DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Baltimore, MD 21244-1850

State Demonstrations Group

July 29, 2016

Tyler Ann McGuffee
Insurance and Healthcare Policy Director
Office of Governor Michael R. Pence
State House, Second Floor
Indianapolis, IN 46204

Dear Ms. McGuffee:

Thank you for your letter discussing two issues related to the Healthy Indiana Plan 2.0 (HIP 2.0) section 1115 demonstration (Project No. 11-W-00296/5). We are writing to respond to these issues, which concern your interest in: 1) adding to the demonstration a lockout from coverage for Medicaid beneficiaries, regardless of income level, who do not complete the annual eligibility redetermination process; and 2) discontinuing a prior claims payment program for retroactive coverage of medical costs incurred prior to the date a parent is enrolled in HIP 2.0.

I appreciate that the Centers for Medicare & Medicaid Services (CMS) and Indiana have been able to work together on HIP 2.0 to expand Medicaid coverage to low-income people in Indiana. One central element of our 2014 and 2015 HIP 2.0 discussions was under what circumstances the demonstration could test applying a lockout to Medicaid beneficiaries who do not pay premiums. Exclusions from coverage, such as lockouts, are not permitted under Medicaid law. In approving Indiana's unique lockout for people with incomes above 100 percent of the FPL we agreed to undertake a rigorous evaluation of the effects of that policy. We did not authorize in Indiana, nor have we since authorized in any section 1115 demonstration, lockouts for individuals with incomes below 100 percent of the FPL. Likewise, we did not authorize in Indiana, nor have we since authorized in any section 1115 demonstration, lockouts for individuals who do not complete the redetermination process.

Your letter requests that CMS consider adding to the terms of Indiana's HIP 2.0 demonstration a lockout for people who fail to complete the annual eligibility redetermination process. Under the lockout policy described in your letter, people at all income levels would be locked out of coverage for six months should they fail to complete the annual eligibility redetermination process. Such a change would require an amendment to the demonstration. For the following reasons, CMS is not prepared to approve such a request.

Authorizing a lockout for individuals at any income level who do not complete their annual eligibility redetermination is not consistent with the objectives of the Medicaid program, which include ensuring access to affordable coverage. Many low-income individuals face challenges in completing the redetermination process. These challenges include language access issues, as well as frequent moves and other difficulties obtaining their mail. Low-income individuals are also more likely to experience disabling conditions, including mental illness, or face temporary or chronic homelessness. Such conditions make completing the tasks associated with the redetermination

process in a timely manner challenging. For example, the eligibility redetermination deadline may coincide with an acute health event or loss of housing. Maintaining access to health coverage for such individuals is important, as it promotes access to treatment and medication that can prevent physical or behavioral health conditions from worsening. Under the proposed lockout, however, low-income individuals who fail to complete redetermination paperwork due to any of these challenges would then be barred from obtaining treatment under Medicaid for their condition for six months. Your letter notes that five percent of the HIP 2.0 population do not complete the renewal process. That means that under the state's proposed lockout approximately 18,850 people would be excluded from coverage each year.

CMS appreciates that the state has undertaken a streamlined approach to the annual redetermination process for Medicaid to help ensure that it does not pose a substantial burden on beneficiaries. However, the streamlined process described in your letter is consistent with federal regulations at 42 CFR 435.916 which, as you know, apply to all states. This process, and the 90 day advance notice that you provide to beneficiaries, do not, as evidenced by your data, eliminate the challenges low-income individuals face in completing the required paperwork. These challenges are not an appropriate basis for denying Medicaid coverage.

As you note in your letter, the HIP 2.0 demonstration's special terms and conditions (STCs), which Indiana reviewed in draft form before accepting, do not authorize any lockout related to failure to complete an eligibility redetermination. We appreciate the commitment made in your letter to suspend implementation of the additional lockout policy. This suspension is critical to maintaining coverage for individuals who could have been impacted by a lockout beginning in April 2016.

You also request to discontinue a program providing retroactive coverage of medical costs incurred prior to the date of enrollment in HIP 2.0 for parents. This issue was also extensively discussed during of our negotiations on HIP 2.0. As you note in your letter, collaboration and problem solving helped CMS and Indiana reach agreement on HIP 2.0. As a result of that effort, an agreement was reached that the state was not required to provide retroactive coverage. Instead, CMS required the state to operate its prior claims program for certain parents for at least one year, and if CMS determines necessary, potentially longer. The STCs require the state to submit data after one year, to allow for evaluation of whether there are gaps in coverage that could be remediated by the provision of retroactive coverage.

In our post-approval conversations, Indiana raised a concern that the STCs do not offer a sufficiently clear utilization standard against which the state's prior claims payment program would be evaluated. CMS acknowledged that the STC language could be read as allowing the program to continue if any individuals incurred costs which could be covered by the program, which may have been a more stringent test than the state understood it to be at the time of approval. After examining the state's data, we relayed that we would be open to establishing a threshold of five percent of eligible individuals having claims needing payment, which represents a reduction by approximately half of the state's reported utilization of the prior claims payment program. Particularly in light of other flexibilities we approved under the HIP 2.0 demonstration, we believe that maintaining the prior claims payment program continues to be important. For example, because Indiana may delay effectuating beneficiaries' coverage until a premium payment is made (for some, a delay of up to 60 days), the amount of time that

individuals who are newly applying for coverage may incur personal health care bills is lengthened. The prior claims program helps address expenses that beneficiaries incur during this time period.

The state's latest data indicates that 455 out of 3,263 eligible individuals are incurring costs averaging $1,561 per person that would have been reimbursed in the absence of the demonstration. At 13.9 percent of eligible individuals, this does not meet the five percent threshold we discussed. As a result, consistent with the terms we agreed upon, Indiana must continue the prior claims payment program until it has met the five percent threshold for three consecutive months and may not discontinue the prior claims payment program at this time.

We appreciate your interest in ensuring that HIP 2.0 successfully serves low-income adults in Indiana, and look forward to our continued collaboration on this program. Should you have additional questions or concerns, please call Eliot Fishman, Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.

Sincerely,

/s/

Vikki Wachino
Director

cc: Ruth Hughes, Associate Regional Administrator, CMS Chicago Regional Office