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Medicaid Expansion in Indiana

In January 2015, the Centers for Medicare and Medicaid Services (CMS) approved Indiana's amendment of its § 1115 demonstration, the Healthy Indiana Plan (HIP).[1] The amended waiver implements the Affordable Care Act's (ACA) Medicaid expansion by building on the prior HIP demonstration.[2] Beginning February 1, 2015, the new demonstration will cover nearly all adults ages 19-64 with income from 0-138% of the federal poverty level (FPL, about $16,242 per year for an individual in 2015) – an estimated 350,000 beneficiaries.

Indiana describes its demonstration as a "consumer-driven health plan,"[3] which seeks to "[r]educe the number of uninsured, low income Hoosiers and increase access to healthcare services; [p]romote value-based decision-making and personal health responsibility; [p]romote disease-prevention and health promotion to achieve better health outcomes; [p]romote private market coverage. . . ; and [a]ssure State fiscal responsibility and efficient management of the program."[4]

While all waivers involve some amount of administrative complexity, Indiana's demonstration is more complex than others approved to date. The program has multiple parts, including four different Medicaid benefit packages for the populations covered by the waiver (aside from premium assistance for employer-sponsored insurance). It also requires administering and tracking a number of elements, such as premium payments or co-payments, compliance with healthy behaviors, health savings account balances and rollover funds, presumptive eligibility determinations, and services that would have been covered retroactively for certain groups. Beneficiaries are treated differently based on their coverage group, and beneficiaries within the same coverage group are treated differently depending upon their income level, medical frailty status, and whether they have paid premiums.

Indiana's waiver is different than other Medicaid expansion waivers approved to date in that it allows the state to prevent certain newly eligible beneficiaries (non-medically frail adults above the federal poverty level) from re-enrolling in coverage for six months after they are disenrolled for non-payment of premiums. The waiver provides a less generous benefit package to newly eligible beneficiaries at or below the federal poverty level who do not pay premiums. To receive the more generous benefit package, even beneficiaries with very little or no income (0-5% FPL, up to $589 per year for an individual in 2015) must pay premiums of $1.00 per month. Medically frail beneficiaries have access to the state plan benefit package, in accordance with federal law, but those above the federal poverty level who do not pay premiums continue to be billed and must pay state plan co-payments; the waiver does not describe how medically frail beneficiaries will be identified.

Indiana's waiver also differs from others approved to date in that it makes coverage effective on the date of the first premium payment (or at the expiration of a 60 day payment period for those at or below the federal poverty level), rather than on the date of application. The waiver also includes § 1916(f) authority to test graduated co-payments for non-emergency use of the emergency room (ER) up to $25, which is over three times the amount in federal law.

Key elements of Indiana's waiver include:

- Establishing premiums through monthly contributions to a Personal Wellness and Responsibility (POWER) health savings account for most newly eligible adults with income from 0-138% FPL, with services delivered through capitated managed care organizations (MCOs). Premiums are a condition of eligibility for non-medically frail beneficiaries from 101-138% FPL and are limited to 2% of income ($27/month for those at 138% FPL); premiums for those with income below 5% FPL ($49 or less per month for an individual in 2015) are $1.00 per month;
    - Beneficiaries who pay premiums will be eligible for HIP Plus, which includes expanded benefits and co-payments only for non-emergency use of the ER. Coverage in HIP Plus begins the first day of the month in which a beneficiary pays a premium, instead of the date of Medicaid application;
    - Most beneficiaries with income from 101-138% FPL who fail to pay premiums within a 60 day grace period will be disenrolled from coverage and barred from re-enrolling for 6 months;
    - Beneficiaries with income at or below 100% FPL who fail to pay premiums will receive HIP Basic, with fewer benefits (such as no coverage for adult dental and vision) and required co-payments in state plan amounts;
    - Non-expansion parent/caretaker relatives and those receiving Transitional Medical Assistance have the option of paying premiums in lieu of co-payments for services. These beneficiaries receive the Medicaid state plan benefit package;
- Waiving non-emergency medical transportation (NEMT) for most newly eligible adults for one year, to be extended based on the results of an evaluation assessing the impact on access to care;
- Establishing a two year demonstration under §1916(f) with a control group to evaluate whether graduated co-payments (first instance $8, subsequent $25) discourage non-emergency use of the ER by non-expansion parent/caretakers and newly eligible adults; and
- Offering optional Medicaid premium assistance for newly eligible adults with employer-sponsored insurance.

While not implemented through waiver authority, Indiana plans to increase Medicaid provider reimbursement rates to 75% of Medicare rates for physician and physician extender services.

Indiana sought wavier authority to require a work referral as a condition of eligibility, which was not approved by CMS. Instead, Indiana may administer a voluntary state-run work search and job training program, which is separate from the Medicaid expansion demonstration.[5] Indiana's requested wavier of Early Periodic Screening Diagnostic and Treatment (EPSDT) benefits (specifically, vision and dental) for 19 and 20 year olds in the HIP Basic plan also was denied by CMS.

To date, CMS has approved waivers in Arkansas, Iowa, Michigan, and Pennsylvania to implement the ACA's Medicaid expansion. New Hampshire has a waiver application pending with CMS, and Tennessee and Utah have proposals pending at the state level.

Some features of Indiana's demonstration are similar to those approved to date in other states. For example, Iowa and Pennsylvania's demonstrations include non-emergency medical transportation waivers for the first demonstration year and monthly premiums as a condition of eligibility for those above 100% FPL.[6] Iowa,

Michigan, and Pennsylvania also allow beneficiaries to reduce premiums and/or co-payments by completing specified healthy behavior activities.

Indiana's demonstration is distinct from other states in its use of health savings accounts to fund covered services, its waivers of reasonable promptness and retroactive coverage making coverage effective on the date of initial premium payment, the six month lock-out for non-payment of premiums for beneficiaries above 100% FPL, and its testing of graduated co-payments (in amounts that exceed federal law) for non-emergency use of the emergency room.

In addition to changing how coverage works for beneficiaries who were covered under Indiana's prior demonstration, implementation of the new demonstration also will require people between 100-138% currently enrolled in Marketplace coverage to transition to Medicaid, which will require terminating their Marketplace coverage and reconciling any premium tax credits that they may have received. More details about Indiana's demonstration are provided in Table 1.

Table 1: Indiana's Section 1115 Medicaid Expansion Demonstration Waiver Provisions

Element	Indiana Waiver Provision
Overview:	Implements the ACA's Medicaid expansion by requiring most newly eligible adults with incomes from 0-138% FPL to pay monthly premiums by contributing to a Personal Wellness and Responsibility (POWER) health savings account. Newly eligible adults who pay premiums will be eligible for HIP Plus, an expanded benefit package with co-payments only for non-emergency use of the ER. Those with incomes from 101-138% FPL who fail to pay premiums after a 60 day grace period will be disenrolled from coverage and barred from re-enrolling for 6 months. Beneficiaries with incomes at or below 100% FPL who fail to pay premiums will receive HIP Basic, a more limited benefit package with state plan level co-payments. Also allows non-expansion parent/caretakers to pay premiums in lieu of cost-sharing for state plan services and offers optional Medicaid premium assistance for employer-sponsored insurance (ESI) for newly eligible adults over age 21.
Duration:	2/1/15 to 1/31/18
Coverage Groups:	Covers adults ages 19-64 with incomes from 0-138% FPL, including non-expansion (§ 1931) parent/caretakers, those eligible for Transitional Medical Assistance (formerly eligible as § 1931parent/caretakers), and adults newly eligible through the ACA's Medicaid expansion (approximately 350,000 beneficiaries statewide). Excludes children, seniors, and dual eligible beneficiaries. American Indian/Alaska Natives may opt out of the demonstration 30 days after enrollment. Newly eligible AI/ANs who remain in the demonstration will have the more generous (HIP Plus) benefit package, with coverage effective on the date of application, and no premiums or co-payments.
Coverage Effective Date:	Waives reasonable promptness so that HIP Plus coverage begins on the first day of the month in which a beneficiary makes an initial premium payment instead of the date on which beneficiary is determined eligible for Medicaid (retroactive to the application date). Beneficiaries have 60 days from the date of their eligibility determination to make this payment. However, individuals determined presumptively eligible (described below) will maintain presumptive Medicaid coverage for at least 60 days, and those found presumptively eligible who are subsequently determined fully eligible will have no gap in coverage. For those at or below 100% FPL, HIP Basic coverage begins on the first day of the month in which the 60 day premium payment period expires. Once in HIP Basic, beneficiary cannot move to HIP Plus until eligibility renewal, receipt of rollover funds (described below) or at other times designated by the state.

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Fast Track Payments:	Effective April 1, 2015, state shall allow for an optional $10.00 fast track initial POWER account pre-payment that makes enrollment effective the first day of the month in which payment is received, once a beneficiary is determined eligible. However, the beneficiary cannot change MCOs for a year after making a fast track payment. The fast track payment is refundable if the applicant is determined ineligible. If the beneficiary's regular monthly premium is less than $10.00, the MCO shall credit the remaining portion of the fast track payment to subsequent premium payments. If the beneficiary's regular monthly premium is more than $10.00, the beneficiary will be billed the difference on the next POWER account invoice.
Presumptive Eligibility:	State shall include FQHCs, RHCs, CMHCs, and health department sites in an expanded presumptive eligibility program. Presumptive eligibility enables applicants to receive Medicaid-covered services as of the date that a qualified provider entity preliminarily determines that the applicant is financially and categorically eligible for Medicaid, while the final eligibility determination is pending with the state Medicaid agency . To maintain the reasonable promptness waiver, the state must make final eligibility determinations for a certain percentage of presumptively eligible applicants (out of eligibility determinations made on all types of applications), beginning January 2016. If the state fails to meet this standard, the reasonable promptness waiver will be suspended for the next 6 months. The state shall propose the standard based on the first 9 months of the demonstration.
Retroactive Coverage Transition Program:	Waives retroactive coverage of services incurred during the 90 days prior to Medicaid eligibility. However, for one year, the state will reimburse providers for services received up to 90 days prior to the effective Medicaid coverage date for non-expansion parent/caretaker relatives who were not determined presumptively eligible. If CMS determines that these beneficiaries are incurring costs that would have been reimbursed by Medicaid without the retroactive eligibility waiver (based on data provided by the state by Nov. 1, 2015), this transition program shall continue for the remainder of the demonstration.
Delivery System and Health Savings Accounts:	Services provided by MCOs. MCOs also must bill and collect premiums from beneficiaries. POWER accounts are jointly funded by beneficiary premiums and the state. POWER account funds are used to fund the first $2,500 of covered claims, except for preventive services required by 42 USC § 300gg-13,[7] the cost of which are not charged against POWER account funds. Other preventive services are covered, subject to a $500 annual cap, and are charged against POWER account funds. State pays capitated rate to MCOs for services after the $2,500 POWER account funds are exhausted. Within 30 days after demonstration approval, the state must submit an operational protocol to describe the process for collecting POWER account contributions.
Beneficiary Premiums:	Monthly premiums apply to all beneficiaries from 0-138% FPL and are the greater of 2% of income (up to $27 per month for an individual at 138% FPL) or $1.00. Premiums for those at or below 5% FPL ($49 per month for an individual in 2015) will be $1.00/month. Premiums are a condition of eligibility only for non-medically frail beneficiaries from 101-138% FPL. Cost-sharing (both premiums and co-payments) limited to 5% of quarterly household income. POWER account contributions cannot exceed 2% of household income (although each beneficiary will have their own POWER account). Beneficiary premium amounts are adjusted at annual renewal and anytime the state is made aware of an income change during the current coverage period. Beneficiary premiums shall be reduced by any POWER account contributions made by third parties, such as employers or non-profit organizations.

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State Contributions:	The state funds the difference between the beneficiary's monthly premiums and the full $2,500 POWER account value. The state will make an initial $1,300 account contribution upon the beneficiary's MCO enrollment, and any additional amount owed by the state to the MCO for services provided to the beneficiary shall be reconciled after 12 months.
Consequences of Premium Non-Payment:	Newly eligible adults from 101-138% FPL who do not make a premium payment within a 60 day grace period will be disenrolled from coverage and locked out for six months. Prior to disenrollment, the state shall review all other bases of Medicaid eligibility and notify the beneficiary about the option to request a medical frailty determination, and the MCO must provide 2 written notices about the delinquent payment. Beneficiaries who are disenrolled for non-payment of premiums are not subject to the lock-out if they re-apply with verification of non-payment due to a "qualifying event," such as moving to another state and then returning, experiencing domestic violence, or medical frailty.[8] Individuals who never make their initial premium payment are not subject to the 6 month lock-out. Newly eligible adults from 101-138% FPL who are medically frail who do not pay premiums will not be terminated from coverage. Instead, these beneficiaries must continue to have access to the state plan benefit package,[9] are subject to state plan co-payments for services, and continue to be billed for premiums. Newly eligible adults at or below 100% FPL who do not make an initial premium payment within 60 days of their eligibility determination or who do not make a subsequent premium payment within the 60 day grace period will be automatically enrolled in the HIP Basic plan. These beneficiaries will be subject to state plan co-payments for services, which may exceed the cost of monthly premiums applicable under HIP Plus.[10] Non-expansion parent/caretakers and newly eligible adults at or below 100% FPL who are medically frail who do not pay premiums retain their existing benefit package (described below) and are subject to state plan co-payments.
Debts/Refunds Upon Disenrollment:	Payment of unpaid premiums is not a condition of Medicaid re-enrollment but may be owed as a debt.[11] MCOs may attempt to collect unpaid premiums from beneficiaries but may not report debt to collection agencies, place a lien on beneficiary's home, refer cases to debt collectors, file a lawsuit, seek a court order to garnish wages, or sell the debt to a third party for collection. If beneficiaries have paid excess premiums,[12] they are owed a refund, subject to a 25% penalty if the beneficiary is terminated for non-payment of premiums.
Healthy Behavior Incentives:	HIP Plus beneficiaries who make timely premium payments will be eligible to rollover their share of the unused POWER account balance at the end of 12 months. If the beneficiary completes unspecified age and gender appropriate preventive services, the rollover balance for HIP Plus beneficiaries will be doubled by the state, not to exceed the beneficiary's total premium payments for the year. HIP Basic beneficiaries can rollover unused POWER account funds, up to 50% of the amount of premiums required for HIP Plus, if they obtained unspecified age and gender appropriate preventive services. Rollover funds can be used to reduce the required beneficiary premiums in the subsequent year. Debts may be collected from rollover account balances.
Co-Payments for Non-Emergency Use	All demonstration beneficiaries must pay a co-payment for non-emergency use of the ER, which is waived if the beneficiary calls the MCO's 24 hour nurse hotline prior to using the ER. These co-payments must be refunded if the beneficiary has an emergency condition or is admitted to the

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of the ER:	hospital on the same day. Grants § 1916(f) waiver authority for two year demonstration (until Jan. 31, 2017) to test whether graduated co-payments ($8 for first visit and $25 for subsequent visits in the same year) discourage non-emergency use of the ER. ($25 exceeds the $8 maximum amount authorized by federal law.) This authority applies to all demonstration populations (newly eligible adults and non-expansion parent/caretakers). By May 1, 2015, state must establish a control group with a minimum of 5,000 beneficiaries who will not be subject to the increased co-payments; selection of the control group will be detailed in the state's protocol submitted to CMS.
Benefit Packages:	Newly eligible adults 0-138% FPL who pay premiums receive HIP Plus, an ABP that includes the ACA's essential health benefits and covers more services than HIP Basic. Newly eligible adults at or below 100% FPL who do not pay premiums receive HIP Basic, an ABP that includes the ACA's essential health benefits but with fewer covered services (no vision or dental coverage) compared to HIP Plus. HIP Basic includes all EPSDT services for 19 and 20 year olds, consistent with federal law. Newly eligible adults who are medically frail must have access to the state plan benefit package.[13] Non-expansion parent/caretaker relatives and those receiving Transitional Medical Assistance receive the Medicaid state plan benefit package. (Benefit package contents are specified in state plan amendments, not the waiver terms and conditions.)
Non-Emergency Medical Transportation:	Waives non-emergency medical transportation (NEMT) for newly eligible adults, except pregnant women and those who are medically frail, for demonstration year 1. CMS will consider an extension of the NEMT waiver based on an evaluation of its impact on access to care.
Optional Premium Assistance for ESI:	Newly eligible adults age 21 or older with access to ESI may choose to receive premium assistance and assistance with cost-sharing through a POWER account. The state will fund the POWER account with $4,000 per year for an individual or $8,000 per year for 2 adults in the same household covered by ESI. POWER account funds will be used to pay the state's portion of the ESI premium and contribute to the employee's ESI cost-sharing (deductibles, co-payments, co-insurance). Beneficiaries must contribute to their ESI premium by a payroll deduction of at least $1.00 but not less than 2% of their monthly income. The employer must contribute at least half of the employee's premium, and the ESI benefit package must comply with the requirements for an approved Medicaid ABP.
Financing:	State shall finalize budget neutrality agreement with CMS by Feb. 1, 2015. The state plans to fund the state share of Medicaid expansion costs (beginning in 2017) with existing cigarette tax revenues and funds from an existing hospital assessment fee (which may be adjusted as needed.) These funding sources will pay for the state's costs of expanding HIP 2.0, the state share of payments to fund an increase to 75% of Medicare reimbursement rates for physician and physician extender services provided under current Medicaid programs including Hoosier Healthwise, programs for beneficiaries who are aged, blind or disabled, and other non-HIP programs, and annual funding of $50M staring in 2017 to fund the Medicaid program and contributions to the HIP trust fund to assure appropriate reserves and funding for 1 year of HIP operational costs.
Evaluation and Reporting:	Requires state to submit data after one year to evaluate whether there are gaps in coverage that would be remedied by retroactive coverage. Requires monthly and annual reporting on presumptive eligibility.

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	Requires independent entity to annually survey statistically significant groups of those enrolled in demonstration, those eligible but not enrolled, and those disenrolled for non-payment of premiums. Requires independent evaluation of NEMT waiver by Nov. 1, 2015; also requires independent evaluations of the graduated non-emergency use of ER co-payments and the retroactive coverage waiver and transition uncompensated care program.
Public Input:	The state shall hold a forum for public comment within 6 months of demonstration implementation and annually thereafter.

Endnotes

[1] CMS Healthy Indiana Plan Special Terms and Conditions (Feb. 1, 2015 – Jan. 31, 2018), available at http://www.in.gov/fssa/hip/files/IN_HIP_2.0_CMS_Approved_STCs_1_27_15.pdf.

[2] Prior to the enactment of the ACA, states could only cover non-disabled childless adults through a waiver. Indiana's HIP demonstration waiver expanded coverage to parents and childless adults below 100% FPL. Enrollment for parents was not capped; however, enrollment for childless adults was capped at 36,500 and limited to open enrollment periods.

[3] Press release: Indiana Wins Approval of Plan to Cover 350,000 Uninsured (Jan. 27, 2015), available at http://www.in.gov/fssa/hip/2418.htm.

[4] Ind. Fam. & Soc. Servs. Admin., HIP 2.0 1115 Waiver Application at (July 2, 2014), available at 14 http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-Waiver-Application-07022014.pdf. Indiana's waiver application also included the goals of "promot[ing]. . . family coverage options to reduce network and provider fragmentation within families" and "facilitate[ing] HIP member access to job training and stable employment to reduce dependence on public assistance" but those features were not included in the approved waiver authorities.

[5] Press release: CMS and Indiana Agree on Medicaid Expansion (Jan. 27, 2015), available at http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-01-27.html; *see also* Letter from CMS Administrator Marilyn Tavenner to Medicaid Director Joseph Moser (Jan. 27, 2015), available at http://www.in.gov/fssa/hip/files/IN_HIP_2.0_CMS_Approval_Ltr_1_27_15.pdf.

[6] Pennsylvania's NMET waiver requires that the state provide NEMT beginning in year 2. Iowa and Pennsylvania waive premiums in the first year of their demonstrations. Iowa provides a 90 day grace period, and the state must waive premiums for beneficiaries who self-attest to financial hardship. Pennsylvania provides a 90 day grace period, and beneficiaries may re-enroll in coverage without a lock-out period after termination for non-payment. Michigan's demonstration also includes premiums up to 2% of income for beneficiaries above 100% FPL, but premiums are not a condition of eligibility and are waived for at least the first six months of the demonstration.

[7] These include all services rated "A" or "B" by the U.S. Preventive Services Task Force, immunizations recommended by the CDC Advisory Committee on Immunization Practices, and services for infants, children, adolescents, and women supported by HRSA guidelines.

[8] Other qualifying events include obtaining and subsequently losing private coverage, losing income after being disqualified for increased income, residing in a county subject to a disaster declaration within 60 days prior to termination for non-payment, and other circumstances specified by the state.

[9] Technically, these beneficiaries receive an ABP that is equivalent to the state plan benefit package.

[10] Copayments under HIP Basic:

Service	HIP Basic Plan Co-Payments
Preventive services*	$0
Outpatient services	$4
Inpatient services	$75

Preferred drugs	$4
Non-preferred drugs	$8
Non-emergency ER visit	$8 for first visit, $25 for subsequent visits**

*Including family planning services
** $8 for all visits for control group

[11] The debt is limited to the amount of the beneficiary's pro rata share of claims paid during the coverage period or amounts permissible under Medicaid cost-sharing rules for deductibles, whichever is less.

[12] Refunds are based on premium payments in excess of the beneficiary's pro rata share of claims at disenrollment.

[13] Technically, these beneficiaries receive an ABP that is equivalent to the state plan benefit package.