

Medicaid Update

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Manatt on Medicaid: CMS Approves Indiana Waiver to Expand Medicaid

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On January 27, 2015, the Centers for Medicare and Medicaid Services (CMS) approved Indiana's waiver request under Section 1115 of the Social Security Act to implement its Medicaid expansion. Referred to as the Healthy Indiana Plan (HIP) 2.0, the three-year demonstration builds on Indiana's existing Medicaid managed care and HIP waivers, allowing expansion to take effect on February 1, less than a week after the demonstration's approval.

HIP 2.0 will cover an estimated 350,000 individuals in the new adult group as well as parents and caretakers who were previously eligible for Medicaid.¹ Pregnant women are generally excluded from the demonstration. The primary HIP 2.0 coverage mechanism is a high-deductible (Medicaid) health plan. The \$2,500 deductible under the plan is paid by the enrollee's POWER account, a health savings (HSA)-like account funded with a combination of enrollee contributions, Medicaid funds and, in some instances, contributions from employers, providers, or other third parties. The amount an enrollee is expected to contribute varies by income and eligibility category, as do the implications for failing to contribute to the account. The State is also offering individuals with access to cost-effective employer-sponsored coverage a premium assistance option, in which the State would cover the beneficiary's premium and cost sharing for the employer-sponsored plan.

Notably, the Indiana expansion waiver includes several provisions that we have not seen in earlier alternative expansion models, permitting the State to:

- Charge contributions (premiums) to newly eligible individuals with incomes as low as 0% of the federal poverty level (FPL).
- Extend its existing six-month "lockout" period (under its HIP 1.0 waiver) to most newly eligible individuals with incomes above 100% of the FPL who do not pay their contributions within a 60-day grace period.
- Impose co-pays of up to \$25 for repeated nonemergency use of the emergency department.
- Waive retroactive coverage.

¹ American Indians/Alaskan Natives are permitted to opt out of the demonstration and receive coverage through the State's fee-for-service Medicaid program.

CMS did not approve Indiana's request to waive Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for 19- and 20-year-olds who do not make POWER account contributions, nor did it allow the State to condition Medicaid eligibility on work requirements.

Key features of HIP 2.0 include the following:

- **POWER Accounts.** The POWER accounts are administered through managed care organizations and, as noted above, are used to pay for health plan deductibles. Medicaid enrollees are expected to make monthly contributions to the account on an income-based sliding scale. Contributions are set at 2% of monthly income except in cases where household income is less than or equal to 5% of the FPL; for these individuals, monthly contributions are a minimum of one dollar.

Enrollees with incomes above 100% of the FPL who fail to make a POWER account contribution are given a 60-day grace period during which the POWER account remains active and their managed care plan advises them of their payment obligation. Thereafter, failure to contribute results in termination of Medicaid eligibility. Individuals who are terminated for failure to contribute to their POWER account are not able to reapply for Medicaid coverage for six months, with limited exceptions such as if the individual lost recently-obtained private coverage or if the individual moved back to Indiana after residing in another state. After six months, the individual may reapply for coverage. Any unpaid contribution amounts remain as a debt, but do not have to be repaid in order to reenroll in Medicaid. Medically frail individuals are not subject to a lockout period.

Enrollees with incomes at or below 100% of the FPL who fail to make the required contribution to the POWER account do not risk loss of Medicaid coverage; their POWER account remains active and is fully funded, but these enrollees receive a less generous benefit package than those individuals who remain current in their POWER account contributions. (See below for details of the three HIP benefit packages.)

Medically frail expansion adults and low-income parents and caretakers also have the POWER account but are not required to make contributions.

- **Covered Benefits.** Depending on income, eligibility category and contribution to the POWER account, individuals have access to one of three benefit packages as follows:
 - *HIP Plus* is available to individuals with incomes above 100% of the FPL and to individuals with incomes at or below 100% of the FPL who contribute to the POWER account. HIP Plus covers the 10 essential health benefits (EHBs) plus enhanced benefits including vision, dental, and a comprehensive drug benefit. The State has received a one-year waiver of nonemergency medical transportation (NEMT) for individuals enrolled in the HIP Plus plan.
 - *HIP Basic*, a more limited benefit package than HIP Plus, is available to individuals with incomes at or below 100% of the FPL who do not contribute to the POWER account by 60 days after Medicaid enrollment. It covers all benefits required by the ACA for the new adult

population, including the 10 EHBs. However, it does not cover dental or vision services, and it has a less comprehensive drug benefit than HIP Plus. The State also received a one-year waiver of NEMT for individuals enrolled in the HIP Basic plan.

- *State Plan/Standard* is available to medically frail new adults and low-income parents and caretakers previously eligible for Medicaid. Unlike HIP Basic or HIP Plus, this benefit package includes long-term care services. Individuals enrolled in the State Plan/Standard benefit package have access to NEMT.
- **POWER Account Incentives.** Incentives available to enrollees depend on whether they are enrolled in HIP Basic or HIP Plus and whether they meet certain healthy behavior standards.
 - Enrollees in HIP Plus who have a balance in their POWER account and who have not been disenrolled from HIP 2.0 during the year are eligible to roll over a portion of their unused personal contributions according to a formula developed by the State. If they have received recommended preventive care services, the rollover amount is matched by the State. The rollover funds can be used by HIP Plus enrollees to reduce or eliminate their POWER account contributions during the next plan year.
 - Enrollees in HIP Basic who have funds left in their POWER account at the end of the plan year and have received recommended preventive health services are eligible for discounted contributions provided they are enrolled in HIP Plus during the next plan year. The amount of the discount is tied to the percentage of funds remaining in the POWER account, and the discount is no greater than 50% of the amount they would otherwise have been required to contribute.
- **Cost Sharing.** Cost sharing varies based on whether an individual is contributing to the POWER account and also the benefit package in which the individual is enrolled. In all cases, total cost sharing plus contributions to the POWER account are capped at 5% of the household income, as required by federal Medicaid rules.
 - New adults enrolled in HIP Plus have no point-of-service cost-sharing obligations, with the exception of a co-pay for nonemergency use of the emergency department. The first nonemergency visit is subject to an \$8 co-pay; thereafter, the co-pay is \$25 for subsequent nonemergency visits that year. These co-pays are waived if the individual contacts his or her managed care plan 24-hour nurse hotline before going to the emergency department. To test the impact of this co-pay approach, the State will establish a control group of up to 5,000 enrollees that will be charged an \$8 co-pay for all nonemergency visits and meet the other requirements of Section 1916(f) of the Social Security Act. CMS has only approved the waiver allowing for \$8 and \$25 co-pays for nonemergency use of the emergency department for the first two years of the demonstration.

- New adults enrolled in HIP Basic are subject to Medicaid-compliant cost sharing for all services; no co-pays are imposed on preventive care, family planning, or maternity services. These enrollees are also subject to the \$8 and \$25 co-pays on nonemergency use of the emergency department, as described above.
- Medically frail new adults and low-income parents and caretakers enrolled in the State Plan/Standard Medicaid benefit are not subject to point-of-service cost sharing if they contribute to the POWER account. If these individuals do not contribute to the POWER account, the State fully funds the account, but they are subject to voluntary cost sharing consistent with federal Medicaid law and the \$8 and \$25 co-pays for nonemergency use of the emergency department.
- **Health Insurance Premium Payment Program.** Newly eligible adults ages 21 and over who have access to cost-effective employer-sponsored insurance have the option of enrolling in HIP Link – a Health Insurance Premium Payment (HIPP) program. For HIP Link enrollees, the State provides premium assistance in the form of a \$4,000 annual contribution to the individual’s POWER account. Individuals enrolled in HIP Link are not required to contribute to their POWER account; instead, they contribute to the cost of their coverage through a monthly payroll deduction between one dollar and 2% of monthly household income. HIP Link enrollees use their POWER accounts to pay the State portion of their employer-sponsored plan premium. Remaining POWER account funds can be used to pay co-pays beyond Medicaid limits, deductibles, and out-of-pocket costs. The State only approves employer-sponsored plans that provide benefits that align with one of the State’s alternative benefit plans. The State’s one-year waiver of NEMT applies to individuals enrolled in HIP Link with the exception of pregnant women. The State monitors HIP Link enrollee cost sharing, and if an individual’s cost sharing approaches 5% of household income, the State transitions the individual to HIP Plus.²
- **Retroactive Coverage.** CMS granted Indiana a waiver of the requirement to provide retroactive coverage to individuals determined eligible for Medicaid. Under HIP 2.0, individuals begin receiving HIP Plus coverage on the first day of the month in which they make their first POWER account contribution. Individuals with incomes at or below 100% of the FPL who do not make an initial contribution for HIP Plus receive HIP Basic coverage beginning the first day of the month when the 60-day HIP Plus grace period ends. Through presumptive eligibility and its fast track pre-payment program described below, the State provides two pathways for individuals to secure more immediate coverage. The State is also required to reimburse providers for medical care received by previously eligible adults (the section 1931 group) for 90 days prior to the effective date of coverage. Finally, the State is required to provide CMS at the end of year one with significant data on its experience without retroactive coverage under this demonstration.

² Generally, the State allows individuals to move from HIP Link to HIP Plus at least once per year. Individuals are permitted to transition midyear if they meet qualifying circumstances, such as self-identifying as medically frail or becoming ineligible for their employer-sponsored coverage.

- **Presumptive Eligibility.** To allow new adults to gain immediate access to coverage, Indiana is operating an “expanded presumptive eligibility program,” in which Federally Qualified Health Centers, Rural Health Centers, Community Mental Health Centers, and Health Departments, in addition to hospitals, are permitted to enroll individuals into Medicaid immediately. Individuals enrolled through the presumptive eligibility program can receive coverage for at least 60 days (during which they are expected to pay their contribution), and the coverage starts on the first day of the month during which they apply. Individuals who make their POWER account contribution during the 60-day presumptive eligibility period experience no gap in coverage.

Individuals with incomes at or below 100% of the FPL determined eligible for HIP 2.0 who do not contribute to their POWER account are able to transition immediately to HIP Basic after the end of their presumptive coverage. Only individuals with incomes above 100% of the FPL who do not contribute to their POWER account within 60 days after applying for HIP 2.0 lose coverage. CMS has imposed rigorous monitoring requirements on Indiana to ensure that the presumptive eligibility program is operating as envisioned.

- **Fast Track Pre-Payment.** As a second mechanism for facilitating timely coverage, the State is developing a fast track POWER account pre-payment process to allow individuals to pay \$10 when applying for HIP 2.0 to gain immediate coverage on the first day of the month of their eligibility determination. Once the individual has been enrolled in HIP Plus, the State reconciles the \$10 contribution with the individual’s actual required contribution amount. The State refunds contributions paid by individuals found ineligible for HIP 2.0.
- **Work Referrals.** In its waiver application, the State requested that unemployed individuals and those working fewer than 20 hours per week be referred to the State’s forthcoming Gateway to Work program for job training and job search support. The State envisioned that these individuals would be required to acknowledge this referral as part of HIP 2.0 enrollment process. CMS did not approve this request, instead acknowledging in its waiver [approval letter](#) that the State will make the Gateway to Work program available to interested individuals outside of the HIP 2.0 demonstration.
- **Funding.** The HIP 2.0 demonstration is authorized through January 31, 2018; as a result, the State will not receive 100% federal match through the entirety of the demonstration. Indiana [plans](#) to fund the State share from January 2017 forward through a combination of its cigarette tax revenue and its hospital assessment. The Indiana Hospital Association supports this approach.

Moving Forward

As noted above, the Indiana waiver builds on earlier alternative expansions and introduces several features that CMS has not previously approved in the context of expansion waivers, including the waiver of retroactive coverage, the six-month lockout period and premiums for individuals below 50% of the federal poverty level. Notably, these provisions were features of the earlier Indiana HIP waiver and in this demonstration are subject to extensive monitoring and evaluation requirements as well as enhanced presumptive eligibility requirements with respect to the waiver of retroactive coverage. Other states may

well seek to incorporate these new flexibilities provided by CMS to Indiana in existing or new demonstration programs. Indeed, in its draft expansion waiver amendment, Tennessee noted that it was not proposing a lockout period for individuals who fail to pay premiums but “reserve[d] the right” to request this provision if CMS granted Indiana a waiver allowing for a lockout period. It remains to be seen whether and under what conditions CMS will permit other states to adopt similar provisions to those approved in Indiana.

Several other features of the Indiana waiver deserve mention. First, this is the first time any state has used Section 1916(f) to waive cost-sharing limits; specifically to impose a \$25 co-pay for repeated nonemergency use of the ER. As required by Section 1916(f), Indiana must set up a control group to test the impact of this co-pay requirement and meet a number of other statutory requirements. In addition, it should be noted that new adults may not be entitled to any coverage of nonemergency use of the emergency room, as such coverage is generally not considered one of the 10 EHBs as defined by the base benchmark plan. Second, while no other state has tied payment of premiums to the type of benefit package the individual receives (here, HIP Plus or HIP Basic), it should be emphasized that even the more limited benefit package meets minimum coverage requirements.

The introduction of a voluntary premium assistance program for Medicaid beneficiaries with access to cost-effective employer-sponsored coverage builds on a long-standing Medicaid option. The difference here (and also as proposed by Tennessee) is that individuals would receive a lump sum amount from the state Medicaid agency that they would have to manage to cover their co-premiums and cost sharing. Typically, the state is on the hook for all payments above Medicaid levels. However, in Indiana, the program is voluntary, leaving the beneficiary with the decision as to whether the program makes sense for him or her. In addition, if the beneficiary’s cost-sharing obligation exceeds 5% of household income, they transition out of the premium assistance program (HIP Link).

Consistent with other alternative Medicaid expansions, Indiana uses an HSA-like account and, like Michigan, relies on its Medicaid managed care plans to administer them. Following Pennsylvania, it builds in a non-mandatory work referral.

Indiana’s waiver and the pending expansion proposals in Montana, Wyoming, Utah and Tennessee reinforce the themes of earlier alternative expansions, embracing elements of personal responsibility through premiums, cost sharing and healthy behavior standards and relying more on the private market through Medicaid managed care plans, qualified health plans and third-party administrators.