Eric Holcomb, Governor
State of Indiana

Office of Medicaid Policy and Planning
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Daniel Tsai
Deputy Administrator and Director of Center for Medicaid and CHIP Services (CMCS)
Department of Health and Human Services
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244-1850

RE: Request for Immediate Reissuance of Healthy Indiana Plan 1115 Demonstration

Dear Director Tsai:

On June 27, 2024, the United States District Court for the District of Columbia issued an order in *Rose v. Becerra* vacating the approval of the Healthy Indiana Plan (HIP) section 1115 demonstration and remanding the matter to the U.S. Department of Health and Human Services (HHS). The implications of this removal of the ten-year approval for the HIP section 1115 demonstration ("HIP Demonstration") are expansive. While the underlying litigation primarily took aim at HIP's Personal Wellness and Responsibility ("POWER") account contributions or premium-like payments, the removal of the entire HIP Demonstration approval will shift benefit coverage for many HIP members and creates substantial uncertainty for program operations and funding. The ruling also has implications that conflict with Indiana state law.

To preserve access to services for current HIP members and ensure the stability of program operations, we are seeking a stay of the District Court's order, which we ask CMS to support. In the absence of a stay, we urgently request that CMS reissue the HIP Demonstration approval in its entirety, which we believe CMS has the authority to do under the circumstances.

First enacted in 2007 by bipartisan state legislation, HIP has been approved continually, first as a limited pilot program and then as the vehicle for the State's Medicaid expansion. Three separate gubernatorial administrations have supported and operated this program, which has been approved under both Republican and Democrat federal administrations. The HIP program covers approximately 760,000 Hoosiers today, over 10% of the state's population and nearly 40% of the total Indiana Medicaid enrollment, and has been a successful pillar of Indiana Medicaid programs: health care access and outcomes have improved; medication adherence and preventative screenings have increased; and enrollment and coverage for pregnant women have

been streamlined.[1] Furthermore, HIP served as a critical lifeline to Hoosiers during the public health emergency.

Under the District Court's order that HIP members will be covered under the state plan rather than the HIP Demonstration, hundreds of thousands of HIP members will have fewer benefits along with higher cost-sharing in the form of copayments. In the absence of the waiver being immediately reissued (or the District Court ruling stayed), we will be forced to start transitioning over 335,000 Medicaid members into HIP Basic, resulting in a loss of certain benefits described below. The higher benefits and more predictable cost-sharing provided under the HIP Demonstration project are more than sufficient to establish that the project will expand benefits and meet the test articulated by the District Court for the Secretary's exercise of his Section 1115 authority.

Reissuance of the demonstration approval is appropriate and necessary given that failure to reestablish the waiver authorities will directly decrease coverage of services. That a reapproval of HIP is likely to promote the objectives of Medicaid is also fully consistent with the history of Medicaid expansion in Indiana, which was contingent on approval of HIP 2.0, including POWER account contributions, as the vehicle for expansion. This is evident from the repeated letters from the state officials to the federal government and state legislators in the wake of *NFIB v. Sebelius*,[2] and in the Indiana legislature's codification of key elements of HIP into state law, including the requirement for Indiana Medicaid to collect POWER account contributions and the explicit restriction on the state Medicaid agency's ability to negotiate reductions to contribution amounts. As you are aware, HIP's innovative design – including premium-like payments and the waiver of retroactive coverage – reflects Indiana's commitment to preparing HIP members for a transition to other forms of commercial coverage. By incentivizing HIP members to be health care consumers and maintain year-long coverage, HIP serves as a bridge to commercial insurance.[3]

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[1] *See* 2018-2020 Healthy Indiana Plan Summative Evaluation Report, submitted to CMS on June 30, 2022 and resubmitted on May 18, 2023.

[2] Letter from Gov. Michael R. Pence to President Barack Obama, dated Oct. 2, 2014 (https://www.in.gov/fssa/hip/files/Governor_Pence_Letter_to_President_Obama.pdf); Letter from Gov. Michael R. Pence to HHS Secretary Kathleen Sebelius, dated March 4, 2014 (https://www.in.gov/fssa/hip/files/Secretary_Sebelius_Thank_You_Letter.pdf); Letter from Gov. Michael R. Pence to Indiana House Insurance Committee Ranking Minority Member Rep. Ed DeLaney and Indiana House Public Health Committee Ranking Minority Member Rep. Charlie Brown dated Jan. 16, 2014 (https://www.in.gov/healthcarereform/files/GOV_HIP_201401301514.pdf); Letter from Gov. Michael R. Pence to HHS Secretary Kathleen Sebelius, dated Nov. 15, 2013 (https://www.in.gov/fssa/hip/files/Letter_from_Governor_Pence_to_Secretary_Sebelius.pdf); Letter from Gov. Michael R. Pence to Senate Democratic Leader Sen. Tim Lanane and House Democratic Leader Rep. Scott Pelath dated March 14, 2013 (https://www.in.gov/fssa/hip/files/3.14.13_MRP_Letter_to_Lanane_and_Pelath_re_HIP.pdf).

[3] *See* Healthy Indiana Plan Demonstration Application to Expand (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); Indiana Healthy Indiana Plan 2.0 Interim Evaluation Report dated July 6, 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); Healthy Indiana Plan Sec. 1115 Demonstration Waiver Extension Request dated 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); and Healthy Indiana Plan Sec. 1115 Demonstration Waiver Extension Request dated 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).

Without reissuance of the HIP Demonstration, HIP members will see changes to their benefit structure and potentially increased co-payments outside of the POWER account structure, and significant program administration changes will be necessary requiring both financial, staff, and systems resources. These impacts are detailed below but may not represent an exhaustive list given the limited time to review all relevant state laws, the Medicaid State Plan, and the now-vacated HIP Demonstration approval as well as all operational and financial aspects and IT systems of this program.

Coverage Implications and Benefits Analysis

HIP Basic Benefit Package

With the waiver for the HIP Demonstration vacated, covered benefits for HIP members are now derived from the state Medicaid plan. Under the state plan, "HIP Basic" is the alternative benefit package for "individuals up to and including 100% federal poverty level (FPL) as based on MAGI income standards who do not pay a contribution to their HIP Plus Personal Wellness and Responsibility (POWER) account."[4] HIP Basic includes all essential health benefits, but does not include vision, dental, chiropractic visits, bariatric surgery, or temporomandibular joint (TMJ) surgery, and has a cap on therapy visits. These additional benefits are part of our second alternative benefit plan—HIP Plus—but HIP Plus is the benefit option only for "individuals with income up to and including 133% of the federal poverty level (FPL) as based on MAGI income standards who make a contribution to their Personal Wellness and Responsibility (POWER) account."[5]

In addition to more limited benefits, the HIP Basic alternative benefit plan also imposes the copayments described in the HIP Demonstration project; all of those copayments are within Medicaid limits and do not operate under the Secretary's waiver authority, so we believe they continue in effect.

There is also considerable uncertainty as to what, if any, benefits are available to adults with incomes between 100% and 133% of the FPL, because HIP Basic is limited to adults up to 100% of the FPL, and HIP Plus requires a POWER account contribution. At this time, our best interpretation of the state plan is that individuals with income up to and including 133% of the federal poverty level (FPL), and who are not a special category such as pregnant women or individuals with a disability, are at most entitled to the "HIP Basic" benefit plan, since the State is not authorized to collect POWER account contributions. In the absence of a reissued HIP Demonstration approval, HIP Basic will also become the only benefit package available for certain adult Medicaid members; and individuals in this group who previously were required (or willing) to make POWER account contributions to obtain more benefits will no longer have that option.

Non-Emergency Medical Transportation (NEMT)

HIP State Plan members, pregnant members, and those members meeting the medically frail definition receive full non-emergency medical transportation (NEMT) benefits. The alternative benefit plan in our state plan for both HIP Basic and HIP Plus does not include an assurance that

[4] Indiana State Plan, Section H1.1.
[5] Indiana State Plan, Section H2.1.

NEMT will be provided, consistent with the waiver of that requirement in the HIP Demonstration. Because we have not elected that assurance in the state plan, coverage under the alternative benefit plans will not result in the provision of NEMT for HIP members unless and until CMS requires us to amend the state plan to provide that assurance. Our understanding is that 12 other states also have at least one waiver of NEMT coverage.

We note that MCEs can opt to provide the benefit to HIP Basic or HIP Plus members as part of their value-added benefit, and all four HIP managed care entities (MCEs) offer some level of NEMT services to all HIP members. These MCEs also provide transportation benefits outside of medical transportation, such as transportation to Women, Infants, and Children (WIC) clinics, food pantries, and health education events.

If CMS were to require us to amend our state plan to assure NEMT benefits for all HIP Basic and Plus members—in place of the value-added benefit approach currently used—the State would require significant resources, planning, and implementation time. The needed changes could be implemented in no less than 12 months. We are continuing to calculate an estimated fiscal impact. Furthermore, a funding source for the increased program expenditures that would result would need to be identified and secured. From there, MCE capitation rate recalculations and contract amendments would be required which would necessitate certification and approval of the rates and contracts from CMS.

In addition, the State would need to perform an NEMT broker transportation capacity evaluation. With the launch of a new Indiana managed long-term services and supports (mLTSS) program on July 1, 2024, additional capacity would need to be built over time to ensure member access could be appropriately balanced across programs. NEMT broker contracts would need to be renegotiated and amended and would likely require an increased cost to incentivize network expansion. Member materials would need to be updated, including member notices, handbooks, and websites.

These significant changes would result in limited added value for HIP members since most receive this benefit from the MCEs already without a coverage mandate and resulting capitation rate increase.

Retroactive Coverage

Indiana state law specifies that the HIP program does not have retroactive coverage,[6] and all systems and operational processes are built to allow HIP coverage to begin no sooner than the first day of the month of application. This federal authority was also established in the now vacated HIP Demonstration approval. Our understanding is that 23 other states also have at least one waiver of retroactive eligibility.

In addition to addressing the conflict with state law, adding retroactive coverage to HIP would require substantial policy, operational, and systems implementation work and could not be accomplished with less than 12 months of lead time.[7] Similar to the NEMT issue, a funding

[6] Ind. Code § 12-15-44.5-4.7.

[7] While pregnant women covered through HIP do receive retroactive coverage, the process by which this happens cannot be directly replicated for other HIP members without substantial process redesign as that systematic eligibility is linked to the member's pregnancy status indicator.

source for the increased program expenditures that would result from this change would need to be identified and secured. We are continuing to calculate an estimated fiscal impact.

A determination would first need to be made as to whether retroactive coverage would be provided via a fee-for-service or managed care delivery system. From there, extensive system changes would be necessary to interface between the eligibility system and the Medicaid Management Information System (MMIS). Member communications, notices, and benefit manuals would need to be revised. Design and development of these system changes would take a minimum of 12 months and possibly longer given upcoming work needing to be prioritized related to the new federal eligibility final rules.

A fee-for-service design option would also require extensive MMIS changes to develop a retroactive category for HIP to allow for enrollment and payment of claims. While a managed care option would require fewer system changes at the state operation level, capitation would need to be developed and managed care contracts amended. Significant system changes would likely be needed by the MCEs.

Program Financing

The total annual HIP program budget is approximately $5.6B and the vast majority of the 10% state share of this funding comes from Indiana's Hospital Assessment Fee (HAF), a provider-related tax authorized under state law. The fee annually generates over $415M to fund the HIP program and is a fundamental element of Indiana's Medicaid expansion. The authority for the State to collect the HAF ceases if HHS "makes a final determination that the [HIP] waivers are not approved or cannot be validly implemented."[8] A similar provision is triggered in the case of an appellate court final determination. Indeed, Indiana law goes so far as to mandate a "phase out period" of the HIP program upon Indiana Medicaid's receipt of written notice by HHS of its decision to "terminate or suspend the waiver demonstration for the plan" or "withdraw the waiver or expenditure authority for the plan."[9]

While our interpretation is that the specific conditions of the statute – HHS notification and/or an appellate court decision – have not occurred, the vacatur of the HIP demonstration creates a risk that the State's ability to continue collecting the HAF for purposes of funding the HIP program is challenged. Without this funding source, it is difficult to see a path forward for HIP to continue at its current enrollment, utilization, and reimbursement levels. However, immediate reissuance of the waiver in a manner complying with the District Court's ruling would remove this risk and stabilize funding authority for the program.

Other Administrative Authorities

As stated above, there are likely other programmatic impacts that have yet to be identified by removal of the HIP Demonstration approval. At a minimum, the loss of managed care attribution authorities is likely to impact systems design around auto-assignment, coverage start dates, annual benefit periods, and plan change rules. Further, while the District Court's decision attempts to separate Indiana's Substance Use Disorder / Serious Mental Illness (SUD / SMI) 1115 demonstration approval from the HIP program approval, it is unclear procedurally how this

[8] Ind. Code § 16-21-10-6(b).
[9] Ind. Code §§ 12-15-44.5-1, 16-21-10-5.3.

can occur and what this will mean for the SUD / SMI program as it reaches its expiration at the end of 2025.

Although the District Court makes reference in its ruling to the decision being one that attempts to "maintain the status quo", the vacatur of the HIP Demonstration approval makes it impossible for Indiana Medicaid to do so. As detailed here, HIP members will experience loss of benefits with higher copayments, program operations will be significantly impacted, and funding mechanics for the program will be subject to challenges without reissuance of the HIP Demonstration approval in its prior form.

Thank you for your expeditious attention to this matter. We look forward to working with you to resolve this issue for the benefit of Indiana Medicaid members.

Sincerely,

Cora Steinmetz

Cora Steinmetz
Medicaid Director