HEALTHY INDIANA PLAN SECTION 1115 MEDICAID DEMONSTRATION FACT SHEET

February 1, 2018

Name of Section 1115 Demonstration:	Healthy Indiana Plan
Waiver Number:	11-W-00296/5
Date Proposal Submitted:	January 31, 2017
Date Approved:	February 1, 2018
Date Originally Implemented:	February 1, 2015
Date Expires:	December 31, 2020

BACKGROUND

On January 31, 2017, the State of Indiana submitted a request to CMS to extend the "Healthy Indiana Plan" (HIP) section 1115 demonstration. On July 20, 2017, the state submitted a request to amend the state's demonstration.

This section 1115(a) demonstration provides authority for the state to offer HIP, which provides health care coverage for adults and an account similar to a health savings account called a Personal Wellness and Responsibility (POWER) Account. Two primary routes to coverage are established under the demonstration: HIP Plus for those who contribute to the Personal Wellness and Responsibility (POWER) account, and HIP Basic for those who do not make such contributions. The state shall make contributions to POWER accounts for individuals enrolled in HIP Plus and HIP Basic. The POWER Account will be used to pay for some of beneficiaries' health care expenses covered under the demonstration. Through the use of such accounts the state intends to promote the efficient use of healthcare, including encouraging preventive care and discouraging unnecessary care.

Under this approval, Indiana is building on and changing its previous HIP program in multiple ways, including through POWER Account contributions determined by income tier, implementation of a tobacco user contribution surcharge, the addition of some chiropractic coverage, a change in the timing of managed care organization (MCO) selection, a non-eligibility period for failure to timely complete the redetermination process, a substance use disorder (SUD) treatment program, and required participation in community engagement.

The state's goals include, but are not limited to determining whether:

- Moving the monthly payment obligation to a tiered structure, linked to a POWER account, will result in more efficient use of health care services, be easier for beneficiaries to understand, and increase compliance with payments;
- Implementing a community engagement requirement will lead to sustainable employment and improved health outcomes among HIP beneficiaries and former HIP beneficiaries who experience a lapse in eligibility or who transition to employer-sponsored coverage or commercial coverage; and
- Charging beneficiaries an increased monthly contribution for tobacco use will

discourage tobacco use and increase the utilization of tobacco cessation benefits.

ELIGIBILITY

The demonstration covers individuals in the following groups: 1931 parents and caretaker relatives, adults with incomes at or below 133 percent of the federal poverty level (FPL) plus a 5 percent income disregard (including pregnant women), and the Transitional Medical Assistance (TMA).

BENEFITS

Both HIP Plus and HIP Basic provides coverage of a full alternative benefit plan (ABP) for individuals in the new adult group, authorized through an amendment to the state plan. Individuals in the HIP Plus ABP have access to additional benefits not available in the HIP Basic ABP, although all individuals, whether enrolled in Plus or Basic, will receive all essential health benefits required by law. The demonstration provides authority for the state to not offer non-emergency medical transportation (NEMT) for the new adult group. Pregnant women receive full state plan benefits.

COST SHARING

The demonstration authorizes the state to collect monthly premiums (contributions to the POWER account) from individuals up to 133 percent of the FPL based on the tiered structure outlined in the special terms and conditions (STC). POWER account contributions are required as a condition of eligibility for individuals with incomes above 100 percent of the FPL but not for individuals with lower incomes, who will enroll in HIP Basic if they do not make POWER account contributions.

Individuals covered under the demonstration, regardless of income, who make POWER account contributions shall be enrolled in HIP Plus. Those enrolled in HIP Plus will not be subject to cost sharing, with the exception of an $8 copayment for nonemergency use of emergency department services. Beneficiaries enrolled in HIP Plus who are identified as tobacco users will have a tobacco user surcharge equal to a 50 percent increase in individual contribution amount. Adults with incomes at or below 100 percent of the FPL who do not choose to make contributions will be enrolled in HIP Basic and will be subject to co-payments at levels permitted under federal Medicaid rules.

Individuals with incomes above 100 percent of the FPL, who begin but subsequently cease making POWER account contributions will, after a 60 day grace period, be disenrolled from HIP coverage and disqualified from such coverage for six months. Exceptions to this period of non-eligibility will be afforded to individuals who are medically frail and those with specific circumstances as described in the special terms and conditions. Because payment of premiums (contributions to the POWER account) is not a requirement for coverage for individuals with incomes at or below 100 percent of the FPL, if such individuals begin but cease making payments, they will not lose coverage (or be subject to a period of non-eligibility) but will be automatically enrolled, without a new application or gap in coverage,

into HIP Basic (instead of HIP Plus).

Also reflecting the unique design of HIP, coverage will be effective: 1) the first day in the month in which an individual makes a POWER account contribution; or, for those with incomes at or below 100 percent of the FPL who do not make a POWER account contribution, coverage will start 2) the first of the month in which the 60 days payment period expires. Expanded access to presumptive eligibility processes will be available at qualified entities throughout the state for individuals seeking immediate coverage, and a "fast track" method for billing and paying POWER account contributions will be available to all individuals under the demonstration to expedite coverage.

OTHER COMPONENTS

Community Engagement

Starting 2019, Indiana will implement a community engagement requirement as a condition of eligibility for non-exempt HIP beneficiaries (as listed in the STCs), ages 19 to 59. To maintain eligibility, non-exempt beneficiaries will be required to participate in various activities which include employment, education, job skills training, or community service for eight months out of a calendar year. Beneficiaries who do not meet the requirement in a calendar year, will be suspended starting in January of the next calendar year. During a suspension period, any beneficiary who becomes pregnant, becomes eligible for Medicaid under an eligibility group not subject to the provisions of the community engagement suspension, or meets an exemption can reactivate their eligibility with an effective date consistent with the beneficiary's new eligibility category or status. If a HIP beneficiary is in a suspension for failure to meet the requirement on his or her redetermination date, and does not meet the requirement or qualify for an exemption (including a good-cause exemption) in the month of redetermination, Indiana will deny that beneficiary's eligibility and terminate his or her enrollment at that time.

The state has made several assurances related to the community engagement requirement, including an assurance that it will assess areas within the state that experience high rates of unemployment, areas with limited economies and/or educational opportunities, and areas with lack of public transportation to determine whether there should be further exemptions from the community engagement requirements and/or additional mitigation strategies, so that the community engagement requirements will not be impossible or unreasonably burdensome for beneficiaries to meet.

Indiana will provide reasonable accommodations related to meeting the community engagement requirement for beneficiaries with disabilities protected by the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act, and Section 1557 of the Patient Protection and Affordable Care Act, when necessary, to enable them to have an equal opportunity to participate in and benefit from the program. Reasonable modifications must include exemptions from participation where an individual is unable to participate for disability-related reasons, modification in the number of hours of participation required where an individual is unable to participate for the required number of hours, and provision of support services necessary to participate, where participation is possible with supports. In addition, the state must evaluate individuals' ability to participate and the types of reasonable modifications and supports needed.

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

Non-Eligibility Period for Failure to Complete Redetermination
Consistent with Medicaid regulations, beneficiaries failing to provide necessary information or documentation to complete the annual redetermination process will be disenrolled from HIP. Beneficiaries will be granted an additional 90 day reconsideration period in which to submit their redetermination paperwork to be reenrolled in HIP. Upon the expiration of the 90 day reconsideration period, individuals, unless otherwise exempt, will be prohibited from re-enrollment in the demonstration for up to six months, unless the individual meets a good cause exception.

DELIVERY SYSTEM

Services for the demonstration will be provided primarily using managed care organizations through the state's approved state plan.

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