3) (requiring states to determine eligibility within 90 days for individuals who apply on the basis of disability and 45 days for all others). An individual may apply for and enroll in Medicaid at any time. 42 U.S.C. § 1396a(a)(8); 42 C.F.R. § 435.906.

40. Multiple Medicaid Act provisions require states to provide retroactive coverage for medical assistance provided in or after the third month before the month of application, as long as the enrollee would have been eligible for Medicaid at the time the services were received. 42 U.S.C. §§ 1396a(a)(34), 1396a(a)(10), 1396d(a).

41. The purpose of the retroactive coverage provision is to protect individuals "who are eligible for [M]edicaid but do not apply for assistance until after they have received care, either because they did not know about the [M]edicaid eligibility requirements or because the sudden nature of their illness prevented their applying." S. Rep. No. 92-1230, at 209 (1972); Social Security Amendments of 1965, Pub. L. No. 89-97, § 1905(a), 79 Stat. 286, 351-52. The provision ensures that low-income individuals can obtain timely care and avoid medical debt.

42. The Medicaid Act sets forth mandatory services that participating states must include in their Medicaid programs and optional services that participating states may include in their Medicaid programs. 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a).

43. States must ensure that Medicaid enrollees have necessary transportation to and from Medicaid services, referred to as non-emergency medical transportation (NEMT). *See* 42 U.S.C. § 1396a(a)(4); 42 C.F.R. § 431.53; *see also* 42 U.S.C. § 1396u-7(a)(1)(F) (requiring states to ensure provision of NEMT to individuals receiving benchmark-related coverage).

44. The Medicaid Act also establishes the states' options for imposing premiums and cost sharing on enrollees. To ensure affordability, the Act permits states to impose premiums and cost sharing only in limited circumstances.

45. In 1982, Congress amended the Medicaid Act to remove the substantive premium and cost sharing provisions from Section 1396a, amend them, and place them in a new provision, Section 1396*o*. Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, 96 Stat. 324, 367.

46. As a result of that amendment, Section 1396a, which generally lists the requirements that a state plan must satisfy, provides that "enrollment fees, premiums, or similar charges, and deductions, cost sharing, or similar charges" may be imposed "only as provided in section 1396*o*." 42 U.S.C. § 1396a(a)(14).

47. With respect to premiums, Section 1396*o* of the Medicaid Act provides that "no enrollment fee, premium, or similar charge will be imposed under the plan (except for a premium imposed under subsection (c))." *Id.* § 1396*o*(a)(1). Subsection (c) authorizes limited premiums, but generally prohibits a state from imposing any premiums on anyone whose income falls below 150% of FPL. *Id.* § 1396*o*(c)(1).

48. In 2006, Congress added Section 1396*o*-1 to specify additional flexibilities for states to impose premiums and cost sharing on enrollees; however, this provision likewise prohibits a state from imposing premiums on anyone with household income below 150% of FPL. Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4, 82 (codified at 42 U.S.C. § 1396*o*-1(b)(1)(A)).

49. Nothing in Section 1396*o* or 1396*o*-1 gives the Secretary authority to waive the limits on premiums.

50. Over the years, Congress has amended the Medicaid Act to allow states to require certain Medicaid-eligible individuals to enroll in employer-sponsored group health plans. *See* 42 U.S.C. §§ 1396e, 1396e-1. States electing this option must maintain the premium protections set forth in Section 1396*o*. *Id*. §§ 1396e(a)(3), 1396e-1(e).

51. The Medicaid Act requires states to "provide such safeguards as may be necessary to assure that eligibility for care and services . . . and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients." *Id*. § 1396a(a)(19).

C. The Secretary's Section 1115 Waiver Authority

52. Section 1115 of the Social Security Act, codified at 42 U.S.C. § 1315, grants the Secretary a limited authority to waive a state's compliance with certain requirements of the Medicaid Act under certain conditions. The Secretary exercises this authority through CMS.

53. The Secretary may grant a Section 1115 Medicaid waiver only in the case of an "experimental, pilot, or demonstration project which . . . is likely to assist in promoting the objectives" of the Medicaid Act. *Id*. § 1315(a).

54. The Secretary may only waive requirements of Section 1396a of the Medicaid Act. *Id*. § 1315(a)(1).

55. The Secretary may not waive compliance with requirements that Congress has placed outside of Section 1396a.

56. The Secretary may grant a Section 1115 waiver only "to the extent and for the period . . . necessary" to enable the state to carry out the experimental, pilot, or demonstration project. *Id*.

57. Section 1115 does not provide the Secretary with a freestanding expenditure authority. Section 1115(a)(2) provides that the costs of an experimental project, upon approval, are regarded as expenditures under the state Medicaid plan.

58. The Secretary must follow procedural requirements before approving a Section 1115 project. *Id*. § 1315(d); 42 C.F.R. §§ 431.400 to 431.416. After receiving a complete application from a state (following a state-level public comment period), the Secretary must provide a 30-day public notice and comment period. 42 U.S.C. § 1315(d); 42 C.F.R. § 431.416.

59. Section 1115 places explicit limits on any extension of "state-wide, comprehensive demonstration projects." 42 U.S.C. §§ 1315(e), (f). The statute permits an initial extension of a state-wide comprehensive project of up to three years, or for a project involving individuals eligible for both Medicare and Medicaid (known as "dual eligibles"), up to five years. *Id*. § 1315(e)(1)-(2). The statute permits one subsequent extension of a state-wide comprehensive project "for a period not to exceed three years," or in the case of a project involving dual eligibles, not to exceed five years. *Id*. § 1315(f)(6).

60. In 2017, CMS issued an Informational Bulletin announcing its intent to "[w]here possible and subject to the public notice and transparency requirements . . . approve the extension of *routine, successful, non-complex*" Section 1115(a) waivers for a period of up to 10 years. CMS,

CMCS Informational Bulletin 3 (Nov. 6, 2017), https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/cib110617.pdf (emphasis added) ("2017 Informational Bulletin").

61. CMS did not explain how this new policy could possibly comply with Section 1115, which only permits the Secretary to waive provisions of Section 1396a to the extent and for the period necessary to enable a state to carry out an experimental, pilot, or demonstration project. *See* 42 U.S.C. § 1315(a)(1), (2).

D. Medicaid in Indiana and the Healthy Indiana Plan

62. Indiana has elected to participate in Medicaid. *See* Ind. Code §§ 12-15-1 to 12-15-44.5 (2019); 405 Ind. Admin. Code. The Indiana Family and Social Services Administration (FSSA) administers the program at the state level.

63. The federal government generally reimburses Indiana for approximately 65% of the cost of providing medical assistance through its Medicaid program. *See* 88 Fed. Reg. 81090, 81092 (Nov. 21, 2023). However, as noted above, the federal government reimburses Indiana for 90% of the cost of providing medical assistance to the expansion population. *See* 42 U.S.C. § 1396d(y).

64. In 2007, Indiana passed legislation to extend health care coverage to low-income adults who, at the time, were not otherwise eligible for coverage under the Medicaid Act. 2007 Ind. Acts 3525.

65. To implement that legislation, Indiana submitted an application for a Section 1115 project called the Healthy Indiana Plan (HIP). CMS approved the project, effective January 1, 2008 through December 31, 2012. Letter from Kerry Weems, Acting Adm'r., CMS, to E. Mitchell Roob, Jr., Sec'y, Ind. Fam. & Soc. Servs. Admin. (Dec. 14, 2007) ("2007 Approval Letter") (Ex. A, hereto).

66. The approval allowed the State to operate a comprehensive, state-wide project covering adults who were not otherwise eligible for Medicaid or Medicare, had been uninsured for six months, did not have access to coverage through their job, and had household income up to 200% of FPL. CMS, Special Terms and Conditions HIP 9 (2007) ("2007 STCs") (Ex. B, hereto).

67. Indiana designed HIP to resemble a commercial high-deductible health insurance plan. *Id*. at 2. According to the Secretary's approval, the State was "test[ing] a model of health coverage that emphasizes private health insurance, personal responsibility, and 'ownership' of health care." 2007 Approval Letter at 2.

68. As such, the Secretary permitted Indiana to impose a number of restrictions on coverage, including: setting annual and lifetime limits on benefits, 2007 STCs at 18; charging enrollees monthly premiums, *id*. at 20-21; terminating coverage for enrollees who do not pay their premiums and prohibiting them from re-enrolling in HIP for 12 months, *id*. at 25; imposing a lockout penalty on individuals who did not complete the redetermination process by the deadline, *id*. at 26; eliminating retroactive eligibility, *id*. at 48; and eliminating NEMT, *id*. at 47.

69. Enrollees paid their monthly premiums into a Personal Wellness and Responsibility (POWER) account. *Id*. at 10. Generally, enrollees used the account to pay for health care (other than preventive services) until they reached their deductible. *Id*. Enrollees with money remaining in the POWER account at the end of the 12-month eligibility period could rollover the balance to the following year to reduce the amount of their monthly premiums. *Id*. at 24. However, enrollees who did not receive all recommended preventive services during the eligibility period could only rollover any amounts that they—not the State—may have contributed to the account. *Id*.

70. HIP began operation on January 1, 2008.

71. After passage of the ACA in 2010, the Indiana legislature gave the Secretary of FSSA permission to amend HIP "in a manner that would allow Indiana to use the plan to cover" the Medicaid expansion population. 2011 Ind. Acts 1653.

72. Between 2012 and 2015, CMS approved several short-term extensions of HIP while it continued negotiations with Indiana regarding coverage of the expansion population. These extensions also included some modifications to the project. For example, in 2013, the Secretary allowed Indiana to drop the income eligibility limit to 100% of FPL. *See* Letter from Cindy Mann, Dir., Ctr. for Medicaid & CHIP Servs., to Debra F. Minott, Sec'y, Ind. Fam. & Soc. Servs. Admin. (Sept. 3, 2013).

73. Indiana contracted with an outside evaluator to assess the effect of HIP. *See* Ind. Fam. & Soc. Servs. Admin., *HIP 2.0 1115 Waiver Application*, 10 (2014), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-exp-app-07022014.pdf ("2014 Waiver Application").

74. In July 2014, Indiana submitted an application to extend HIP, now labelled HIP 2.0, for five more years, with several modifications. In particular, Indiana proposed to include parents/caretakers and the entire Medicaid expansion population in the project as a way to "replace traditional Medicaid for all non-disabled adults ages 19-64." 2014 Waiver Application at 4.

75. In January 2015, CMS approved HIP 2.0 for three years, effective February 1, 2015. Letter from Marilyn Tavenner, Adm'r. CMS, to Joseph Moser, Medicaid Dir., Ind. Fam. & Soc. Servs. Admin. (Jan. 27, 2015) ("2015 Approval Letter"); CMS, Waiver List for HIP 2.0 ("2015 Waiver List"); CMS, Special Terms and Conditions HIP 2.0 (2015) ("2015 STCs"), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/

downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-appvl-01272015.pdf. As approved, HIP 2.0 included parents/caretaker relatives, individuals receiving TMA, and the Medicaid expansion population. 2015 STCs at 8-9.

76. Effective February 1, 2015, Indiana amended its state plan to include coverage of the Medicaid expansion population. State Plan Amendment IN-15-0001-MM1, https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/IN/IN-15-0001-MM1.pdf.

77. The features of HIP 2.0 mirrored those of the initial HIP project. In approving HIP 2.0, the Secretary allowed Indiana to: charge enrollees monthly premiums; terminate coverage for individuals with household incomes above 100% of FPL who do not pay their premiums and prohibit them from re-enrolling in the project for six months; eliminate retroactive eligibility; and eliminate NEMT for the expansion population. 2015 Waiver List at 1-3; *see also* Letter from Eliot Fishman, Dir., CMS State Demonstrations Grp., to Joseph Moser, Medicaid Dir., Ind. Fam. & Soc. Servs. Admin. (Nov. 25, 2016), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-nemt-temp-ext-ltr-11252016.pdf (extending the NEMT waiver through January 31, 2018).

78. In addition, the approval of HIP 2.0 allowed Indiana to offer two different benefit packages to individuals in the expansion population, HIP Basic and HIP Plus, with HIP Plus covering all HIP Basic services plus vision and dental care. 2015 STCs at 14. With the exception of medically frail individuals, expansion enrollees with household incomes at or below 100% of FPL who did not pay their monthly premiums received HIP Basic. *Id*.

79. Indiana contracted with an outside evaluator to assess certain features of the HIP 2.0 project. *See, e.g.,* Lewin Grp., *Indiana HIP 2.0 Interim Evaluation Report* (2016), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-interim-evl-rpt-07062016.pdf; Lewin Grp., *Indiana HIP 2.0: POWER Account Contribution Assessment* (2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf ("Lewin POWER Account Contribution Assessment"); Lewin Grp,, *Indiana HIP 2.0: Final Evaluation of Non-Emergency Medical Transportation (NEMT) Waiver* (2016), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-nemt-final-evl-rpt-11022016.pdf.

80. In January 2017, Indiana applied to extend HIP 2.0 for three years. Ind. Fam. & Soc. Servs. Admin., *Healthy Indiana Plan: Section 1115 Waiver Extension Application* (Jan. 31, 2017) ("2017 HIP 2.0 Extension Application"); Letter from Gov. Eric J. Holcomb to Norris Cochran, Acting Sec'y, Dep't of Health & Hum. Servs. (Jan. 31, 2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-demo-app-02152017.pdf.

81. In its extension application, Indiana requested permission to "maintain and develop" HIP 2.0 "as Congress and the Administration develop much needed plans for repealing and replacing ObamaCare." Letter from Holcomb to Cochran (Jan. 31, 2017).

82. Indiana reiterated that it designed HIP 2.0 to "align with standard commercial market policies to educate members and prepare them" to use private insurance coverage. 2017 HIP 2.0 Extension Application at 4.

83. Indiana stated that HIP 2.0 "empower[s] enrollees to become active consumers of healthcare services." The POWER account and premiums "give[] participants 'skin-in-the-game' and provide[] a financial incentive for members to . . . adopt[] healthy behaviors and to seek price transparency to make value conscious decisions, leading to better health outcomes. . . ." *Id*. Indiana requested to re-implement the redetermination lockout penalty to encourage enrollees "to take personal responsibility" and to prepare them for commercial coverage. *See id*. at 27-28.

84. In the same application package, Indiana proposed to add a substance use disorder program for individuals with substance use disorder. *Id*. at 33-37.

85. In May 2017, Indiana submitted an amendment to its application to extend HIP 2.0, requesting permission to add work requirements to the project. *See* Letter from Gov. Eric J. Holcomb to "Fellow Hoosiers" (May 24, 2017), https://www.in.gov/fssa/hip/files/HIP_Amendment_EJH_Letter.pdf; Ind. Fam. & Soc. Servs. Admin., *Amendment Request to Healthy Indiana Plan (HIP) Section 1115 Waiver Extension Application*, 4-8 (May 24, 2017), https://www.in.gov/fssa/hip/files/HIP_Amendment_-_FINAL_Publication_Version.pdf; *see also* Letter from Gov. Eric J. Holcomb to Thomas Price, Sec'y, Dep't of Health & Human Servs. (July 20, 2017); Ind. Fam. & Soc. Servs. Admin., *Amendment Request to Healthy Indiana Plan (HIP) Section 1115 Waiver Extension Application* (July 20, 2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-demo-app-07202017.pdf.

86. On February 1, 2018, CMS approved Indiana's amended request to renew HIP through December 31, 2020. Letter from Demetrios L. Kouzoukas, Principal Deputy Adm'r., CMS, to Allison Taylor, Medicaid Dir., Ind. Fam. & Soc. Servs. Admin. (Feb. 1, 2018) ("2018 Approval Letter"); CMS, HIP Special Terms and Conditions ("2018 STCs"); CMS, HIP Waiver List ("2018 Waiver List"), https://www.medicaid.gov/sites/default/files/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-cms-amend-appvl-02012018.pdf.

87. The CMS approval also authorized Indiana to implement the "Opioid Use Disorder (OUD)/Substance Use Disorder (SUD) Program" ("the SUD Program"). 2018 STCs at 29-37. After the approval, Indiana submitted separate quarterly reports and separate evaluation designs for HIP and the SUD Program. *See* Healthy Indiana Plan, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81641 (last accessed Jan. 31, 2024). The SUD Program, which, as noted below, has been amended to include people diagnosed with serious mental illness (SMI), is a separate project. (Thus, as used in this Supplemental Complaint, terms such as "the extended HIP project," "the 2020 HIP extension," or "the approved 2020 HIP extension" do not incorporate the SUD/SMI Program.)

88. The 2018 extension applied to the same state plan population groups as the initial HIP 2.0 project, as well as to pregnant women with household incomes up to 133% of FPL. *See* 2018 STCs at 8-9.

89. In granting the 2018 extension, the Secretary described the objectives of the project as to "improve health outcomes, promote increased upward mobility and improve quality of life, increase individual engagement in health care decisions, and prepare individuals who transition to

commercial health insurance coverage to be successful in this transition." 2018 Approval Letter at 6; *see also id*. at 3 (listing the factors CMS examined in considering the project).

90. Effective October 18, 2018, Indiana paused implementation of the redetermination lockout penalty.

91. On September 23, 2019, Plaintiffs filed their Complaint challenging the HIP 2.0 extension, alleging that the approval violated the Administrative Procedure Act and the Constitution. Compl., ECF No. 1.

92. On October 31, 2019, Indiana paused implementation of the work requirements as a result of this case. News Release, Ind. Fam. & Soc. Servs. Admin., *Pending Resolution of Federal Lawsuit, FSSA Will Temporarily Suspend Gateway to Work Reporting Requirement* (2019), https://www.in.gov/fssa/files/Gateway_to_Work_suspension_announcement.pdf.

E. 2020 Extension and Amendment of the Healthy Indiana Plan

93. With the 2018 extension set to expire at the end of 2020, Indiana submitted an application to CMS requesting a 10-year extension of HIP "with no substantive changes." Ind. Fam. & Soc. Servs. Admin., *Renewal Request for the Healthy Indiana Plan (HIP) Section 1115 Waiver*, 1, 4 (Jan. 31, 2020), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/in-healthy-indiana-plan-support-20-pa8.pdf. (the "2020 HIP Extension Application Amendment"). Indiana asked for the 10-year extension "[b]ased on the long-tenure and demonstrated success of HIP," *id*. at 4, stating that shorter approval periods "create[] unnecessary administrative burdens for the State and federal government, and do[] not meaningfully enhance the oversight or transparency of the demonstration, *id*. at 5." *See also id*. at 29-31 (citing the 2017 Informational Bulletin).

94. In a separate document, the State requested a five-year extension of the SUD Program, which had recently been amended to include services for people diagnosed with serious mental illness (SMI). *See* Ind. Fam. & Soc. Servs. Admin., *Renewal Request for the Healthy Indiana Plan (HIP) Section 1115 Waiver – Substance Use Disorder & Serious Mental Illness IMD Waiver*, (Jan. 31, 2020), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/in-healthy-indiana-plan-support-20-pa8.pdf.

95. CMS held a public comment period on the application from February 21, 2020 through March 21, 2020. Nearly 200 comments were submitted to CMS online. *See* Medicaid.gov, Comments Received for Healthy Indiana Plan – State Extension Request, https://1115publiccomments.medicaid.gov/jfe/form/SV_6XuSeaFpQMzTaMB (last visited Jan. 31, 2024).

96. When the COVID-19 pandemic hit the United States, Indiana suspended the premium requirements. *See* Gov. Eric Holcomb, Exec. Order No. 20-05 (Mar. 19, 2020), https://www.in.gov/gov/files/EO_20-05.pdf. The State also suspended all cost-sharing for HIP beneficiaries and automatically enrolled all eligible applicants in HIP Plus. *See* HIP DY 7 Annual Report 2021 at 4 (Mar. 30, 2022), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/in-healthy-indiana-plan-hip-dy-annul-rprt.pdf.

97. Seven months later, on October 26, 2020, the Secretary approved Indiana's extension application. *See* Letter from Anne Marie Costello, Acting Deputy Adm'r., CMS, to Allison Taylor, Medicaid Dir., Ind. Fam. & Soc. Servs. Admin. (Oct. 26, 2020) ("2020 Approval Letter"); CMS, HIP Special Terms and Conditions ("2020 STCs"); CMS, HIP Waiver List ("2020 Waiver List"), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/in-healthy-indiana-plan-support-20-ca-01012021.pdf.

98. The 2020 HIP extension applies to the same population groups as the 2018 extension. *See* 2020 STCs at 8-10.

99. All of the population groups affected by HIP 2.0 continue to be described in the Medicaid Act and to derive their eligibility as state Medicaid plan populations covered by Indiana's approved state Medicaid plan. *Id*. at 9.

100. The 2020 HIP extension includes the same key features as the 2018 extension. However, the Secretary conditioned approval of the work requirements, the lockout penalty for failure to pay premiums, and the redetermination lockout penalty on the Supreme Court issuing a decision in *Gresham v. Azar* "that legally authorizes these elements." 2020 Approval Letter at 1; 2020 Waiver List at 2.

101. The Secretary approved the remaining features of the HIP extension for a 10-year period. 2020 Approval Letter at 2.

102. The Secretary approved the SUD/SMI Program for a five-year period. *Id*.

103. The approval stated that HIP would continue "to furnish medical assistance and other services to vulnerable populations," which he acknowledged was "an important objective of the Medicaid program." 2020 Approval Letter at 2.

104. As support for the finding that the demonstration will promote coverage, the Secretary pointed only to the SUD/SMI Program. *Id*. at 7-8.

105. The Secretary did not estimate how many individuals would lose coverage as a result of the waivers.

106. The Secretary did not meaningfully respond to the concerning data raised by commentators regarding the HIP extension's negative impacts on coverage.

107. Rather than explain how the HIP project would promote coverage, the Secretary stated that the project would "improve the sustainability of the safety net, *id*. at 8-10, promote financial independence among beneficiaries, leading to better health outcomes, *id*. at 10-12, and remove potential obstacles to a successful transition to commercial coverage, *id*. at 12-13.

108. The Supreme Court did not issue a decision in *Gresham v. Azar* that "legally authorizes" work requirements or lockout penalties. *See Becerra v. Gresham*, 142 S. Ct. 1665 (2022) (vacating the D.C. Circuit opinion and remanding to that court with instructions to direct the district court to vacate its judgment and dismiss the case as moot under *United States v. Munsingwear, Inc.*, 340 U.S. 36 (1950)).

109. In February 2021, CMS notified Indiana that it had "preliminarily determined" that the work requirements "would not promote the objectives of the Medicaid program," and it was beginning a process of determining whether to withdraw its conditional approval of the requirements. *See* Letter from Elizabeth Richter, Acting Adm'r, CMS, to Allison Taylor, Medicaid Dir., Ind. Fam. & Soc. Servs. Admin. 1 (Feb. 12, 2021), https://www.medicaid.gov/sites/default/files/2021-02/in-healthy-indiana-plan-support-20-cms-ltr-state-demo-02122021.pdf ("February 2021 Letter"). CMS also informed the State that it was reviewing the other waiver authorities approved as part of the HIP 2.0 project and would follow up with the state upon completion of that review. *Id*. at 2.

110. In June 2021, CMS withdrew its conditional approval of Indiana's work requirements based on its determination that they are not likely to promote the objectives of the Medicaid Act. *See* Letter from Chiquita Brooks-LaSure, Adm'r, CMS, to Allison Taylor, Medicaid Dir., Ind. Fam. & Soc. Servs. Admin. (June 24, 2021), https://www.medicaid.gov/sites/default/files/2023-12/in-healthy-indiana-plan-cms-withdr-commu-engmnt.pdf ("June 2021 Letter"). As a result, the

work requirements and lockout penalties are no longer a part of the approved HIP 2.0 project. In the same letter, CMS reiterated that its re-assessment of the other waiver authorities approved in 2020 was ongoing. *Id*. at 23.

The key features of the HIP project that remain in place are described in detail below.

Monthly Premiums and Penalties for Failure to Pay

111. With the exception of pregnant women, HIP continues to charge enrollees at all income levels monthly premiums. 2020 STCs at 19; 2023 Letter at 2.

112. The Secretary has approved Indiana to charge the following premiums: $1 per month for individuals with incomes 0-22% of FPL; $5 per month for individuals with incomes 23-50% of FPL; $10 per month for individuals with incomes 51-75% of FPL; $15 per month for individuals with incomes 76-100% of FPL; $20 per month for individuals with incomes 101-133% of FPL. 2020 STCs at 21-22.

113. Spouses each pay half of the monthly amount, with the exception of those with incomes below 22% of FPL, who each pay $1. *Id*.

114. The Secretary also approved a surcharge for tobacco use. Beginning in their second year of enrollment in HIP, individuals who use tobacco are charged an additional 50% on their premiums. *Id*. at 21-22.

115. CMS gave Indiana the authority to modify the amount of the premiums annually without requesting an amendment, so long as the premiums do not exceed 3% of household income. *Id*. at 22; 2020 Approval Letter at 6.

116. In general, HIP enrollees subject to the premium requirement do not receive Medicaid coverage until the first day of the month in which they pay the initial premium. *Id*. at 10.

117. Individuals with household incomes above 100% of FPL who do not pay their initial premium within 60 days of receiving an invoice are not enrolled in Medicaid. *Id*. at 19. Individuals who do enroll, but do not pay a subsequent monthly premium within 60 days of the due date, are terminated from Medicaid, unless they are determined medically frail. *Id*. at 23-24.

118. Individuals with household incomes at or below 100% of FPL who do not pay an initial or subsequent premium within 60 days of receiving an invoice are subject to copayments at the point of service. *Id*. at 19-20. Expansion enrollees who are not determined medically frail are subject to an additional penalty—they are moved into HIP Basic and receive fewer benefits (*i.e*., no vision, dental, and chiropractic services). *Id*. at 12, 19, 24.

119. Enrollees in HIP Basic cannot regain access to HIP Plus until their annual redetermination period, unless the State, at its sole discretion, adds additional times for transition back to HIP Plus. *Id*. at 19-20.

120. Enrollees may be required to spend up to 5% of household income per quarter on premiums and cost sharing combined. *See id*. at 24.

121. Indiana contracts with managed care organizations to deliver services to HIP 2.0 enrollees. The managed care organizations are responsible for billing for and collecting premiums from enrollees. *Id*. at 20.

122. In the 2018 approval letter, the Secretary described the purpose of the premiums and associated consequences for inability to pay as "to prepare beneficiaries to participate in the commercial market." 2018 Approval Letter at 7.

123. The 2020 approval letter described the purpose of the premiums as to help "prepare beneficiaries for their transition from Medicaid into a commercial health insurance plan," 2020 Approval Letter at 18, and to "improve beneficiary health and wellness," *id*. at 10. *See also id*. at

6 (stating that the tobacco surcharge "will continue to test whether incentivizing beneficiaries to change behavior and engage in their own healthcare will help achieve better health outcomes").

124. At the time of the 2020 extension, the imposition of premiums had been authorized in Indiana under Section 1115 for nearly 13 years–since January 1, 2008.

125. Data show the premiums and associated consequences for failure to pay have reduced enrollment in Medicaid in Indiana. *See, e.g.*, Lewin Power Account Contribution Assessment at ii, 8-12.

126. Commenters cited many previous studies of the effects of premiums on low-income individuals' health coverage. This redundant research consistently concludes that such premiums reduce enrollment in Medicaid.

127. Indiana has expressed its intent to resume the approved premium requirements in July 2024. Joint Status Rpt. ¶10 (Jan. 12, 2024) (ECF No. 49).

No Retroactive Eligibility

128. Under the HIP extension approval, enrollees (other than pregnant women), will not receive the three months' retroactive eligibility required by the Medicaid Act. 2020 Waiver List at 3. As outlined above, the State will generally only pay for services received on or after the first day of the month in which an individual pays their initial monthly premium. 2020 STCs at 10.

129. According to the 2020 approval letter, the waiver of retroactive eligibility is expected to improve beneficiary health by "improving uptake of preventive services." 2020 Approval Letter at 11. The Secretary explained that Indiana is testing whether the waiver will encourage individuals "to obtain and maintain health coverage, even when healthy, or to obtain health coverage as soon as possible after becoming eligible, rather than potentially waiting until they are sick, knowing that

the costs of the illness would be covered by a retroactive eligibility period." *Id*; *see also* 2018 Approval Letter at 5 (setting forth a similar rationale).

130. Commenters alerted CMS to data showing that the elimination of retroactive coverage reduces access to coverage among low-income individuals and has no effect on when individuals enroll in Medicaid.

131. At the time of the 2020 extension, the termination of retroactive coverage had been authorized in Indiana pursuant to Section 1115 for nearly 13 years—since January 1, 2008.

132. On December 23, 2023, CMS issued a decision allowing the State to maintain the waiver of this requirement without discussion. *See* Letter from Daniel Tsai, Deputy Adm'r and Dir., Ctr. for Medicaid & CHIP Servs., to Cora Steinmetz, Medicaid Dir., Ind. Fam. & Soc. Servs. Admin. 1 (Dec. 22, 2023) ("2023 Letter"), https://www.medicaid.gov/sites/default/files/2023-12/in-cms-ltr-to-the-state-12222023_1.pdf. ("December 2023 Letter").

Elimination of NEMT

133. The Secretary approved Indiana's request not to cover NEMT for HIP enrollees, with the exception of individuals determined medically frail, parents/caretakers, and pregnant women. *See* 2020 Waiver List at 2.

134. The Secretary stated that the purpose of the NEMT waiver is to enable Indiana to "better contain Medicaid costs and more efficiently focus resources on providing accessible and high-quality health coverage, thus improving the fiscal sustainability of the Medicaid program." 2020 Approval Letter at 8-9. This explanation reflects that the waiver of NEMT is nothing more than a cut in benefits.

135. Commenters cited evidence showing that many beneficiaries cannot access care without NEMT. While the Secretary pointed to a 2016 evaluation to support his contention that

the waiver of NEMT is not harmful, commenters explained that the evaluation actually shows that thousands of HIP members have missed appointments due to transportation barriers.

136. At the time of the 2020 extension, the elimination of NEMT had been authorized in Indiana under Section 1115 for nearly 13 years—since January 1, 2008.

137. The December 2023 Letter allowed the State to maintain the waiver of this requirement without discussion. *See* December 2023 Letter.

Length of Approval

138. The major difference between the 2020 HIP extension and the 2018 extension is the duration of the project.

139. In 2020, the Secretary explained that in deciding the length of the approval period, CMS "considered whether the authorities the state requested for a 10-year extension had been previously or currently implemented over a sufficient period of time to support a long-term extension . . . In addition, CMS looked into the evidence available on the importance, performance, and potential effectiveness of the various HIP demonstration components in making a determination about the approval period." 2020 Approval Letter at 4-5. The Secretary also justified the 10-year approval on the basis that short-term extensions and changes to program features over time made "a comprehensive and conclusive impact analysis . . . difficult to accomplish." *Id*. at 5. The approval letter acknowledged that "some of these policies have never before been approved by CMS for a period longer than five years, [but] CMS believes that—given the initial promising evidence for these policies . . . it is appropriate for CMS to extend this demonstration for a period of ten years." *Id*.

140. The approval letter did not reference CMS's existing policy regarding the criteria for the approval of a Section 1115 project for ten years, *see* 2017 Information Bulletin at 3 (limiting

ten-year approvals to "routine, successful, non-complex" waivers), or explain how a ten-year extension here was consistent with that policy. Nor did the letter acknowledge any statutory limits on extensions.

F. The December 2023 Decision to Allow HIP to Proceed

141. As noted above, in the February 2021 Letter concerning the work requirements, CMS informed the State that it was reviewing the other waiver authorities approved as part of the HIP project. February 2021 Letter at 2.

142. In the June 2021 Letter withdrawing approval for work requirements, CMS again stated that it was reassessing the other authorities previously approved in the HIP project. June 2021 Letter at 23.

143. On December 22, 2023, CMS announced the completion of its review of the 2020 HIP extension of premium requirements and waivers of retroactive eligibility and NEMT. *See* December 2023 Letter at 1.

144. CMS decided that it would maintain those authorities. CMS based the decision on its conclusion that withdrawal could be disruptive for the State as it prioritizes its efforts to unwind Medicaid eligibility for enrollees who kept Medicaid coverage during the COVID public health emergency (PHE). *Id*. at 1-2. This, despite the fact that Indiana has not been implementing the premium requirements for nearly four years and their planned resumption in July 2024 is what will result in a change to the status quo.

145. CMS cited extensive evidence showing that "premiums beyond those authorized under the Medicaid statute may reduce access to coverage and care among populations that Medicaid is designed to serve." *Id*. at 4-11. Most of the evidence CMS cited regarding the negative effects of premiums on access to coverage and care pre-dates the 2020 HIP extension. *See id*.

146. CMS stated that it is not aware of evidence indicating that charging beneficiaries premiums beyond those authorized in the Medicaid Act "facilitates coverage directly or indirectly." *Id*. at 10.

147. CMS went so far as to "encourage[]" the State to "terminate the premium requirement" if the State could do so "without impacting their PHE unwinding efforts." *Id*. at 2.

148. Two years earlier, CMS denied Arkansas's and Montana's requests to extend premium requirements through Section 1115 based on its determination that "premiums can present a barrier to coverage, and therefore, charging beneficiaries premiums beyond those specifically permitted under the Medicaid statute are not likely to promote the objectives of Medicaid." Letter from Chiquita Brooks-LaSure, Adm'r, CMS, to Dawn Stehle, Deputy Dir. for Health & Medicaid, Ark. Dep't of Hum. Servs. 2 (Dec. 21, 2021), https://www.medicaid.gov/sites/default/files/2021-12/ar-arhome-ca.pdf (allowing a non-renewable, one-year period to phase-out premiums) ("Arkansas 2021 Letter"); Letter from Chiquita Brooks-LaSure, Adm'r, CMS, to Marie Matthews, Medicaid Dir., Mont. Dep't of Pub. Health & Hum. Servs. 1 (Dec. 21, 2021), https://www.medicaid.gov/sites/default/files/2021-12/mt-HELP-program-ca.pdf (same) ("Montana 2021 Letter").

149. In November 2023, only one month prior to announcing its contrary decision for Indiana, CMS amended Wisconsin's Section 1115 project to eliminate the State's ability to impose monthly premiums. Once again, it explained, "CMS has determined that premiums can present a barrier to coverage, and therefore, charging beneficiaries premiums beyond those specifically permitted under the Medicaid statute are not likely to promote the objectives of Medicaid." Letter from Daniel Tsai, Deputy Adm'r and Dir., CMS, to Jamie Kuhn, State Medicaid Dir., Wis. Dep't

of Health Servs. 1 (Nov. 17, 2023), https://www.medicaid.gov/sites/default/files/2023-11/wi-badgercare-reform-cms-tmpry-extns-amndmt-aprvl.pdf.

150. In refusing to allow premiums to continue in Arkansas, Montana, and Wisconsin, CMS relied on "findings in recent research across different states with section 1115 demonstrations, which show that charging beneficiaries premiums . . . resulted in shorter enrollment spells, and were associated with lower initial enrollment rates and increased obstacles to accessing care in several states." *Id*. at 1-2; Arkansas 2021 Letter at 2; Montana 2021 Letter at 1-2. Indiana's experiences with premiums were included among CMS's evidence of harm. *Id*.

151. The December 2023 Letter did not discuss its decision to allow the waivers of retroactive coverage and NEMT to continue.

G. Effects of the HIP 2.0 Extension Approval on the Plaintiffs

152. The HIP premiums and associated consequences for inability to pay, elimination of retroactive coverage, and elimination of NEMT benefits have harmed and will continue to harm Plaintiffs. Specifically:

153. Plaintiff Monte A. Rose, Jr. is 52 years old and lives alone in Bloomington, Indiana.

154. He completed high school and took some college courses. In the past he was an attendant at a recycling facility, worked as a research assistant at Indiana University, and has been a reporter and columnist for local newspapers.

155. Mr. Rose does not currently have paid work or any income. He has started a nonprofit to provide green jobs and grow organic foods and hopes to one day become self-employed as administrator of the nonprofit.

156. He receives a housing subsidy from the Bloomington Housing Authority to pay for his rent and stretches utility assistance with frugal use of electricity. He was previously homeless

for a period of four years. Mr. Rose goes to his local food pantry for food, and he eats organic vegetables that he grows himself.

157. Mr. Rose does not have internet service in his home. He does not have a driver's license or a car. He rides a bicycle for his primary mode of transportation and for exercise. When medical appointments are too far to bike, he has had to hire a costly taxi, and as a result, sometimes missed appointments.

158. He has Meniere's disease, an inner ear condition that periodically causes migraines, vertigo, nausea, and ringing in his ears. He applied for disability in 2008 but was denied.

159. In addition, since 2020 Mr. Rose has contended with Long COVID, experiencing a number of symptoms including cardiac symptoms, glandular swelling, vision problems, fatigue, anxiety, and depression. He has also recently been diagnosed with hypothyroidism and frozen shoulder, due to an overactive autoimmune response.

160. He has been unable to find paid work that will accommodate his health conditions. Mr. Rose is an unpaid caregiver for an elderly friend.

161. Mr. Rose has been enrolled in HIP since approximately 2018. Since that time, he has used his coverage to obtain new glasses and to receive dental care, which he had not been able to access previously. In addition, he has received vaccinations, diagnostic tests, and treatment for his chronic health conditions. Mr. Rose still has medical debt from before he enrolled in HIP for emergency room visits.

162. Under the HIP extension, when the premium requirements are reinstated he will be required to pay $1 per month. In the past, he has been able to rely on the kindness of others to pay the premium. He does not know where he will be able to get the money to pay his premiums in the future.

163. Plaintiff Emily Rames is 29 years old and lives with her partner in Lafayette, Indiana.

164. She works at the reference desk of a public library, averaging 20-25 hours of work pre week and earning $15.25 per hour. Her gross income in 2023 was approximately $17,790. Ms. Rames finds her work rewarding, especially helping people find answers to their questions. She would like to be full-time; however, there are very few positions over 20 hours per week.

165. She and her partner pay monthly rent, utilities, internet, electricity, and food. She has student loan debt. Her household gets about $225/month in SNAP benefits.

166. Ms. Rames is driving a 1998 Toyota Corolla that she expects will break down soon.

167. Ms. Rames first applied for HIP in late 2022 or early 2023. Prior to that, she spent much of her adult life uninsured or using unaffordable employer-sponsored plans. When she was enrolled in employer-sponsored insurance, she incurred medical debt for emergency room charges that were sent to a collections agency. During times she was uninsured, Ms. Rames avoided seeking medical treatment because she feared medical debt.

168. HIP provides Ms. Rames with the opportunity to take care of her physical and mental health needs. It allows her the peace of mind that, despite her financial situation, she will have access to good health care if she needs it. She plans to use HIP in the near future for vision care, as well as for primary care. If her car breaks down, she will have difficulty accessing appointments and would need assistance with non-emergency medical transportation.

169. In November or December of 2023, Ms. Rames received a notice informing her that she was approved for another year of HIP. She has been notified that she will have a premium requirement, but that due to the public health emergency, it is on hold.

170. A premium payment will be a financial hardship for Ms. Rames. Given her income, if she does not pay the monthly premium, she will lose her Medicaid coverage. Loss of coverage would cause her a great deal of stress and anxiety.

171. Plaintiff Chelsey Lang is 30 years old and lives with her partner in Indianapolis, Indiana.

172. Ms. Lang is a first-generation college graduate and currently a 3rd year law student at the Indiana University Robert H. McKinney School of Law in Indianapolis. She is the Executive Managing Editor of the Health Law Review and has a note pending publication on lead contamination in housing in Northwest Indiana.

173. Prior to law school, Ms. Lang spent five years teaching middle school science. She hopes to use what she learns in law school to enrich the lives of others, as she did with the students she taught.

174. While a teacher, Ms. Lang used the employer-sponsored coverage offered to her through her job. When she left that job, she was briefly without any coverage and during that time incurred medical expenses.

175. Ms. Lang enrolled in HIP in late 2021 or early 2022. At that time, she was informed that she had a $20/month premium payment but that due to the public health emergency, it was waived. She has used her coverage to have regular primary care visits and genetic counseling.

176. Toward the end of April 2023 and after responding to FSSA's request for additional documentation, Ms. Lang received a new one-year eligibility period for HIP.

177. In August of 2023, she was notified that her premium payment would be $1.00/month.

178. Ms. Lang had paid work in the fall of 2023 and attempted to report this income change through the online portal, but is unclear if the report was successful. She made another report of

income change through the online portal in December 2023. Ms. Lang is currently a law clerk at a private law firm, working 10-12 hours per week, on average, and making $17.00/hour. Due to the demands of law school, she is not able to take on additional work. It will be difficult for Ms. Lang to afford the premium, as every month her expenses exceed her income.

CLAIMS FOR RELIEF

COUNT ONE: VIOLATION OF ADMINISTRATIVE PROCEDURE ACT (HIP 2.0 PROJECT AS A WHOLE)

179. Plaintiffs repeat and incorporate herein by reference each and every allegation contained in the preceding paragraphs as if fully set forth herein.

180. The Administrative Procedure Act provides that a reviewing court may "hold unlawful and set aside" agency actions that are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law"; "contrary to constitutional right, power, privilege, or immunity"; "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right"; or "without observance of procedure required by law." 5 U.S.C. § 706(2)(A)-(D).

181. Section 1115 only gives the Secretary the authority to approve a project for the period necessary to carry out the experiment. 42 U.S.C. § 1315(a).

182. Section 1115 further limits this authority by authorizing the Secretary to grant one initial and one subsequent renewal of state-wide comprehensive demonstration projects. *Id*. § 1315(e)(1), (f). The renewals cannot exceed three years for projects that do not involve dual eligibles. *Id*. § 1315(e)(2), (f)(6).

183. CMS first approved HIP as a state-wide comprehensive demonstration project in 2007. The project has been in place since 2008. CMS has now given Indiana permission to continue the project through December 31, 2030.

184. The HIP extension project is not an experimental, pilot, or demonstration project that is likely to promote the objectives of the Medicaid Act.

185. The Secretary did not adequately explain why it was necessary to approve HIP for an additional 10-year period.

186. In approving the 2020 HIP extension, the Secretary relied on factors which Congress has not intended him to consider, entirely failed to consider several important aspects of the problem, offered an explanation for his decision that runs counter to the evidence, and/or failed to acknowledge or explain changes in agency position.

187. The Secretary's approval of the 2020 HIP extension exceeded his Section 1115 waiver authority; otherwise violated the Medicaid Act; and was arbitrary and capricious and an abuse of discretion.

COUNT TWO: VIOLATION OF ADMINISTRATIVE PROCEDURE ACT (DECEMBER 2023 DECISION LETTER)

188. Plaintiffs repeat and incorporate herein by reference each and every allegation contained in the preceding paragraphs as if fully set forth herein.

189. The Administrative Procedure Act provides that a reviewing court may "hold unlawful and set aside" agency actions that are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law"; "contrary to constitutional right, power, privilege, or immunity"; "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right"; or "without observance of procedure required by law." 5 U.S.C. § 706(2)(A)-(D).

190. In December 2023, the Secretary issued a decision allowing the HIP authorities permitting Indiana to impose premium requirements and associated penalties for failure to pay, waive retroactive eligibility, and waive NEMT to remain in place. In issuing that decision, the Secretary relied on factors which Congress has not intended him to consider, entirely failed to

consider several important aspects of the problem, offered an explanation for his decision that runs counter to the evidence, and/or failed to acknowledge or explain changes in agency position.

191. The Secretary's December 2023 decision allowing the State to maintain the HIP authorities permitting Indiana to impose premium requirements and associated penalties, waive retroactive eligibility, and waive NEMT exceeded his Section 1115 waiver authority; otherwise violated the Medicaid Act; and was arbitrary and capricious and an abuse of discretion.

COUNT THREE: VIOLATION OF ADMINISTRATIVE PROCEDURE ACT (PREMIUM REQUIREMENTS)

192. Plaintiffs repeat and incorporate herein by reference each and every allegation contained in the preceding paragraphs as if fully set forth herein.

193. The Administrative Procedure Act provides that a reviewing court may "hold unlawful and set aside" agency actions that are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law"; "contrary to constitutional right, power, privilege, or immunity"; "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right"; or "without observance of procedure required by law." 5 U.S.C. § 706(2)(A)-(D).

194. In extending the HIP premium requirements and associated penalties for failure to pay in 2020, the Secretary purported to waive 42 U.S.C. §§ 1396a(a)(8), (a)(10), (a)(17), (a)(52) and (a)(14) (insofar as it incorporates §§ 1396*o* and 1396*o*-1) pursuant to Section 1115.

195. Authorization of premium requirements, or penalties for not meeting such requirements, is categorically outside the scope of the Secretary's Section 1115 waiver authority.

196. In addition, the approved premium requirements and associated penalties in the 2020 HIP extension and the December 2023 Letter are not an experimental, pilot, or demonstration project that is likely to promote the objectives of the Medicaid Act.

197. In approving the premium requirements and associated penalties in 2020 and 2023, the Secretary relied on factors which Congress has not intended it to consider, entirely failed to consider several important aspects of the problem, and offered an explanation for its decision that runs counter to the evidence.

198. The Secretary's 2020 and 2023 approvals of the HIP premium requirements and associated penalties exceeded his Section 1115 waiver authority; otherwise violated the Medicaid Act; and were arbitrary and capricious and an abuse of discretion.

COUNT FOUR: VIOLATION OF ADMINISTRATIVE PROCEDURE ACT (RETROACTIVE COVERAGE)

199. Plaintiffs repeat and incorporate herein by reference each and every allegation contained in the preceding paragraphs as if fully set forth herein.

200. The Administrative Procedure Act provides that a reviewing court may "hold unlawful and set aside" agency actions that are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law"; "contrary to constitutional right, power, privilege, or immunity"; "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right"; or "without observance of procedure required by law." 5 U.S.C. § 706(2)(A)-(D).

201. In approving elimination of the retroactive coverage required by the Medicaid Act in 2020, the Secretary purported to waive 42 U.S.C. § 1396a(a)(34) pursuant to Section 1115.

202. The elimination of retroactive coverage in the 2020 HIP extension and December 2023 Letter is not an experimental, pilot, or demonstration project that is likely to promote the objectives of the Medicaid Act.

203. In approving the elimination of retroactive coverage in the 2020 HIP extension and December 2023 Letter, the Secretary relied on factors which Congress has not intended him to

consider, entirely failed to consider several important aspects of the problem, and offered an explanation for his decision that runs counter to the evidence.

204. The Secretary's 2020 and 2023 approvals of the elimination of retroactive coverage exceeded his Section 1115 waiver authority; otherwise violated the Medicaid Act; and were arbitrary and capricious and an abuse of discretion.

COUNT FIVE: VIOLATION OF ADMINISTRATIVE PROCEDURE ACT (NON-EMERGENCY MEDICAL TRANSPORTATION)

205. Plaintiffs repeat and incorporate herein by reference each and every allegation contained in the preceding paragraphs as if fully set forth herein.

206. The Administrative Procedure Act provides that a reviewing court may "hold unlawful and set aside" agency actions that are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law"; "contrary to constitutional right, power, privilege, or immunity"; "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right"; or "without observance of procedure required by law." 5 U.S.C. § 706(2)(A)-(D).

207. In approving the 2020 HIP extension's elimination of NEMT benefits for the expansion population (other than for medically frail individuals), the Secretary purported to waive 42 U.S.C. § 1396a(a)(4) (insofar as it incorporates 42 C.F.R. § 431.53) pursuant to Section 1115.

208. The elimination of NEMT coverage in the 2020 HIP extension and December 2023 Letter is not an experimental, pilot, or demonstration project that is likely to promote the objectives of the Medicaid Act.

209. In approving the elimination of NEMT in the 2020 HIP extension and December 2023 Letter, the Secretary relied on factors which Congress has not intended him to consider, entirely failed to consider several important aspects of the problem, and offered an explanation for his decision that runs counter to the evidence.

210. The Secretary's 2020 and 2023 approvals of the elimination of NEMT benefits exceeded his Section 1115 waiver authority; otherwise violated the Medicaid Act; and were arbitrary and capricious and an abuse of discretion.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs respectfully ask that this Court:

1. Declare that Defendants' 2020 approval of the Indiana HIP extension application and Defendants' December 2023 Letter violate the Administrative Procedure Act and the Social Security Act in the respects set forth above;
2. Preliminarily and permanently enjoin Defendants from implementing the practices purportedly authorized by the 2020 approval of the Indiana HIP extension application and Defendants' December 2023 Letter;
3. Award Plaintiffs their reasonable attorney's fees and costs pursuant to 28 U.S.C. § 2412; and
4. Grant such other and further relief as may be just and proper.

//

Dated: January 31, 2024

Respectfully submitted,

/s/ Jane Perkins

Thomas J. Perrelli
Ian Health Gershengorn
Erica S. Turret (application pending)
JENNER & BLOCK
1099 New York Ave., Suite 900
Washington, DC 20001
(202) 639-6869
TPerrelli@jenner.com
Igershengorn@jenner.com
Eturret@jenner.com

Counsel to National Health Law Program

Jane Perkins
Catherine McKee
NATIONAL HEALTH LAW PROGRAM
1512 E. Franklin St., Ste. 110
Chapel Hill, NC 27514
(919) 968-6308 (x101)
perkins@healthlaw.org
mckee@healthlaw.org

Adam Mueller
INDIANA JUSTICE PROJECT
6101 North Keystone Ste. 100, #1118
Indianapolis, IN 46220
(317) 912-1135 ext. 800
amueller@injp.org

Counsel for Plaintiffs

Exhibit A

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DEC 14 2007

Mr. E. Mitchell Roob, Jr.
Secretary
Indiana Family and Social Services Administration
402 West Washington Street
Indianapolis, IN 46207

Dear Mr. Roob:

We are pleased to inform you that the Indiana section 1115 Medicaid demonstration project, entitled Healthy Indiana Plan (HIP) (Project No. 11-W-00237/5) has been approved for a 5-year period, January 1, 2008, through December 31, 2012, in accordance with section 1115(a) of the Social Security Act (the Act).

Our approval of the HIP section 1115(a) demonstration project, including the expenditure authorities provided thereunder, are conditioned upon compliance with the enclosed Special Terms and Conditions (STCs). The STCs set forth in detail the nature, character, and the extent of Federal involvement in the demonstration. The STCs are effective January 1, 2008, unless otherwise specified. All the requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the enclosed expenditure authority list, shall apply to the HIP demonstration.

The Department of Health and Human Services' approval of HIP, including the associated expenditure authorities, is contingent upon compliance with the enclosed list of STCs.

As a result of this approval, the pregnant women, parents, and children who currently receive services through capitated managed care health plans through the 1915(b) waiver will be transferred from the 1915(b) waiver to the HIP section 1115 demonstration project. These populations will continue to receive Medicaid State plan benefits through the Hoosier Healthwise (HHS) program. The members of the Aged, Blind, and Disabled population who receive services through Care Select, the State's primary care case management program, will continue to receive services through the 1915(b) waiver.

The HIP provides a high-deductible health plan and an account styled like a health savings account called a Personal Wellness and Responsibility (POWER) Account to uninsured adults including uninsured custodial parents of Medicaid and State Children's Health Insurance Program (SCHIP) children with family incomes above the Medicaid State plan limit, which is approximately 22 percent of the Federal poverty level (FPL). Therefore, HIP is available to uninsured custodial parents of Medicaid and SCHIP children with family incomes above approximately 22 percent of the FPL and up to and including 200 percent of the FPL. HIP is also available to uninsured custodial parents of Medicaid children with incomes below the Medicaid State plan limits, but above the Medicaid State plan resource limit of $1,000. Finally, HIP is also available to uninsured

non-custodial parents and uninsured childless adults with family incomes up to and including 200 percent of the FPL. Participation in HIP is voluntary, but all enrollees will be required to receive medical care through private health plans. Enrollees must also make specified monthly contributions to their POWER Accounts as a condition of continued enrollment. These contributions will not exceed 5 percent of annual family income. Enrollees must also make specified monthly contributions to their POWER accounts as a condition of continued enrollment. These contributions will not exceed 5 percent of annual family income.

The demonstration is approved with a without waiver per capita cost trend rate of 4.40 percent. The estimated total computable budget neutrality limit for the 5 years of the demonstration is $10,626,086,285. The demonstration will allow Indiana to use a portion of its disproportionate share hospital (DSH) funds to fund the demonstration. The amount of the DSH diversion will equal the State's DSH allotment (Federal share) per year minus $151,183,400 (Federal share). The management of your program within the approved budget cap is essential to successfully meet the terms of budget neutrality for the demonstration project.

Please note that the STCs require that the State identify and verify $15 million (total computable) in additional savings in its Medicaid program. The sources of savings include expanded third-party liability cost recoveries, estate recoveries, and fraud and abuse recoveries. The State may submit an amendment to the demonstration to modify, remove, or propose additional measures of savings. If the State does not achieve savings of $15 million (total computable) by the end of demonstration year 5, the State must return to the Centers for Medicare & Medicaid Services (CMS) the Federal share of the difference between $15 million (total computable) and the verified level of savings (total computable).

With the approval of this demonstration, CMS is permitting the State to test a model of health coverage that emphasizes private health insurance, personal responsibility, and "ownership" of health care. As such, we are also permitting the State to include program features that are compatible with such a model, as described below.

We are permitting Indiana to impose a $300,000 annual benefit limit and a $1 million lifetime benefit limit on HIP Caretakers and HIP Adults. We expect the State to monitor people who approach these benefit limits. The STCs require that the State report on the number of individuals who are within $100,000 of reaching the annual or lifetime benefit limits. The STCs also require that the State evaluate the number of HIP participants who reach the $300,000 and $1 million lifetime benefit limits and how these participants go about meeting their health care needs after their HIP benefits are exhausted.

We are also permitting Indiana to provide only one health plan option to the HIP population in the first year of the demonstration, and to limit participants' ability to switch plans after they have made an initial POWER Account contribution. We expect the State to monitor the effect of these provisions on enrollees' access to care and to include a study of the impact of these provisions in the evaluation of the demonstration. Also, please note that the STCs include a

requirement that at least one additional plan be offered during the demonstration's second year of operation.

As indicated in the STCs, all requirements of the Medicaid program, unless specified otherwise in the STCs, waiver list, or expenditure authorities or otherwise listed as not applicable, shall apply to the demonstration. Therefore, HIP must comply with all section 1927 requirements, which outline the Medicaid Drug Rebate Program.

Finally, Indiana had requested a waiver of section 1902(b)(2) to impose a 12-month State residency requirement. We have not made Indiana exempt from Section 1902(b)(2) of the Act because the U.S. Supreme Court decided in *Shapiro v. Thompson*, 394 U.S. 618 (1969) that a 1-year durational residency requirement for receiving welfare benefits was unconstitutional because it interfered with a person's fundamental right of interstate movement. As a result, Indiana may not impose a 12-month State residency requirement on HIP members.

A full listing of the approved waiver and expenditure authorities for the demonstration is enclosed.

Written notification to our office of your acceptance of this award must be received within 30 days after you receive this letter. Your project officer is Ms. Julie Sharp. She is available to answer any questions concerning this demonstration project. Ms. Sharp's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations
7500 Security Boulevard
Mailstop S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-2292
Facsimile: (410) 786-5882
E-mail: Juliana.Sharp@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Sharp and to Ms. Verlon Johnson, Associate Regional Administrator in our Chicago Regional Office. Ms. Johnson's contact information is as follows:

Centers for Medicare & Medicaid Services
233 N. Michigan Avenue, Suite 600
Chicago, IL 60601-5519

If you have questions regarding this correspondence, please contact Ms. Susan Cuerdon, Acting Director, Family and Children's Health Programs Group, Center for Medicaid and State Operations, at (410) 786-5647.

We look forward to continuing to work with you and your staff.

Sincerely,

Kerry Weems
Acting Administrator

Enclosure

cc: Verlon Johnson, ARA, Region V
Leslie Campbell, State Representative

Exhibit B

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00237/5**

TITLE: **Healthy Indiana Plan**

AWARDEE: **Indiana Family and Social Services Administration**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Indiana's Healthy Indiana Plan (HIP) section 1115(a) Medicaid Demonstration extension (hereinafter referred to as "Demonstration"). The parties to this agreement are the Indiana Family and Social Services Administration ("State") and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration. The STCs are effective January 1, 2008, unless otherwise specified. This Demonstration is approved through December 31, 2012.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Eligibility
V. Hoosier Healthwise
VI. Healthy Indiana Plan
VII. General Reporting Requirements
VIII. General Financial Requirements
IX. Monitoring Budget Neutrality for the Demonstration
X. Evaluation of the Demonstration
XI. Schedule of State Deliverables during the Demonstration

II. PROGRAM DESCRIPTION AND OBJECTIVES

The HIP section 1115(a) demonstration provides authority for the State to operate two distinct health insurance products: the Hoosier Healthwise Program for current Medicaid eligible persons, and the HIP for uninsured adults not currently eligible for Medicaid.

HIP offers the following coverage:

1) A basic commercial benefits package once annual medical costs exceed $1,100;
2) A Personal Wellness and Responsibility (POWER) Account valued at $1,100 per adult to pay for initial medical costs. The POWER Accounts provide incentives for participants

to utilize services in a cost-efficient manner. HIP members make monthly contributions to their POWER Accounts depending on their income level; and

3) $500 in "first dollar" preventive benefits at no cost to HIP members.

Medicaid Managed Care: Hoosier Healthwise and Medicaid Select
Indiana currently requires managed care enrollment for most Medicaid eligibles. Section 1931 children and adults are served under the Hoosier Healthwise program, while the aged, blind, and disabled are served under the Medicaid Select Program.

Indiana began the Hoosier Healthwise program in 1994, when it mandated managed care enrollment for all section 1931 children and adults through a waiver granted by the Secretary under the authority of section 1915(b) of the Social Security Act (the Act). By July 1997, the program was implemented statewide using a combination of managed care organizations (MCOs) and a Primary Care Case Management (PCCM) delivery system. Effective December 2005, all Hoosier Healthwise enrollees are served exclusively by MCOs.

Effective January 1, 2008, the authority for the Hoosier Healthwise program is provided solely through this demonstration.

The Medicaid Select program began in 2002, when Indiana began enrolling the aged, blind and disabled into managed care through a PCCM delivery system. Authority for this program continues to be provided under the authority of section 1915(b) of the Act. On October 1, 2007, an enhanced PCCM system called Indiana Care Select was phased in to provide care management services to the aged, blind, and disabled enrolled in Medicaid Select. All aspects of care delivery and financing of Medicaid Select and Indiana Care Select are separate and apart from this demonstration.

Healthy Indiana Plan (HIP)
The HIP provides a high-deductible health plan and an account styled like a health savings account called a POWER Account to uninsured adults including low-income custodial parents and caretaker relatives of Medicaid and State Children's Health Insurance program (SCHIP) children and uninsured non-custodial parents and childless adults. Participation in HIP is voluntary, but all enrollees will be required to receive medical care through the high deductible health plans and POWER Accounts. Enrollees must also make specified contributions to their POWER Accounts as a condition of continued enrollment. These accounts will be used by enrollees to pay for the cost of health care services until the deductible is reached; however, preventive services up to a maximum amount will be exempt from this requirement. Once the deductible has been met, the health plan will provide coverage for medical services up to an annual maximum amount. Eligible individuals who have certain high-risk conditions will be enrolled in the Enhanced Services Plan (ESP), a separate care delivery mechanism managed by the Indiana Comprehensive Health Insurance Association (ICHIA), the State's high-risk pool.

Under this Demonstration, Indiana expects to achieve the following to promote the objectives of title XIX:

- Access: Ensure availability of necessary health services for Medicaid enrollees while offering health coverage to thousands of uninsured individuals;
- Prevention: Encourage individuals to stay healthy and seek preventive care;
- Personal Responsibility: Give individuals control of their health care decisions and incentivize positive health behaviors;
- Cost Transparency: Make individuals aware of the cost of health care services; and
- Quality: Encourage provision of quality medical services to all enrollees. Encourage quality, continuity, and appropriate medical care.

The following populations will participate in the Hoosier Healthwise (HHW) component of the Demonstration. The three populations derive their eligibility through the Medicaid State plan.

- **Demonstration Population 1: HHW Caretakers.** HHW Caretakers include parents and caretaker relatives of children eligible for Medicaid with family income up to and including the AFDC income limit specified in the State plan and resources less than or equal to $1,000.
- **Demonstration Population 2: HHW Children.** HHW Children include all children eligible for Medicaid under the Medicaid State plan.
- **Demonstration Population 3: HHW Pregnant Women.** HHW Pregnant Women include pregnant women up to and including 200 percent of the Federal poverty level (FPL).

The following populations will participate in the HIP component of the Demonstration:

- **Demonstration Population 4: HIP Caretakers.** HIP Caretakers include uninsured custodial parents and caretaker relatives of children eligible for Medicaid with family income up to and including the AFDC income limit specified in the State plan with resources in excess of $1,000; and, uninsured custodial parents and caretaker relatives of Medicaid and SCHIP children with family income above the AFDC income limit specified in the State plan through 200 percent of the FPL (no resource limit).

- **Demonstration Population 5: HIP Adults.** HIP Adults include uninsured non-custodial parents and childless adults (ages 19 through 64) who are not otherwise eligible for Medicaid or Medicare with family income up to and including 200 percent of the FPL (no resource limit).

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State agrees that it shall comply with all applicable Federal statutes related to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement, unless specified

otherwise in the STCs, waiver list, or expenditure authorities or otherwise listed as not applicable, shall apply to the Demonstration.

3. **Compliance with the Deficit Reduction Act of 2005.** The foregoing requirement shall apply to all applicable regulation and policy issued by CMS with respect to the Deficit Reduction Act of 2005 (DRA) signed into law on February 8, 2006, and applicable CMS regulations in the Code of Federal Regulations (CFR), including but not limited to the documentation of citizenship requirements contained in section 1903(x) of the (the Act) and the cost-sharing limitations in section 1916 of the Act, unless specified otherwise in the STCs, waiver list, or expenditure authorities or listed as not applicable.

4. **Changes in Medicaid Law, Regulation, and Policy.** The State shall, within the time frames specified in law, regulation, or policy directive, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid program that occur during this Demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

5. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

    a. To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State shall adopt, subject to CMS approval, a modified budget neutrality agreement for the Demonstration, as necessary, to comply with such change. The modified budget neutrality agreement would be effective upon implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC.

    b. If mandated changes in the Federal law require State legislation, the changes shall take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

6. **State Plan Amendments.** The State shall not be required to submit title XIX State plan amendments for changes to Demonstration populations made eligible solely through the Demonstration. If a population covered through the State plan is affected by a change to the Demonstration, a conforming amendment to the State plan is required, except as otherwise noted in these STCs.

7. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-Federal share of funding, budget neutrality, and other comparable program elements shall be submitted to CMS as amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 8 below.

8. **Demonstration Amendment Process.** Requests to amend the Demonstration shall be submitted to CMS for approval no later than 120 days prior to the date of implementation and may not be implemented until approved. Amendment requests will be reviewed by the Federal Review Team and must include, but are not limited to, the following:

    a. An explanation of the public process used by the State to reach a decision regarding the requested amendment, as referenced in paragraph 16 of these STCs.

    b. A data analysis that identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality expenditure cap. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment which isolates (by Eligibility Group) the impact of the amendment.

    c. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation.

    d. A description of how the evaluation design shall be modified to incorporate the amendment provisions, if applicable.

9. **Extension of the Demonstration**. If the State intends to extend the Demonstration beyond the period of approval granted under section 1115(a), the requirements in section 1115(e) may apply. During the 6-month period ending 1 year before the date the Demonstration would otherwise expire, the chief executive officer of the State may submit to the Secretary of the Department of Health and Human Services a written request to extend the Demonstration for up to 3 years. If the Secretary fails to respond to the request within 6 months after the date it is submitted, the request is deemed to have been granted. Further, the Secretary shall take such steps as may be necessary to ensure that in the extension of the Demonstration budget neutrality is maintained. The timeframes for an extension under 1115(e) may not apply if the State has requested changes to the Demonstration. The State must also provide an interim evaluation report for the current extension period with the extension request, pursuant to paragraph 73.

10. **Demonstration Phase-Out.** The State may suspend or terminate this Demonstration in whole or in part at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase out the Demonstration, the State must submit a phase-out plan to CMS at least 6 months prior to initiating phase-out activities. Nothing herein shall be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than 6 months when such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval. If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the Demonstration, including services and administrative costs of disenrolling participants.

11. **Enrollment Limitation During Demonstration Phase-Out.** If the State elects to suspend, terminate, or not renew this Demonstration as described in paragraph 10, during the last 6 months of the Demonstration, the enrollment of individuals who would not be eligible for Medicaid under the current Medicaid State plan shall not be permitted unless the Demonstration is extended by CMS. Enrollment may be suspended if CMS notifies the State in writing that the waiver will not be renewed.

12. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration in whole or in part at any time before the date of expiration, whenever it determines, following a hearing, that the State has materially failed to comply with the terms of the project. CMS shall promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.

13. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge CMS' finding that the State materially failed to comply.

14. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS shall promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and shall afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authorities, including services and administrative costs of disenrolling participants.

15. **Adequacy of Infrastructure.** The State will ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other Demonstration components.

16. **Public Notice and Consultation with Interested Parties.** The State shall comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) when any program changes to the Demonstration referenced in paragraph 7 are proposed by the State.

17. **Compliance with Managed Care Regulations.** The State shall comply with the managed care regulations at 42 CFR section 438 *et seq.*, except as expressly waived or expressly identified as not applicable in the expenditure authorities incorporated into the STCs. Capitation rates shall be developed and certified as actuarially sound in accordance with 42 CFR 438.6.

18. **Federal Financial Participation (FFP).** No Federal matching funds for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval letter. No FFP is available for this Demonstration for Medicare Part D drugs.

IV. ELIGIBILITY

19. **Eligibility.** The HIP demonstration includes two distinct components.

The HHW program provides Medicaid State Plan benefits through comprehensive MCOs to children, pregnant women and caretaker adults eligible under the State plan as described below. The HIP provides a high-deductible health plan and a Personal Wellness and Responsibility (POWER) Account through comprehensive managed care organizations to uninsured adults with and without children who have specified income and assets.

The mandatory and optional Medicaid State plan populations described below in Table 1 derive their eligibility through the Medicaid State plan and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid State plan, except as expressly waived. State plan eligibles are included in the Demonstration to generate savings for covering expansion populations and to mandate enrollment in managed care by waiving the freedom of choice of provider requirement.

Groups which are made Demonstration eligible by virtue of the expenditure authorities expressly granted in this Demonstration as described below in Table 2 are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid State plan, except as specified otherwise in the STCs and expenditure authorities or otherwise listed as not applicable.

The eligibility criteria for the HIP demonstration are outlined below. These tables are presented for information purposes and do not change the State plan requirements or otherwise establish policy.

Hoosier Healthwise Component of the Demonstration

The populations described in Table 1 are in the Medicaid State plan and included in the Demonstration to generate savings for covering expansion populations, to mandate enrollment in managed care, and waive other requirements as specified in the Waiver List. None of the Hoosier Healthwise populations participate in the HIP component of the Demonstration. Therefore, none of the Hoosier Healthwise populations have POWER Accounts.

Table 1: Hoosier Healthwise Program

Description	FPL Level and/or other qualifying criteria	Demonstration Eligibility Group
State Plan Mandatory and Optional Groups		
Pregnant women	0% FPL through 200% FPL; no resource limit	HHW Pregnant Women
Qualified Pregnant Women	Pregnant women up to the AFDC income limit for the particular family size as indicated in the State plan; resource limit of $1,000	HHW Caretakers
Children under age 1	0% FPL through 200% FPL; no resource limit	HHW Children
Newborns born to & living with a woman who was eligible and received Medicaid on the date of the child's birth	Eligible for 1 year as long as mother is eligible for Medicaid or would be if pregnant and the child remains in the same household as mother.	HHW Children
Children 1 through 5	0% FPL through 133% FPL; no resource limit	HHW Children
Children 6 through 18	0% FPL through 100% FPL; no resource limit	HHW Children
Blind and Disabled children under age 18 receiving SSI and except for receipt of SSI would be eligible for AFDC	Income up to and including the AFDC income limit for the particular family size as indicated in the State plan FPL; resource limit of $1,000	HHW Children
Custodial parents and caretaker relatives of children eligible for Medicaid	Income up to and including the AFDC income limit for the particular family size as indicated in the State plan; resource limit of $1,000	HHW Caretakers
Blind and Disabled adults 18 years old and older receiving SSI and except for receipt of SSI would be eligible for AFDC	Income up to and including the AFDC income limit for the particular family size as indicated in the State plan; resource limit of $1,000	HHW Caretakers

Healthy Indiana Plan Component of the Demonstration

The populations described in Table 2 are in the HIP component of the Demonstration. All of the populations described below will be required to make monthly contributions to their POWER Accounts.

Table 2: Healthy Indiana Plan (HIP) Program

Description	FPL Level and/or other qualifying criteria	Demonstration Eligibility Group
Demonstration Eligible Groups		
Custodial parents and caretaker relatives currently excluded from the Medicaid State plan who have been uninsured for at least 6 months, and who are not otherwise eligible for Medicaid or Medicare	Income up to the AFDC income limit for the particular family size as indicated in the State Plan with resources in excess of $1,000	HIP Caretakers
Custodial parents and caretaker relatives of children eligible for Medicaid who have been uninsured for at least 6 months, and who are not otherwise eligible for Medicaid or Medicare	Income above the AFDC income limit for the particular family size as indicated in the State Plan and up to and including 200% FPL; no resource limit.	HIP Caretakers
Non-custodial parents and childless adults (19-64) who do not meet the criteria of HIP Caretakers, who have been uninsured for at least 6 months, and who are not otherwise eligible for Medicaid or Medicare	0% FPL through 200% FPL; no resource limit. An enrollment cap may be implemented.	HIP Adults

20. **Eligibility Exclusions.** Notwithstanding the eligibility criteria in paragraph 19, the following persons are excluded from the Demonstration.

Hoosier Healthwise Program

- Persons eligible for Medicaid exclusively through categories other than those listed above in Table 2.
- Individuals eligible for Medicare.

Healthy Indiana Plan

- Individuals eligible for Medicare or Medicaid under the State Plan.
- Individuals who have access to an employer-sponsored health plan.
- Individuals who are currently enrolled in a health insurance program.

21. **Income of HIP Caretakers.** The State will disregard the income of individuals seeking eligibility as HIP Caretakers in the amount of the difference between the standard specified in Supplement 1 to Attachment 2.6A Page 1 of the Medicaid State plan and 200 percent of the FPL for the family size involved. The State will disregard the resources of individuals seeking eligibility as HIP Caretakers.

    The State may submit an amendment to the Demonstration to specify different income and/or asset disregards for new HIP Caretaker applicants than for those already determined eligible following procedures described in paragraph 8.

22. **Enrollment Cap for HIP Adults.** At no point in time may the number of individuals enrolled as HIP Adults exceed 34,000.

V. HOOSIER HEALTHWISE

23. **Benefits.** Benefits offered to HHW enrollees are outlined in the State plan. HHW enrollees may also receive chronic disease management services. All benefits are delivered through a managed care delivery system.

24. **Enrollment.** The State will continue to follow applicable Federal law and regulations for determining eligibility for Medicaid and for enrolling those deemed eligible into MCOs, as well as policies and procedures that are described in the Medicaid State plan. The State may require members of the Medicaid eligibility groups described in paragraph 19 to enroll with an MCO as a condition for receiving medical assistance. The State may allow MCOs to assist enrollees in completing their applications for redeterminations; however, the State will be responsible for making the redetermination decision.

25. **Cost Sharing.** Any cost sharing requirements for HHW enrollees are stipulated in the Medicaid State plan.

VI. HEALTHY INDIANA PLAN (HIP)

26. **General Description.** The HIP provides a high-deductible health plan and an account styled like a health savings account called a Personal Wellness and Responsibility (POWER) Account to uninsured adults including low-income parents and caretaker relatives of Medicaid and SCHIP eligible children and uninsured childless adults. Participation in HIP is voluntary, but all enrollees will be required to receive medical care through one of two delivery systems described below. Enrollees must also make specified contributions to their POWER Accounts as a condition of continued enrollment. These accounts will be used by enrollees to pay for the cost of health care services until the deductible is reached; however, preventive services up to a maximum amount will be exempt from this requirement. Once the deductible has been met, the HIP MCO or Enhanced Services Plan (described below) will provide coverage for medical services up to an annual maximum amount.

    The State provides benefits under the HIP using one of two delivery systems. For those enrollees who have an identified high-risk condition, benefits are rendered through the

Enhanced Services Plan, a prepaid inpatient health plan (PIHP), operated by ICHIA, the same entity that manages the State's high risk pool. All other enrollees receive coverage through MCOs under contract to the State. The MCOs and ESP are subject to the Federal laws and regulations as specified in 42 CFR Part 438.

In all cases, the enrollee is responsible for making contributions to a POWER Account.

Eligibility Determination, Enrollment, and Disenrollment

27. **Enrollment into HIP.** Individuals may apply for HIP in one of two ways. Applicants may apply at Designated Enrollment Centers or directly at the Division of Family Resources (DFR) offices.

    a. **Application through Designated Enrollment Centers (DEC).** Individuals may complete an application through designated enrollment centers (such as hospitals, schools, community organizations, health clinics, etc.). The State will ensure that the DECs, as outstationed eligibililty centers, comply with the regulations set forth at 42 CFR 435.904. The applicant may make an MCO selection at this time. As part of the application, a high-risk health questionnaire will also be required.

    The DECs will forward complete applications, including all supporting documentation, to DFR within 35 days of the application's signature date, either online or via U.S. mail. DFR will make a final eligibility determination within 45 days of the signed application date. This 45-day period is inclusive of the 35 days the DEC has to forward the completed application to DFR.

    b. **Application through the Division of Family Resources (DFR).** The DFR will explain the HIP program and take an enrollee's application for the program. Individuals will also be able to apply for HIP online, over the phone, and by mail. The applicant may make an MCO selection at the time they apply. As part of the application, a high-risk health questionnaire will also be required.

    The applicant's application form will be checked for completeness through an automated process. If the application is not complete, DFR will contact the applicant to obtain the missing information. DFR will make a final eligibility determination within 45 days of the signed application date.

28. **MCO Information and Selection.** The State will contract with an enrollment broker to assist interested applicants with their MCO selection so they can make an informed decision. The enrollment broker will provide the applicant with appropriate counseling on the full spectrum of available MCO choices and will address any questions the applicant may have. Once an MCO has been selected, the enrollee is required to remain in that MCO for 12 months (coverage term), with limited exceptions specified in paragraph 31.

    Individual family members may select different MCOs. If no family member receives coverage through ESP and no eligible family member has selected a plan, all eligible family

members will be auto-assigned to the same MCO. If one of the family members receives coverage through ESP as described in paragraph 29, and no family member has selected a plan, all non-ESP family members will be auto-assigned to the same MCO.

29. **The Enhanced Services Plan for Individuals with High Risk Conditions.**

a. If the high-risk health questionnaire completed at the time of application indicates that the applicant has one of these conditions: cancer, past recipient of organ and/or tissue transplants or awaiting an organ and/or tissue transplant, HIV/AIDS, aplastic anemia, or hemophilia, the applicant will be enrolled by the State in the ESP. ESP is a PIHP that is managed by ICHIA, the organization that also manages the State's high risk pool. Persons enrolled in ESP will have access to the provider network maintained by ICHIA, and will be free to receive care from any ICHIA affiliated provider.

b. Demonstration eligibles assigned to ESP will be required to make monthly POWER Account contributions, with amounts determined on the same basis as for HIP MCO enrollees, following paragraphs 40 and 41. Indiana may elect either option (i) or (ii) below with respect to implementation of POWER Accounts for persons assigned to ESP. The State must include a report on which option it is currently using, and any plans to change the option, in each Quarterly Progress Report (as required under paragraph 56).

i. Indiana may elect to make State contributions to ESP enrollees' POWER Accounts, as described in paragraph 42. The State will require ESP to manage their enrollees' POWER Accounts, in conformity with paragraphs 43 through 51. Demonstration eligibles assigned to ESP will receive coverage for services listed in paragraph 34, once their annual deductible has been reached, as well as disease management services provided by ESP. The State will reimburse ESP for the cost of all services provided to an enrollee in excess of those defrayed through the enrollee's POWER Account.

ii. Indiana may elect not to make State POWER Account contributions to ESP enrollees' POWER Accounts. In this case, ESP must collect the required monthly POWER Account contributions and will use these monies to defray the cost of services provided to ESP enrollees within the coverage term. Demonstration eligibles assigned to ESP will receive coverage for services listed in paragraph 34, as well as disease management services provided by ESP. The State will reimburse ESP for the cost of services provided to an enrollee beyond those defrayed by the enrollee's POWER Account contributions. If, during the course of a coverage term, an individual's medical claims do not exceed $1,100 for the year, the enrollee's required contribution for the new year will be based on the POWER Account carry-forward procedures, as described in paragraph 46(c), and calculated as if the State had made a full POWER Account contribution as stipulated in paragraph 42(a).

c. Demonstration eligibles assigned to ESP will not be considered to be enrolled in ICHIA, the State's high risk pool; ESP will provide only administrative services and access to the ICHIA provider network. ESP will also provide disease management services.

d. If the high-risk condition was not disclosed on the high-risk health questionnaire and an MCO later identifies an enrollee who has one of these high-risk conditions, the MCO shall notify the State of the enrollee's high-risk condition. The MCO's notification must be supported by a physical examination or initial claims data, and may be accompanied by a request for the enrollee's transfer to ESP.

After receiving the MCO's request that the HIP member be transferred to ESP, the State will have 21 days to confirm or reject the MCO's request.

If the State does not receive the MCO's notification and/or request within 30 days after the enrollee's coverage under the plan begins, the enrollee will remain in the MCO for the rest of the coverage term.

At the end of the coverage term, the MCO will have another opportunity to use prior claims data and/or a physical exam to notify and/or request that the enrollee be transferred to ESP.

e. The State may also transfer an enrollee from ESP to an MCO if the State or its designee determines that the enrollee does not have a high-risk condition within 30 days of enrollment with ESP. Demonstration eligibles will be transferred to the plan choice identified on their initial application, or if one was not identified, the enrollee will be auto-assigned. If persons auto-assigned have not yet made a POWER Account contribution, they will have the right to switch HIP MCOs without cause from the date of their auto-assignment until the date their first POWER Account contribution is received by the HIP MCO to which they are assigned. If persons auto-assigned have made at least one POWER Account contribution, they will not be able to switch MCOs "without cause" until the end of the coverage year.

   Additionally, the State will review the cases of each enrollee served by ESP during the annual redetermination process to determine if a positive change in the enrollee's health condition warrants transfer from ESP to an MCO.

   The State will develop a process through which a HIP member may appeal the State's decision to move the member out of an MCO to ESP or out of ESP to an MCO. The State shall include a description of this process in the first Annual Report required in paragraph 57.

30. **Auto Assignment to an MCO**. Any applicant who does not make an MCO selection at the time of application may be auto-assigned to a HIP MCO by the State. Auto-assignment may occur after the date in which the State determined their eligibility, or 14 days after the application's signature date, whichever is later.

    Auto-assignment will be done on a rotating basis to assure that applicants are assigned evenly among MCOs. The State may consider assignment to the lowest cost MCO, or to the MCOs that demonstrate strong health outcomes and quality health care services. Enrollees will be advised promptly of the auto-assignment and their right to change MCOs before the first POWER Account contribution is made.

31. **Enrollee's Right to Change MCOs.** For the first year of the Demonstration, HIP members may have only one choice of an MCO. By Demonstration Year 2, the State must offer at least two choices of MCOs. The procedures outlined below will take effect as soon as a second HIP MCO begins accepting clients, but no later than January 1, 2009.

    a. At the beginning of their first coverage year, an enrollee may change HIP MCOs without cause within 60 days after initially choosing or being auto-assigned to a HIP MCO, or the date their HIP MCO received their first POWER Account contribution, whichever comes first.

       The State shall notify HIP members 90 days before the end of their coverage term that they must apply for continued coverage. The State shall also notify HIP members that they may change plans without cause at the time they submit their application for a second or subsequent coverage term. Members may seek assistance from the enrollment broker in choosing an MCO.

b. "Cause" is defined as "receiving poor quality care coverage," which includes, but is not limited to, the following:
   i. Failure of the Insurer to provide covered services;
   ii. Failure of the Insurer to comply with established standards of medical care administration;
   iii. Significant language or cultural barriers.
   iv. Corrective Action levied against the Insurer by the Family and Social Services Administration (FSSA); or
   v. Other circumstances determined by FSSA or its designee to constitute poor quality of health care coverage.

c. The enrollee must submit his or her request for change to the enrollment broker either orally or in writing. The enrollment broker will assure that the enrollee has sought redress through the MCO's grievance system before referring the request to the State for making a determination regarding the change request. The enrollee shall still have access to the State's normal grievance and appeals process required under the managed care regulations.

d. If the State fails to make a determination by the first day of the second month following the month in which the enrollee files the request, the request for change will be considered approved and the enrollee will be transferred into the new MCO.

e. If an enrollee is transferred from the MCO, the MCO must disable the enrollee's POWER Account card immediately, and return the remaining balance of the individual's POWER Account balance to the State within 30 days of the last date of participation with the MCO. The State will then provide the entire POWER Account balance to the new MCO with the information needed to properly track the individual's contribution.

f. The State will ensure that all transferring individuals receive coverage from their new MCO promptly, without any interruption in coverage.

32. **Redetermination of Eligibility**. Redetermination of eligibility for HIP will occur at least once every 12 months. An enrollee may request a redetermination of eligibility for HIP due to a change in family size (e.g., death, divorce, birth, marriage, adoption) at any time, and the State must perform such redeterminations upon request. Requests for redetermination based on changes in income will be subject to a once a year qualifying event. A "qualifying event" is defined as a job loss or other event resulting in a change in income. Each redetermination must include a reassessment of the individual's eligibility for Medicaid, and may result in a reduction of the enrollee's required POWER Account contribution. The State may consider allowing more than one "qualifying event" a year on a case-by-case basis, if the HIP member experiences a job loss or other change in income that results in undue hardship. The enrollee's MCO may assist the enrollee in completing the steps necessary to remain eligible for HIP.

33. **Disenrollment from HIP unrelated to POWER Accounts.** The State may disenroll an enrollee from HIP for any of the following reasons:

    a. The enrollee is determined ineligible for HIP at redetermination;

    b. The enrollee obtains access to employer-sponsored coverage;

    c. The enrollee becomes covered under another health insurance policy or FSSA program; or

    d. The enrollee becomes pregnant. Upon pregnancy, the enrollee will become eligible for Hoosier Healthwise, and will be enrolled in that program.

    e. Should a participant be disenrolled from HIP for any of the reasons listed above, the HIP MCO must return any remaining POWER Account balances to the participant or the State as described in paragraph 48.

Benefits

34. **HIP Covered Benefits.** HIP covers physical, behavioral health and pharmacy services as specified below. All benefits are limited by medical necessity as defined by the State. This list of benefits specifies the minimum set of benefits available to HIP members.

Table 3: Healthy Indiana Plan Benefits

Benefit	Limits
Inpatient Facility	
Medical/Surgical	
Mental Health/Substance Abuse	Covered same as any other service
Skilled Nursing Facility	Subject to a 30-day maximum
Outpatient Facility	
Surgery	
Emergency Room	Co-payment for services determined to be non-emergency as specified in Section VI, paragraph 38(b)
Urgent Care	
Physical/Occupational/ Speech Therapy	25-visit annual maximum for each type of therapy
Radiology/Pathology	
Pharmacy and Blood	
Cardiovascular	
Professional Services	
Inpatient/Outpatient Surgery	
Inpatient/Outpatient/ ER Visits	
Office Visits/ Consults	

Preventive Services	At least $500 annual first dollar coverage
Physical/Occupational/Speech Therapy	25-visit annual maximum for each therapy
Cardiovascular	
Radiology/Pathology	
Outpatient Mental Health/ Substance Abuse	Covered the same as any other illness
Ancillary Services	
Prescription Drug	Brand name drugs are not covered where a generic substitute is available.
Home Health/Home IV Therapy	Excludes custodial care. Includes case management.
Ambulance	Emergency ambulance transportation only, subject to the prudent layperson's standard.
Durable Medical Equipment/ Supplies/Prosthetics	
Family Planning Services	Excludes abortion or abortifacients. Includes contraceptives and sexually transmitted disease testing as described in Medicaid law (42 USC 1396).
Lead Screening Services	Ages 19 and 20 only
Hearing Aides	Ages 19 and 20 only
Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) Services	Subject to the HIP benefit coverage limits
Disease Management Services	

35. **Preventive Benefits.**

a. Enrollees will have an annual budget of at least $500 for "first dollar coverage" to pay for preventive services. Enrollees may not be required to pay any cost sharing for the first $500 of preventive services in any coverage year. The first $500 in preventive care service will not count against the $1,100 annual deductible and will not be accessed using the enrollee's POWER Account card. Preventive services in excess of the "first dollar coverage," are covered, but are subject to the deductible.

b. For coverage terms beginning the first year of the demonstration, each enrollee is required to receive an annual physical by the end of their 12-month eligibility period. For subsequent years of the demonstration, each enrollee will be required to access the appropriate preventive services (defined as care that is provided to an individual to prevent disease, diagnose disease, or promote good health) for their specific age and gender as described in paragraph 35(c) below. These

requirements are for purposes of the carry-forward of POWER Account funds described in paragraph 46(c).

c. As part of the first Quarterly Progress Report (as required under paragraph 56), the State will submit a list of the services (including services codes) that are considered to be preventive services that can be provided from the $500 of "first dollar coverage," and a definition of the preventive services that enrollees must receive in order to qualify for the full carry-forward of POWER Account funds described in paragraph 46(c). Any changes to these must be reported by the State in a subsequent Quarterly Progress Report. The current preventive services requirements to receive full carry-forward of POWER Account funds must be posted promptly to FSSA's public Web site.

36. **Changes to Benefits.** Changes to HIP benefits shall be made by amendment to the Demonstration, in accordance with Section III, paragraph 8.

37. **Annual and Lifetime Benefit Limits.** The benefits available under HIP are limited to $300,000 annually and $1 million over a lifetime.

a. If during a coverage term, an enrollee exceeds the annual benefit limit of $300,000, the enrollee will remain enrolled in the MCO or ESP and must continue to make POWER Account contributions; however, the enrollee will not have access to covered services. After redetermination and at the beginning of a new coverage term, the enrollee will have reinstated access to covered services.

b. If an enrollee exceeds the lifetime benefit limit of $1 million, the enrollee will be disenrolled from HIP following the procedures specified in paragraph 48(c). If enrollees exceed $200,000 in benefits in a year or $900,000 in benefits in a lifetime, they must be informed that they may apply for Medicaid, Medicaid for Employees with Disabilities (M.E.D. Works), and/or ICHIA, the State's high risk pool. Notices must be provided to ensure the enrollee has a reasonable time to provide the necessary documentation.

Cost Sharing

38. **Allowable Cost Sharing**

a. HIP enrollees may not be subject to any cost sharing requirements (as defined in section 1916A(a)(2)(B) of the Act) as a condition for receiving services, other than what is described in (b) below. Neither the required monthly POWER Account contributions discussed in paragraph 40, nor payments made from the POWER Account to defray the cost of services prior to the deductible being reached, are considered cost sharing for this purpose.

b. HIP enrollees may be charged co-payments for non-emergency use of a hospital emergency department, subject to the following conditions.

i. The maximum amounts that can be charged to HIP enrollees are as follows:

Population	Co-Payment Amount
HIP Caretakers With Incomes Above the AFDC Income Limit as Indicated in the State Plan through 100% FPL	$3 per visit
HIP Caretakers Above 100 % through 150% FPL	$6 per visit
HIP Caretakers Above 150 % through 200% FPL	Lower of 20 percent of the cost of the services provided during the visit, or $25
HIP Adults	$25 per visit

ii. The conditions stated in section 1916A(e)(1) of the Act and in the August 15, 2007, State Medicaid Directors Letter (SMDL) #07-010 must be met.

iii. The individual must receive an appropriate medical screening examination under section 1867—the Emergency Medical Treatment and Labor Act, or EMTALA provision of the Act.

iv. Assuming the individual actually has an available and accessible alternate non-emergency services provider and a determination has been made that the individual does not have an emergency medical condition, the hospital must inform the individual before providing non-emergency services that:

- The hospital may require payment of the above-named cost sharing before the service can be provided.
- The hospital provides the name and location of an alternate non-emergency services provider that is actually available and accessible.
- An alternate provider can provide the services without the imposition of the State-specified higher cost sharing for the inappropriate use of the ER.
- The hospital provides a referral to coordinate scheduling of this treatment.

v. The co-payment for HIP Caretakers must be refunded if the person is found to have an emergency condition, as defined in section 1867(e)(1)(A) of the Act, or if the person is admitted to the hospital on the same day as the visit. The co-payment for HIP Adults need not be refunded.

c. For families that include HIP Caretakers, the total aggregate amount of POWER Account contributions, Medicaid and HIP cost sharing, and SCHIP premiums and cost sharing may not exceed 5 percent of the family income of the family involved. Family income will be determined under the methodology applicable to the group under the State Medicaid plan. The State must develop a process for ensuring that families do not exceed the 5 percent cost sharing limit, and must include a description of this process in the first Annual Report required in paragraph 57.

POWER Accounts

39. **General Description.** The POWER Account is modeled in the spirit of a traditional Health Savings Account (HSA) and will, at a minimum, be funded with State, Federal, and enrollee contributions. Employers may contribute as well, with some restrictions. POWER Accounts will be funded with post-tax dollars and are not considered HSAs or other health spending accounts (e.g., Flexible Spending Accounts, Health Reimbursement Accounts, etc.) under Federal law. Therefore, the POWER Accounts are not subject to regulation under the U.S. Tax Code as such. Instead, the functioning of the POWER Accounts shall be governed by these STCs.

    POWER Accounts are designed to encourage preventive care, the appropriate utilization of health care services and personal responsibility. Enrollees will be informed that responsible use of POWER Account funds, as well as utilization of recommended preventive care services, can lead to a reduced financial burden in the subsequent years. If enrollees are aware that prudent management of their health care expenditures can leave them with available funds at the end of the year—and that these funds can be used to lower the following year's contribution—enrollees will be encouraged to make value- and cost-conscious decisions.

    Enrollees will make the same POWER Account contribution regardless of the delivery system under which they receive benefits. The amount of annual POWER Account contributions is based on family size and income. Family income will be determined under the methodology applicable to the group under the State Medicaid plan. The enrollee's coverage will begin on the first of the month after his or her first POWER Account contribution is received and processed.

    Therefore, individuals eligible for HIP are deemed "conditionally eligible" until they make their first POWER Account contribution. Eligibility does not become final until the individual has made their first POWER Account contribution and, if the payment is made by check, the check clears to the MCO or ESP.

40. **Required Participation in a POWER Account.** HIP enrollees are required to help fund the $1,100 deductible by contributing to a POWER Account. Contributions will be determined on a sliding scale based on the enrollee's income, will not exceed 5 percent of an enrollee's gross annual family income, and will be reduced by other payments made to SCHIP, Medicaid, or Hoosier Healthwise.

    a. The sliding scale for POWER Account contributions is as follows:

Table 4 – POWER Account Contributions

Annual Household Income	Maximum POWER Account Contribution
All enrollees at or below 100 percent FPL	No more than 2 percent of income
All enrollees above 100 through 125 percent FPL	No more than 3 percent of income

All enrollees above 125 through 150 percent FPL	No more than 4 percent of income
HIP Caretakers above 150 through 200 percent FPL	No more than 4.5 percent of income
HIP Adults above 150 through 200 percent FPL	No more than 5 percent of income

b. The State will develop an algorithm to determine the amount of an enrollee's annual required contribution and will notify the MCO and ESP of this amount. The MCO and ESP must bill for, and collect, the required enrollee contribution.

c. Enrollees must be given the opportunity to pay their required contribution in equal monthly installments.

41. **Enrollee POWER Account Contributions.** The State will notify new enrollees of POWER Account contribution requirements at the same time the State informs new enrollees that they have been found "conditionally eligible."

a. **Initial Enrollee Contribution.** The first installment will be due 60 days after the enrollee is enrolled into an MCO or ESP, and may not exceed one-twelfth (1/12) of the enrollee's total required annual POWER Account contribution. HIP coverage will not begin until the first day of the coverage month after the first POWER Account contribution installment is received, or, if payment is made by check, the check clears. The MCO or ESP must notify the State within 5 to 30 days after an enrollee's first POWER Account contribution installment has been received.

b. **Ongoing Monthly POWER Account Contributions.** In families with two enrolled individuals, each enrollee will have their own POWER Account. However, the total of both enrollees' POWER Account contributions cannot exceed the total POWER Account contribution that applies to the family's annual household income as specified in paragraph 40(a).

c. **Recalculation of Enrollee POWER Account Contribution Amount**. At the end of each coverage term and after the enrollee has been determined eligible for another coverage term, the enrollee's POWER Account contribution may need to be recalculated for the new coverage term, based on changes in the enrollee's annual household income identified at the time of redetermination.

The State will notify the MCO or ESP of the enrollee's POWER Account contribution for the new coverage term, and within 60 days, the MCO or ESP will:

i. Reduce the enrollee's POWER Account contribution for the new coverage term by the amount of the enrollee's POWER Account balance that was carried forward as calculated in paragraph 46(c);
ii. Notify the enrollee of this roll-over amount, as well as the new amount to be billed to the enrollee in equal monthly installments in the new coverage term; and
iii. Reconcile any overpayments or underpayments made by the enrollee as a result of the overlapping timeframes of monthly payments and recalculation of new contribution amounts for the new coverage term.

42. **State POWER Account Contributions.**

a. The State will fund any gap between a non-ESP enrollee's annual required POWER Account contribution and the $1,100 deductible. The State will make its entire contribution to the POWER Account promptly after receiving notice from the MCO that the enrollee's first POWER Account contribution has been received and processed.

b. The State may choose whether or not to fund the gap between an ESP enrollee's annual required POWER Account contribution and the $1,100 deductible, following requirements addressed in paragraph 29.

43. **"Up -Front" POWER Account Contribution by MCO or ESP.**

a. In the case where a covered service may exceed the member's current POWER Account balance, the MCO or ESP must reimburse the provider for the balance according to its normal claims processing procedures. The MCO or ESP can recover the funds it paid on the member's behalf with future POWER Account contributions paid by the member.

b. If an enrollee is terminated under the provisions in paragraphs 47 and 49 before the full annual POWER Account contribution is paid to the MCO or ESP, the MCO or ESP will levy the enrollee's account and notify the State of the enrollee's debt.

c. The MCO or ESP may attempt to collect the unpaid POWER Account contributions from the enrollee, including reporting the debt to credit reporting agencies. However, the MCO or ESP may not "sell" or assign the debt for collection by a third-party.

d. If the enrollee should reapply for HIP, after the mandatory 12-month waiting period specified in paragraphs 46 and 48, the enrollee must pay the prior POWER Account debt as well as the first month's contribution before services can begin.

44. **Employer Contributions**. Employers are permitted and encouraged to contribute to their employees' POWER Accounts. An employer's contribution must be used to offset the employee's required contribution only—not the State's.

45. **POWER Account Card.** The MCO or ESP must issue a card to each enrollee promptly after processing the enrollee's first POWER Account contribution, within thirty (30) days. This card may have all POWER Account contributions loaded onto it.

a. An electronic account update will be e-mailed to the enrollee by the MCO or ESP each time a contribution is credited to the enrollee's POWER Account in order to reflect the new balance.

b. The card may be used by enrollees only to pay for covered services performed by network providers.

c. For covered services provided out-of-network, if the out-of-network provider lacks the capacity to conduct the transaction using the enrollee's card, the MCO or ESP will reimburse the out-of-network provider with funds from the enrollee's POWER Account. ESP and the MCOs may also reimburse in network provides with funds from the enrollee's POWER Account if the network providers lack the capacity to conduct the transaction using the enrollee's card.

d. The MCOs and ESP are required to have an internal system of safeguards for the cards and to manage the POWER Accounts. The State will actively monitor plans and their management of the POWER Accounts either through a separate annual audit or will require the plans to fund annual independent audits.

46. **Use of POWER Account Funds.** Each enrollee will be responsible for the use of funds in his or her POWER Account until the deductible is met. However, POWER Account funds can only be used by the enrollee to pay for the MCO's covered services, including any enhanced services the MCO may choose to offer.

a. **Out of Network Providers.** In spending POWER Account funds, enrollees will be permitted to pay for the following covered services, even if obtained through out-of-network providers:

i. Family planning services;

ii. Emergency medical services, subject to the prudent layperson standard of an "emergency medical condition," as specified in 42 CFR 438.114;

iii. Medically necessary covered services, if the MCO's network is unable to provide the service within a 30-mile radius for primary care and a 60-mile radius for specialty care of the enrollee's residence; and

iv. Nurse practitioner services.

b. **Payment for Out of Network Providers.** For the out-of-network services specified in subparagraph (a), the MCO must coordinate with the out-of-network provider to ensure that the cost to the enrollee is no greater than it would be if the services were provided in-network. If the out-of-network provider lacks the capacity to conduct the transaction using the enrollee's POWER card, the provider must be instructed to bill the MCO and the MCO must reimburse the out-of-network provider with funds from the enrollee's POWER Account.

c. **Carry-Forward and Use of Excess Funds.** At the end of a 12-month coverage term, there may be funds remaining in a enrollee's POWER Account. Some or all of the funds remaining in an enrollee's POWER Account may be carried forward to the next coverage term to reduce the enrollee's required POWER Account contribution in that coverage term. The amount of leftover funds available to be carried forward will depend on several factors outlined below.

i. If the enrollee has obtained all the recommended preventive care services, as advised in writing, appropriate for the enrollee's age, gender, and medical condition, the entire remaining POWER Account balance, including monies contributed by the State, will be carried forward. The enrollee's required contribution for the new year will be the amount determined using the State's algorithm (paragraph 40(b)), reduced by the amount carried forward. If the amount carried forward is greater than the amount determined using the State's algorithm, the required contribution for the new coverage year is $0. For non-ESP enrollees, the State must then contribute to the POWER Account an amount equal to the difference between the sum of the rollover amount and the enrollee's (reduced) annual POWER Account contribution, and $1,100.

ii. If the enrollee has not obtained all the recommended preventive care services, as advised in writing, appropriate for the enrollee's age, gender, and medical condition, only the pro rata share of the enrollee's portion of the POWER Account balance may be carried forward. The pro rata share of the enrollee's portion equals the amount the enrollee's required contribution for the expiring coverage term, plus any enrollee balances rolled over from previous coverage terms, multiplied by the unspent percentage of the POWER Account from the expiring term. The State's portion of the unspent POWER Account balance, calculated similarly to the enrollee's portion of the unspent POWER Account balance, must be returned by the HIP MCO to the State. The enrollee's POWER Account contribution for the next coverage term is the amount determined using the State's algorithm (paragraph 40(b)), minus the amount carried forward as calculated above. The State must contribute an amount equal to the difference between the sum of the rollover amount and the enrollee's (reduced) annual POWER Account contribution, and $1,100. The State may collapse the recovery of the State share of the POWER Account balance and its contribution for the next coverage term into a single, net transaction.

iii. If the amount of funds available to be carried is in excess of the enrollee's required POWER Account contribution for the next coverage term, the excess amount will be credited to the State to reduce the State's contribution in the next coverage term. This shall occur regardless of whether or not the enrollee obtained his or her recommended preventive care services.

iv. The HIP MCOs and ESP must develop and maintain accounting systems capable of tracking POWER Account balances and sub-balances according to whether they were initially contributed by the enrollee or the State. POWER Account balances must maintain their identity as enrollee or State contributions throughout the process.

47. **Non-Payment of Monthly POWER Account Contribution.** If an enrollee does not make a required monthly contribution within 60 days of its due date, the enrollee will be terminated from participation in HIP and disenrolled from the MCO or ESP. The enrollee will also forfeit 25 percent of the enrollee's pro rata share of funds remaining in the POWER account.

a. Before terminating the enrollee, the MCO or ESP must provide at least one written notice advising the enrollee of the delinquent payment, and the date by which the contribution must be paid to prevent disenrollment, as well as notice of the enrollee's appeal rights. The notice must be sent to the enrollee on or before the seventh day of delinquency and must state that the enrollee will be disenrolled from the MCO or ESP and terminated from participation in HIP if payment is not received prior to the date specified in the notice. The notice must explain that if the enrollee is terminated from participation in HIP, the enrollee will not be able to reapply for HIP coverage for a period of at least 12 months.

b. The MCO or ESP is required to refund the enrollee's pro rata portion of the POWER Account, which must be distributed to the enrollee no later than sixty (60) days after the last date of participation in the MCO or ESP. The amount payable to the enrollee shall be determined as follows:

i. Calculate the total enrollee contribution to the POWER Account for the coverage term, including all enrollee balances carried forward from prior coverage terms (E^T);

ii. Calculate the amount actually contributed by the enrollee to the POWER Account for the coverage term, including all enrollee balances carried forward from prior coverage terms (E^A);

iii. Calculate the percentage of the POWER Account expended during the coverage term, which will equal the total dollar amount expended, divided by $1,100 (u);

iv. Multiply the result in (iii) by the result in (i), and subtract from the result in (ii) ($R = E^A - u*E^T$).

v. If the result in (iv) is positive, the MCO or ESP must return 75 percent of this amount to the enrollee and 25 percent of this amount to the State.

vi. If the result in (iv) is negative, the result is the amount that the enrollee owes to the MCO or ESP as described in paragraphs 43(b) through 43(d).

vii. The MCO or ESP must return to the State all unexpended State POWER Account contributions, including amounts carried forward from prior coverage terms.

48. **Loss of Eligibility for HIP and POWER Account Contributions.** If an enrollee becomes ineligible for HIP, either at redetermination or at another time, the MCO or ESP must refund the enrollee's pro rata share of his or her POWER Account balance, if any, within 60 days of the enrollee's last date of participation in the MCO or ESP. The amount payable to the enrollee shall be determined as in paragraph 47(b), except that in step (v), 100 percent of the result must be returned to the enrollee.

49. **Failure to Redetermine Eligibility and POWER Account Contributions.** If an enrollee fails to complete all necessary steps to maintain eligibility for HIP at the end of a coverage term, the enrollee will not be permitted to reapply for HIP for a period of at least 12 months.

    The MCO or ESP will be required to refund the enrollee's pro rata share of his or her POWER Account balance, if any, within 60 days of the enrollee's last date of participation in the MCO. The amount payable to the enrollee shall be determined using the calculations specified in paragraphs 47 and 48. Unspent State POWER Account contributions must be returned to the State.

50. **POWER Account Balance Transfers.** If an enrollee transfers to a new MCO or ESP, the enrollee's POWER Account balance will be transferred to the State within thirty (30) days from the date the MCO or ESP was notified by the State.

    For a transfer at the end of a coverage term, the current MCO or ESP remains responsible for determining the amount of the enrollee's POWER Account that may be carried over, and forwarding that amount to the State. The State will forward the balance to the new MCO or ESP.

51. **POWER Account Reporting to State.** Each MCO and ESP must submit a report to the State each month that provides the following for each terminated or ineligible enrollee:

    a. Demographic information on the enrollee;

    b. The balance remaining in the enrollee's POWER account;

    c. The amount paid to the enrollee as required under paragraphs 46 through 49; and

    d. The amount to be returned to the State.

VII. GENERAL REPORTING REQUIREMENTS

52. **General Financial Requirements.** The State shall comply with all general financial requirements under title XIX set forth in these STCs.

53. **Reporting Requirements Relating to Budget Neutrality.** The State shall comply with all reporting requirements for monitoring budget neutrality set forth in this agreement. The State must submit any corrected budget and/or allotment neutrality data upon request.

54. **Compliance With Managed Care Reporting Requirements.** The State shall comply with all managed care reporting regulations at 42 CFR Part 438 *et seq.,* except as expressly waived or referenced in the expenditure authorities incorporated into these STCs.

55. **Monthly Calls.** CMS will schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment, cost-sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting related to budget neutrality issues, MCO financial performance that is relevant to the Demonstration, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers, or State plan amendments the State is considering submitting. CMS shall update the State on any amendments or concept papers under review, as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS shall jointly develop the agenda for the calls.

56. **Quarterly Progress Reports:** The State must submit progress reports in accordance with the guidelines in Attachment A no later than 60 days following the end of each quarter (March, June, September, and December of each year). The intent of these reports is to present the State's analysis and the status of the various operational areas. These quarterly reports must include, but not be limited to:

    a. An updated budget neutrality monitoring spreadsheet;

    b. A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including, but not limited to: approval and contracting with new plans, benefits, enrollment and disenrollment, grievances, quality of care, access, health plan contract compliance and financial performance that is relevant to the Demonstration, pertinent legislative or litigation activity, and other operational issues;

    c. Action plans for addressing any policy, administrative, or budget issues identified;

    d. Quarterly enrollment reports for Demonstration eligibles that include the member months for each Demonstration population, as required to evaluate compliance with the budget neutrality agreement, and as specified in Section VIII, paragraph 61; and other statistical reports listed in Attachment A; and

    e. Evaluation activities and interim findings including the number of individuals who are within $100,000 of reaching the annual or lifetime benefit limit. The State shall report on its efforts to refer these individuals to the regular Medicaid program, M.E.D. Works, or ICHIA.

    f. A report on which option the State is currently using and any plans to change the option regarding State contributions to ESP enrollees' POWER Accounts as outlined in paragraph 29(b).

g. A list of services (including service codes) that are considered to be preventive services that can be provided from the $500 of "first dollar coverage," and a definition of the preventive services that enrollees must receive in order to qualify for the full carry-forward of POWER Account funds as outlined in paragraph 35(c).

57. **Annual Report.**

a. The State shall submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, interim evaluation findings, and policy and administrative difficulties and solutions in the operation of the Demonstration.

b. In addition, the State shall include information on the following in its draft annual report:

i. The level of preventive services compliance, including a summary of member compliance and non-compliance with Office of Medicaid Policy and Planning (OMPP) recommended preventive services.
ii. The number of HIP Caretakers and HIP Adults who are within $100,000 of exceeding the annual and or lifetime benefit limit and the State's efforts to refer these individuals to the regular Medicaid program, M.E.D. Works, or ICHIA.
iii. The progress of Indiana's care management program for the Aged, Blind, and Disabled (ABD) population and the feasibility of moving part or all of the ABD population into managed care.
iv. Any strategies the State is examining to reduce the uninsurance rate in the State, such as restructuring the Small Group Reinsurance Pool to make it more attractive to small groups.
v. Incentive programs developed by HIP MCOs for providers and HIP members. Potential areas include emergency room utilization, access to care, asthma, obesity, preventive service utilization, and smoking cessation.
vi. A description of how health information technology (HIT) is progressing in the State and how the Demonstration has assisted in progressing HIT, including any HIT and data sharing initiatives that are developed or implemented by HIP MCOs to improve quality, efficiency, and safety of health care delivery in Indiana.
vii. A description of the process through which a HIP member may appeal the State's decision to move the member out of an MCO to ESP or out of ESP to an MCO as outlined in paragraph 29(e).
viii. A description of the process for ensuring that families do not exceed the 5 percent cost sharing limit as outlined in paragraph 38(c).
ix. A description of the progress made in achieving the $15 million (total computable) in additional savings as outlined in paragraph 58.

c. The State shall submit the draft annual report no later than 120 days after the end of each Demonstration year (DY) for CMS review. The State shall finalize and submit the final draft report within 60 days from receipt of CMS' comments.

58. **Additional Savings Projects.** The State must achieve a total of $15 million (total computable) in additional savings to its Medicaid program by the end of the Demonstration period through enhancements in Medicaid operations such as more effective cost recovery efforts.

The State must report on the progress made in improving the efficiency and economy of Medicaid State operations and achieving the $15 million (total computable) in savings in each Annual Report (as required under paragraph 57). The measures of savings, the baselines from which the savings will be compared, and where the State must report the savings are outlined in the table below. The State may submit an amendment to the Demonstration to modify, remove, or propose additional measures of savings, such as strategic purchasing agreements, following procedures described in paragraph 8, but will be held to a total of $15 million in savings for the Demonstration period. Savings for each DY will be measured as the difference between the baseline amount and the amount actually reported for that year. Each year's savings amounts for each measure will be added together to determine if the State achieved the $15 million target.

Measure	FFY 2007 Baseline (Total Computable)	Reporting	Computation of Savings
Third party liability cost recoveries	$ 19,614,846	CMS-64, line 9a	Difference between actual reported amount and baseline
Estate recoveries	$ 9,532,345	CMS-64, line 9b	Difference between actual reported amount and baseline
Collections identified through fraud and abuse effort	$ 4,295,099	CMS-64, line 9c	Difference between actual reported amount and baseline

The reported expenditures will be reconciled at the end of the Demonstration with the State's Medicaid Budget and Expenditure System (MBES) submissions. If the State does not achieve savings of $15 million by the end of DY 5, the State must return to CMS the Federal share of the difference between $15 million (total computable) and the verified level of savings (total computable). The State will not be required to return more than the Federal share of $15 million. Any repayment required under this paragraph will be accomplished by the State making an adjustment for its excessive claim for FFP on the Form CMS-64 by entering an amount in line 10(b) of the Summary sheet.

VIII. GENERAL FINANCIAL REQUIREMENTS

59. **Quarterly Expenditure Reports.** The State must provide quarterly expenditure reports using the form CMS-64 to report total expenditures for services provided under the Medicaid program, and to separately identify expenditures provided through the Demonstration under section 1115 authority, which are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS shall provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section IX.

60. **Reporting Expenditures Under the Demonstration**. The following describes the reporting of expenditures subject to the budget neutrality expenditure limit:

    a. **Tracking Expenditures.** In order to track expenditures under this Demonstration, Indiana must report Demonstration expenditures through the MBES and State Children's Health Insurance Program Budget and Expenditure System (CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All Demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration project number assigned by CMS, including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made. For this purpose, DY 1 is defined as the year beginning January 1, 2008, and ending December 31, 2008. DY 2 and subsequent DYs are defined accordingly. All title XIX service expenditures that are not Demonstration expenditures and are not part of any other title XIX waiver program should be reported on Forms CMS-64.9 Base/64.9P Base. Expenditures for HHW Caretakers, HHW Children, and HHW Pregnant Women with dates of service December 31, 2007, and before, but with dates of payment January 1, 2008, and after, should be reported on Forms CMS-64.9 Base and 64.9P Base.

    b. **Reporting of HIP Plan Premiums and POWER Account Contributions** The State must report HIP plan premiums and POWER Account contributions as follows:

        i. HIP MCO Premiums. HIP plan premiums must be reported on Forms CMS-64.9 Waiver and CMS-64.9P Waiver, using Line 18A.
        ii. State's Contributions to Participants' POWER Accounts. The State's contributions to participants' POWER Accounts must be reported on Forms CMS-64.9 Waiver, using Line 18E. (Because individual participants' POWER Account contributions are collected by the HIP plans, and are not subject to Federal matching, they are not to be reported on the CMS-64.)
        iii. Recouped State Contributions to Participants' POWER Accounts. In the event that the State recoups State POWER Account contributions from HIP MCOs (for example, when a participant disenrolls from HIP; see paragraphs 45(c)(ii), 47(b)(vii), 48, 49, and 50), the amounts collected must be reported as a prior period adjustment using Line 10B of the Forms CMS-64.9P Waiver on Line 18E.
        iv. Forfeited Participant Contributions. In the event that a participant's eligibility for HIP

is terminated for non-payment of POWER Account contributions, resulting in forfeiture of 25 percent of the remainder of the participant's share of their POWER Account balance (see paragraph 47(b)(v)), the State must recover the forfeited funds from the HIP MCO and must report the recovery as a collection on Form CMS-64, Line 9D. The State must also provide a supplementary report on the Narrative section of Form CMS-64, stating the amount reported on Line 9D attributable to the recovered participant POWER Account balances, along with a disaggregation of the amount reported by eligibility group, as specified in subparagraph (e).

v. Service Expenditures Through ESP. Expenditures for health care services provided to ESP other than those funded through State or enrollee POWER Account contributions, must be reported on CMS-64.9 Waiver and CMS-64.9P Waiver, by eligibility group on the appropriate service line. In addition, expenditures for administrative services provided to ESP must be reported on CMS-64.9 Waiver and CMS-64.9P Waiver, by the appropriate eligibility group—"HIP Caretakers Adm" or "HIP Adults Adm" as described in subparagraph (g) below.

c. **Disproportionate Share Hospital (DSH) Expenditures.** The following rules govern DSH expenditures for the Demonstration. All DSH expenditures will continue to be reported on forms CMS-64.9 Base and CMS 64.9P Base.

i. Indiana may not claim FFP of more than $163,721,400 for DSH expenditures for FFY 2008. This amount consists of one-quarter of the full FFY 2008 DSH allotment ($50,333,850 in Federal share) plus three quarters of the State's planned DSH expenditures for a full year. This calculation anticipates a Demonstration implementation date of January 1, 2008. In its proposal, the State indicated that it would spend $151,183,400 (Federal share) on DSH for each year of the Demonstration and would use whatever funds remained up to the State's DSH allotment to fund HIP.

ii. Indiana may not claim FFP of more than $151,183,400 for DSH expenditures for FFY 2009 through FFY 2012. This is the amount of DSH allotment that Indiana will continue to spend on DSH expenditures each year of the Demonstration.

iii. Indiana may not claim FFP of more than $37,795,850 plus three-quarters of the FFY 2013 DSH allotment for DSH expenditures in FFY 2013. Should the Demonstration be extended beyond December 31, 2012, appropriate adjustments can be made to these requirements in conjunction with the extension. One-quarter of the amount that Indiana will continue to spend on DSH during each year of the Demonstration is $60,290,078 (total computable) or $37,795,850 (Federal share). Three-quarters of the amount that Indiana will continue to spend on DSH during each year of the demonstration is $180,870,234 (total computable) and $113,875,550 (Federal share).

d. **Cost Settlements.** For monitoring purposes, cost settlements attributable to the Demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlements not attributable to this Demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.

e. **Use of Forms**. The following eight (8) waiver Forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted each quarter (when applicable) to report title XIX expenditures for individuals enrolled in the Demonstration. The expressions in quotation marks are the waiver names to be used to designate these waiver forms in the MBES/CBES system.

i. "HHW Caretakers" expenditures

ii. "HHW Children" expenditures

iii. "HHW Pregnant Women" expenditures

iv. "HIP Caretakers" expenditures

v. "HIP Adults" expenditures

f. **Title XIX Expenditures Subject to the Budget Neutrality Expenditure Limit**. For the purpose of this section, the term "expenditures subject to the budget neutrality expenditure limit" refers to all title XIX expenditures on behalf of individuals who are enrolled in this Demonstration, as defined in Section IV, paragraph 19, including all service expenditures net of premium collections and other offsetting collections. All title XIX expenditures that are subject to the budget neutrality expenditure limit are considered Demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver.

g. **Administrative Costs.** The following provisions govern reporting of administrative costs during the Demonstration.

i. In accordance to Federal regulations at 42 CFR 488.812(b)(2), the portion of the State's payments to ESP that is for administrative services must be claimed by the State as an administrative cost at the Federal matching rates available for the costs of administration of the Medicaid program. These administrative expenses are costs of the Demonstration waiver that are subject to the budget neutrality expenditure limit described in section IX of these STCs. These administrative costs must be reported on Forms CMS-64.10 Waiver and/or 64.10P Waiver, identified by the Demonstration project number assigned by CMS, including the project number extension, which indicates the DY for which the administrative services were paid. Separate forms must be submitted, using the waiver name "HIP Caretakers Adm" to report expenses related to the management of HIP Caretakers' services, and "HIP Adults Adm" to report expenses incurred for the management of HIP Adults' services.

ii. Administrative costs attributable to the Demonstration that are described in (i) must be reported under waiver name "HIP." These expenses are not subject to the budget neutrality limit.

iii. Administrative costs not related to the Demonstration should be reported on the appropriate CMS-64.10 Base or 64.10P Base, or another waiver schedule as appropriate, and not subject to the budget neutrality test for this Demonstration.

h. **Claiming Period**. All claims for expenditures subject to the budget neutrality expenditure limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the Demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately on the CMS-64 waiver forms the net expenditures related to dates of service during the operation of the section 1115 Demonstration, in order to account for these expenditures properly to determine budget neutrality.

61. **Reporting Member Months:** The following describes the reporting of member months for HIP:

a. For the purpose of calculating the budget neutrality expenditure limit, the State must provide to CMS, as part of the quarterly report required under Section VII, paragraph 56, the actual number of eligible member months for all HIP eligibility groups defined in Section IV, paragraph 19. The State must submit a statement accompanying the quarterly report, certifying the accuracy of this information. Member months should be reported only for individuals who are participating in the Demonstration, as defined in Section IV, paragraph 19.

A template for reporting member months in the quarterly progress reports is provided in Attachment A. Member months for "HHW Caretakers," "HHW Children," "HHW Pregnant Women," and "HIP Caretakers" are reported in section 6A of the template, and are used in the calculation of the budget neutrality expenditure limit. Member months for "HIP Adults" are reported in section 6B of the template, and are not used to calculate the budget neutrality expenditure limit.

b. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of 4 eligible member months.

c. "Eligible member months" does not include the number of months in which an individual participating in the Demonstration cannot access services as a result of reaching the lifetime benefit limits outlined in Section VI, paragraph 37.

62. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the Demonstration. The State must estimate matchable Demonstration

expenditures (total computable and Federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 (narrative section) for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

63. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the Demonstration as a whole as outlined below, subject to the budget neutrality limits described in Section IX.

    a. Administrative costs, including those associated with the administration of the Demonstration;

    b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid State plan and waiver authorities;

    c. Net expenditures and prior period adjustments, made under approved Expenditure Authorities granted through section 1115(a)(2) of the Act, with dates of service during the operation of the Demonstration.

64. **Sources of Non-Federal Share.** The State provides assurance that the matching non-Federal share of funds for the Demonstration is State/local monies. The State further assures that such funds shall not be used as the match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

    a. CMS may review at any time the sources of the non-Federal share of funding for the Demonstration. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

    b. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

    c. Under all circumstances, health care providers must retain 100 percent of the HIP reimbursement amounts claimed by the State as Demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the State and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting

business (such as payments related to taxes (including health care provider-related taxes), fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

d. FFP will not be available for individual contributions to the POWER Accounts. FFP will be available for State contributions to the POWER Accounts, payments to MCOs, and service expenditures through ESP. Payments to the MCOs are based on the assumption of a $1,100 deductible.

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

IX. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

66. **Limit on Title XIX Funding.** The State shall be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The limit will consist of two parts, and is determined by using a per capita cost method, with an aggregate adjustment for projected DSH payments. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire Demonstration. Actual expenditures subject to the budget neutrality expenditure limit shall be reported by the State using the procedures described in Section VIII, paragraph 60.

67. **Risk.** Indiana shall be at risk for the per capita cost (as determined by the method described below in this Section) for Medicaid eligibles in the following eligibility groups: "HHW Caretakers," "HHW Children," "HHW Pregnant Women," and "HIP Caretakers," but not for the number of Demonstration eligibles in each of the groups. By providing FFP for HIP enrollees in these eligibility groups, Indiana shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing Indiana at risk for the per capita costs for HIP enrollees, CMS assures that the Federal Demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no Demonstration. Indiana will be at risk for both per capita costs and enrollment for "HIP Adults" eligibles.

68. **Budget Neutrality Annual Expenditure Limits.** For each DY, two annual limits are calculated.

a. **Limit A.** Limit A consists of the sum of five components. Components one through three are calculated as the projected per member per month (PMPM) cost times the actual number of member months (reported by the State in accordance with paragraph 61) for "HHW Caretakers," "HHW Children," "HHW Pregnant Women," each multiplied by the Composite Federal Share (defined below). Component four equals three-quarters of Indiana's Federal share DSH allotment for the FFY that ends during the DY, minus $113,387,550 (Federal share). Component five equals one-quarter of Indiana's Federal

share DSH allotment for the FFY that begins during the DY, minus $37,795,850 (Federal share). The calculations used to derive these figures are explained in paragraph 60(c).

b. **Limit B.** Limit B is calculated as the projected PMPM cost times the actual number of member months for "HIP Caretakers," multiplied by the Composite Federal Share.

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

	Trend	DY 1	DY 2	DY 3	DY 4	DY 5
HHW Caretakers	4.40%	$330.69	$345.24	$360.43	$376.28	$392.84
HHW Children	4.40%	$181.90	$189.91	$198.26	$206.99	$216.10
HHW Pregnant Women	4.40%	$477.40	$498.41	$520.34	$543.23	$567.14
HIP Caretakers	4.40%	$312.59	$326.34	$340.70	$355.69	$371.34

d. **Composite Federal Share.** The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the State on actual demonstration expenditures during the 5-year approval period, as reported on the forms listed in paragraph 60(e), by total computable Demonstration expenditures for the same period as reported on the same forms. Should the Demonstration be terminated prior to the end of the 5-year approval period (see paragraphs 10, 12, and 14), the Composite Federal Share will be determined based on actual expenditures for the period in which the Demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be used.

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

70. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the Demonstration rather than on an annual basis, by combining the annual limits calculated following paragraph 68 into lifetime limits for the demonstration. The following describes how budget neutrality will be enforced.

    a. Test A consists of application of the combined annual Limits A to Demonstration spending reported on the following schedules, as defined in paragraph 60(e) and 60(g): "HHW Caretakers," "HHW Children," "HHW Pregnant Women," "HIP Adults," "HIP Adults Adm."

b. Test B consists of application of the combined annual Limits B to Demonstration spending reported on the "HIP Caretakers" and "HIP Caretakers Adm" schedule.

c. If Test A expenditures exceed Limit A, the State must refund excess expenditures from Test A to CMS. Test B savings cannot be used to offset excess expenditures from Test A.

d. If Test B expenditures exceed Limit B and Test A shows savings, a second test is performed by combining Tests A and B. The State must refund excess expenditures (if any) from the combined test to CMS.

e. If both Tests A and B show excess expenditures, the State must refund the excess expenditures from both tests to CMS.

f. If the Demonstration is terminated prior to the end of the budget neutrality agreement, an assessment of the State's compliance with these requirements shall be based on the time elapsed through the termination date.

g. **Interim Checks/Corrective Action Plan.** If the State exceeds the calculated cumulative target limit for both Tests A and B combined by the percentage identified below for any of the DYs, the State shall submit a corrective action plan to CMS for approval.

DY	Cumulative Target Definition	Percentage
Year 1	Cumulative budget neutrality expenditure cap plus:	1 percent
Year 2	Cumulative budget neutrality expenditure cap plus:	1 percent
Year 3	Cumulative budget neutrality expenditure cap plus:	0.5 percent
Year 4	Cumulative budget neutrality expenditure cap plus:	0.5 percent
Year 5	Cumulative budget neutrality expenditure cap plus:	0 percent

X. EVALUATION OF THE DEMONSTRATION

71. **Submission of Draft Evaluation Design.** The State must submit to CMS for approval a draft evaluation design for an overall evaluation of the Demonstration no later than 120 days after the effective date of the Demonstration. At a minimum, the draft design must include a discussion of the goals and objectives set forth in Section II of these STCs, as well as the specific hypotheses that are being tested. The draft design must discuss the outcome measures that will be used in evaluating the impact of the Demonstration during the period of approval. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration must be isolated from other initiatives occurring in the State. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

The State shall ensure that the draft evaluation design will address the following evaluation questions:

1. How many HIP participants reach their $300,000 annual benefit limit each year? How do these individuals meet their health care needs during the period of exhaustion of their benefit and the beginning of the next coverage term?
2. How many HIP participants reach their $1,000,000 lifetime benefit maximum? How do they go about meeting their health care needs after their HIP benefits are exhausted?
3. What are the consequences of limiting participants' ability to switch plans after they have made an initial POWER Account contribution? What percentage of HIP applicants are auto-assigned to an MCO?
4. How many enrollees are reassigned from HIP MCOs each year to ESP? How many are reassigned from ESP to a HIP MCO?
5. What percentage of the potentially eligible population enrolls in HIP? How does the percentage vary by major population subgroups (HIP Caretakers, HIP Adults) and income level?
6. What are the consequences of requiring HIP participants with family income less than 150 percent of the FPL to pay monthly premiums? How many of these participants fail to make their first POWER Account contribution? How many of these participants are disenrolled for failure to pay their premiums?
7. To what extent has HIP impacted the uninsurance rate in Indiana?
8. To what extent has HIP reduced uncompensated care provided by Indiana's federally funded health clinics?
9. How many enrollees exhaust their POWER Account each year? How many enrollees are able to roll-over a sufficient POWER Account balance to reduce their subsequent year's required contribution by at least half? How many enrollees are able to achieve a $0 contribution by this means?

72. **Interim Evaluation Reports**. In the event the State requests to extend the Demonstration beyond the current approval period under the authority of §1115(a), (e), or (f) of the Act, the State must submit an interim evaluation report as part of the State's request for each subsequent renewal.

73. **Final Evaluation Design and Implementation**. CMS must provide comments on the draft evaluation design within 60 days of receipt, and the State shall submit a final design within 60 days after receipt of CMS comments. The State must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports. The State must submit to CMS a draft of the evaluation report within 120 days after expiration of the Demonstration. CMS must provide comments within 60 days after receipt of the report. The State must submit the final evaluation report within 60 days after receipt of CMS comments.

74. **Cooperation with Federal Evaluators**. Should CMS undertake an independent evaluation of any component of the Demonstration, the State shall cooperate fully with CMS or the independent evaluator selected by CMS. The State shall submit the required data to CMS or the contractor.

XI. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

Date – Specific	Deliverable	STC Reference
5/01/2008	Submit Draft Evaluation Design	Section X, paragraph 73
1/01/2009	Submit confirmation that HIP members will have a choice of at least two managed care organizations.	Section VI, paragraph 31
6/30/2012	Submit Demonstration Application	Section II, paragraph 9
6/30/2012	Submit Interim Evaluation Report	Section X, paragraph 72

	Deliverable	STC Reference
Annual	By April 1st - Draft Annual Report	Section VII, paragraph 57
Quarterly		
	Quarterly Progress Reports	Section VII, paragraph 56
	Quarterly Expenditure Reports	Section VIII, paragraph 59
	Eligible Member Months	Section VIII, paragraph 61

Attachment A

Quarterly Program Report Guidelines

Under Section VII, paragraph 56 of these STCs, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook is provided.

NARRATIVE REPORT FORMAT:

Title Line One – Healthy Indiana Plan Demonstration

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:
Demonstration Year: 1 (1/01/08 - 12/31/08)
Federal Fiscal Quarter: 2/2008 (1/08 - 3/08)

Introduction:

Information describing the goal of the demonstration, what it does, and key dates of approval/ operation. (This should be the same for each report.)

Eligibility and Enrollment Information:
Please provide the following information. If there was no activity under a particular facet of the tables below, the State should indicate that by "0."

1. The number of HIP members who have reached $200,000 in benefits in a year or $900,000 in benefits in a lifetime. Of these individuals, how many have been referred to the regular Medicaid program, Medicaid for Employees with Disabilities (M.E.D. Works), or ICHIA, the State's high-risk pool.

2. The number of HIP members who have reached the $300,000 annual and $1 million lifetime benefit limits during the quarter. Of these individuals, how many were determined eligible for the regular Medicaid program, and thus have continued coverage available despite having reached their coverage limit? Of these individuals who were not determined eligible for regular Medicaid, how many were determined eligible for M.E.D. Works, and how many were determined eligible for ESP?

3. The number of HIP enrollees who are receiving benefits through ESP.

4. Report on the number of HIP applicants and the disposition of their applications, by income relative to FPL, using the following table:

Attachment A

Quarterly Program Report Guidelines

FPL Level	Column A: Number of Hoosier Healthwise or HIP Applicants	Column B: Number enrolled in the Hoosier Healthwise program	Column C: Number enrolled with a HIP MCO	Column D: Number enrolled in ESP	Column E: Number of enrollees who failed to make POWER Account contribution and were terminated.	Column F: Number of applications declined due to a finding of ESI access or health insurance in the last 6 months
0-22% FPL						
22-50% FPL						
50-100% FPL						
100-150% FPL						
150-200% FPL						

5. Report on HIP enrollment numbers using the following table:

Attachment A

Quarterly Program Report Guidelines

FPL Level	Column A: Number of persons enrolled at start of quarter	Column B: Number of persons enrolled during quarter	Column C: Number of persons disenrolled for non-payment of POWER Account	Column D: Number of persons disenrolled at end of coverage term for failure to recertify	Column E: Number of persons disenrolled for other reasons	Column F: Number of persons enrolled in HIP at the end of the quarter (F)=(A)+(B)-(C)-(D)-(E)
0-22% FPL						
22-50% FPL						
50-100% FPL						
100-150% FPL						
150-200% FPL						

6. Report member-months for budget neutrality:

A. For Use in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
HHW Caretakers				
HHW Children				
HHW Pregnant Women				
HIP Caretakers				

B. Not Used in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
HIP Adults				

Outreach/Innovative Activities:

Attachment A

Quarterly Program Report Guidelines

Summarize outreach activities and/or promising practices for the current quarter.

Operational/Policy Developments/Issues:
Identify all significant program developments/issues/problems that have occurred in the current quarter, including, but not limited to, approval and contracting with new plans, benefit changes, and legislative activity.

Financial/Budget Neutrality Developments/Issues:
Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS-64 reporting for the current quarter. Identify the State's actions to address these issues.

Consumer Issues:
A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences.

Quality Assurance/Monitoring Activity:
Identify any quality assurance/monitoring activity in current quarter.

Demonstration Evaluation
Discuss progress of evaluation design and planning.

Enclosures/Attachments:
Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s):
Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS:

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST

NUMBER: **No. 11-W-00237/5**

TITLE: **Healthy Indiana Plan (HIP) Medicaid Section 1115 Demonstration**

AWARDEE: **Indiana Family and Social Services Administration (FSSA)**

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the State plan mandatory and optional populations. In addition, the provisions of the Social Security Act (the Act) specifically listed as waived in this list are "not applicable" to the Demonstration populations made eligible through expenditure authority, as specified in the individual waivers.

The Demonstration will operate under these waiver authorities and those provisions specified as "not applicable" beginning January 1, 2008. The waiver authorities and the provisions specified as "not applicable" will continue through December 31, 2012, unless otherwise stated.

The following waivers and references to the Act specified as "not applicable" shall enable Indiana to implement the HIP Medicaid section 1115 Demonstration.

Title XIX Waivers

1. Statewideness/Uniformity **Section 1902(a)(1)**

To the extent necessary to enable Indiana to operate the Demonstration and provide managed care plans or certain types of managed care plans, including provider-sponsored networks, only in certain geographical areas.

2. Amount, Duration, and Scope and Comparability **Section 1902(a)(10)(B)**

To the extent necessary to enable Indiana to vary the services offered to individuals, within eligibility groups or within the categorical eligible population, based on differing managed care arrangements or on the absence of managed care arrangements. Individuals enrolled in the Hoosier Healthwise program receive additional benefits such as case management and health education that may not be available to other Medicaid beneficiaries not enrolled in Hoosier Healthwise.

3. Freedom of Choice **Section 1902(a)(23)**

To the extent necessary to enable Indiana to restrict the freedom of choice of providers for the demonstration eligibility groups.

4. Disproportionate Share Hospital (DSH) Payments **Section 1902(a)(13)(A) insofar as it incorporates Section 1923(c)(1)**

To the extent necessary to allow Indiana to divert of a portion of DSH payments made to hospitals to cover the demonstration population.

CENTERS FOR MEDICARE AND MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **No. 11-W-00237/5**

TITLE: **Healthy Indiana Plan (HIP) Medicaid Section 1115 Demonstration**

AWARDEE: **Indiana Family and Social Services Administration**

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, shall, for the period of this Demonstration, be regarded as expenditures under the State's Medicaid title XIX State plan.

The following expenditure authorities shall enable Indiana to implement the Medicaid section 1115 Demonstration (Healthy Indiana Plan).

1. **Demonstration Population 4 (HIP Caretakers).** Expenditures for health care related costs for uninsured adults who are custodial parents and caretaker relatives of children eligible for Medicaid and the State Children's Health Insurance Program (SCHIP) program with family income up to and including 200 percent of the Federal poverty level (FPL) who are not otherwise eligible for Medicaid or Medicare, who do not have access to an employer-sponsored health plan, have been uninsured for 6 months, and whose health care expenditures do not exceed a $1 million lifetime maximum on benefits under the demonstration.

2. **Demonstration Population 5 (HIP Adults).** Expenditures for health care related costs for uninsured adults who are non-custodial parents or childless adults, ages 19 through 64 with family income up to and including 200 percent of the FPL, who are not otherwise eligible for Medicaid or Medicare, who do not have access to an employer-sponsored health plan, have been uninsured for 6 months, and whose health care expenditures do not exceed a $1 million lifetime maximum on benefits under the demonstration.

3. **Expenditures Related to MCO Enrollment and Disenrollment.** Expenditures made under contracts that do not meet the requirements in section 1903(m) of the Act specified below. Indiana managed care plans which serve HIP members will be required to meet all requirements of section 1903(m) except the following:

   Section 1903(m)(2)(A)(vi) and (xi) insofar as they incorporate Federal regulations at 42 CFR 438.56, to the extent that the rules in section 1932(a)(4) of the Act are inconsistent with the disenrollment rules contained in paragraph 31 of the Demonstration's Special Terms and Conditions, such as restricting an enrollee's right to disenroll within 90 days of enrollment in a new managed care organization (MCO). Enrollees may change MCOs without cause within 60 days of enrollment in an MCO or before they make their first POWER account

contribution, whichever occurs first. Enrollees may disenroll from an MCO with cause at any time.

4. **Payments for Non-Risk Contractor**
Payments to the HIP ICHIA prepaid inpatient health plan (PIHP), non-risk, non-capitated contractor more than what Medical Assistance would have paid fee-for-service under the State plan in accordance with the upper limits at 42 CFR 447.362.
Payments shall not exceed Medicare reimbursement rates.

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the list below, shall apply to Demonstration Population 4 and Demonstration Population 5 beginning January 1, 2008, through December 31, 2012.

Title XIX Requirements Not Applicable to Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults)

1. Reasonable Promptness — **Section 1902(a)(3) Section 1902(a)(8)**

To the extent necessary to enable Indiana to prohibit reenrollment for 12 months for individuals in Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults) who are disenrolled for failure to make POWER Account contributions.

To the extent necessary to enable Indiana to delay provision of medical assistance until the first day of the month following an individual's first contribution to the POWER Account.

2. Methods of Administration: Transportation — **Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53**

To the extent necessary to enable Indiana to not assure transportation to and from providers for Demonstration Population 4 (HIP Caretakers) or Demonstration Population 5 (HIP Adults).

3. Eligibility Section — **Section 1902(a)(10)(A)**

To the extent necessary to allow Indiana not to provide medical assistance for Demonstration Population 4 (HIP Caretakers) or Demonstration Population 5 (HIP Adults) until the first day of the month following an individual's first contribution to the POWER Account.

4. Amount, Duration, and Scope of Services — **Section 1902(a)(10)(B)**

To the extent necessary to permit Indiana to offer benefits to Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults) that differ from the benefits offered to the categorically needy group.

To the extent necessary to enable Indiana to vary the amount, duration, and scope of services offered to individuals in Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults) who meet the annual maximum benefit of $300,000.

5. Income and Resource Test **Section 1902(a)(10)(C)(i)**

To the extent necessary to enable Indiana to exclude funds in the POWER account from the income and resource tests established under State and Federal law for purposes of determining Medicaid eligibility for Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults).

6. Freedom of Choice **Section 1902(a)(23) insofar as it incorporates 42 CFR 438.52(a)**

To the extent necessary to enable Indiana to offer only one managed care plan choice for the first year of the Demonstration to Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults).

To the extent necessary to enable Indiana to provide only one choice of plan for individuals in Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults) who are identified as having certain high-risk conditions.

7. Retroactive Eligibility **Section 1902(a)(34)**

To the extent necessary to allow Indiana to not provide medical assistance to Demonstration Population 4 (HIP Caretakers) or to Demonstration Population 5 (HIP Adults) for any time prior to the first of the month following an individual's first contribution to the POWER Account.

8. Prepayment Review **Section 1902(a)(37)(B)**

To the extent necessary to allow Indiana to not ensure that prepayment review be available for disbursements by members of Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults) to their providers.

9. Premiums **Section 1916(a)(1)**

To the extent necessary to enable Indiana to charge premiums for Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults).

10. Dental and Vision Coverage for Certain HIP Caretakers and HIP Adults **Section 1902(a)(43)**

To the extent necessary to enable Indiana not to cover certain vision and dental services described in sections 1905(r)(2) and 1905(r)(3) to 19 and 20 year-old members of Demonstration Population 4 (HIP Caretakers) and Demonstration Population 5 (HIP Adults).