



STATE OF INDIANA
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Michael R. Pence
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Re: HIP 2.0 Outstanding Issues

Dear Director Wachino,

Thank you again for our recent conversation. I wanted to take this opportunity to follow-up on a few outstanding issues the State of Indiana has been discussing with your team over the last few weeks:

Six-Month Lockout for Redetermination

Over the past eight years, since CMS's initial approval of the original Healthy Indiana Plan (HIP) in 2007, Indiana has instituted a lockout provision for individuals failing to comply with the eligibility redetermination process. The original 12-month lockout provision was codified in Indiana state law, and remained unchanged until the most recent 2016 legislative session when the Indiana General Assembly reconfirmed the policy but lowered the lockout time period to six months.

The Indiana redetermination process provides multiple opportunities to complete the eligibility process for redetermination.

- Individuals are provided notice of the procedure for redetermination 90 days before the conclusion of their eligibility period.
- Approximately 45 days following the original notice, individuals are then provided a redetermination mailer, a pre-printed form that requests confirmation of any outstanding eligibility issues required by the State to finalize the redetermination decision.
- The State also automatically re-enrolls individuals when it can verify income data through existing data sources. As a result, over 68 percent of HIP members do not have to submit any information for the State to renew their eligibility.
- Roughly 32 percent of the remaining individuals who are required to provide information for redetermination are given an additional reminder notice 14 days prior to the expiration of their eligibility period.

- If the individual fails to submit the necessary paperwork, the individual's eligibility expires and the individual is subject to the six-month lockout from the date of the termination.
- For the first 90 days of the six-month lockout period, the individual may still return the original redetermination mailer or submit a new application to be reinstated.

As a result of the 90-day advance notice of termination and the subsequent 90-day reinstatement opportunity, individuals have six months to complete their redetermination paperwork. While the lockout period technically begins upon termination, the 90-day opportunity for reinstatement essentially reduces the lockout operationally to three months. Further, throughout the redetermination process, the Indiana managed care plans conduct active outreach to their members encouraging them to complete and return the required paperwork. Also, it is important to note since individuals are required to report any addresses changes, our returned mail is very low at an average of 2.3 percent.

The lockout for redetermination is an essential component of the HIP policy framework that, along with other policies, encourages individuals to maintain health coverage and avoid coverage gaps that interrupt treatment and continuity of care. In addition, the policy prepares individuals for the commercial health insurance market, as the lockout mirrors open-enrollment policies within the Marketplace, employer sponsored health insurance, and other commercial market health plans. **To date, this policy has proven effective, as recent program data indicates an estimated 95 percent of HIP members are compliant with the redetermination process.**

HIP 2.0 Negotiations

As you may know, discussions regarding the expansion of HIP occurred over the course of several years. During these numerous discussions, the Centers for Medicare and Medicaid Services (CMS) clearly indicated its concern with the State's initially proposed 12-month lockout for non-payment, which was primarily based on concerns involving program affordability. At no time from when negotiations began until 2015 when the HIP 2.0 §1115 Demonstration Waiver was approved did CMS raise any issues with the 12-month lockout for failure to comply with the redetermination process. Further, as the redetermination lockout is related to compliance rather than affordability, the State did not believe CMS had concerns with the provision. To this end, the State's waiver submission clearly indicated our intent to maintain and preserve the HIP program in accordance with the 2014 Special Terms and Conditions other than the specifically enumerated program modifications contained in the waiver request (please refer to page 15 of the HIP 2.0 waiver application).

Following CMS approval of HIP 2.0, the Indiana Family and Social Services Administration filed an emergency rule effective February 1, 2015, and then later promulgated an administrative rule, which was posted publicly on May 18, 2015. The redetermination lockout was also adjusted from 12 months to 6 months and all exemptions to the lockout were included as specified in the HIP 2.0 Special Terms and

Conditions (STCs). Consequently, the State was surprised when CMS raised this as an issue earlier this year as it is not a new component of the program and has been in our legislation and our administrative rules governing the program for years, all of which we assumed CMS reviewed as part of its waiver approval process. While we agree this particular program detail is not explicitly included in the HIP 2.0 STCs, we believe this is an oversight that requires technical correction similar to other changes made post-waiver approval. Your staff indicated that they were not interested in any discussion of the issue, but I respectfully request that we have an opportunity to review this further. The state will suspend the lock-out for non-compliance in the meantime, but we are committed to pursuing this legislatively required feature of the program.

Prior-Claims Payment

Lastly, the Medicaid retroactivity policy requires states to cover an eligible individual's medical bills incurred 90 days before an individual applied for coverage. As you know, CMS has allowed at least 23 states to waive retroactivity. In CMS's original draft of the HIP 2.0 STCs, retroactivity waiver language was included for all populations; however, near the end of our negotiations CMS indicated this was not their intent. As a result of this oversight, negotiations were stalled until a solution was crafted, which all parties understood to be temporary, as the STCs even describe it as a one year "transition program" for Section 1931 parents and caretakers.

A year later, as expected, the prior claims payment program has very low utilization. As of March 14, 2016, there were a total of 70,023 Section 1931 parents and caretakers enrolled in HIP 2.0 and during the last quarter, only 4.7 percent or 3,263 of these individuals were eligible for the prior claims payment program. Of this eligible group, only 455 individuals actually used the program, which represents 0.6 percent of the total Section 1931 HIP enrolled population. In addition, at CMS's request, the State surveyed three of the largest Indiana hospital systems (representing 45 percent of all hospitals in the State) all of which confirmed they are not billing HIP 2.0 clients that have incurred bills prior to their eligibility period, as the hospitals' charity care policies allow for the medical bills to be excused.

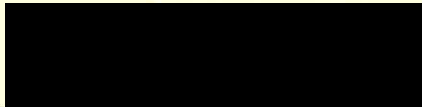
We have strong concerns with CMS's requirement that this program continue until only 5 percent of the eligible population (specifically Section 1931 parents and caretakers who have not previously been enrolled in Medicaid and whom were not found presumptively eligible) are using the prior claims payment program. First, there is no regulatory requirement for a 5 percent basis. Secondly, other states with waivers for retroactive coverage have not been required to meet this standard. Third, if there is a standard applied, it should consider the denominator or basis for the percentage. Under CMS's proposed standard, as the program continues to mature, the number of new Section 1931 enrollees eligible for the prior claim payment program could continue to decrease, such that, for example, only a total of 40 people would be eligible for the prior claims payment program. However, in accordance with CMS's arbitrary 5 percent threshold, under this example, the state would have to continue operating the program even if only three

people were using the program. It is essential that policies consider the number of individuals eligible for the program in relation to the total size of the population.

Given the issues that have been identified with the federal evaluation and these new policies, it is important that the state and CMS engage in meaningful dialogue around these important policy issues, which are fundamental to the program and support the underlying goals of the demonstration. While we understand that these policies are also breaking new ground for CMS, it is imperative that the State and CMS continue the spirit of collaboration and problem solving which led to the approval of HIP 2.0 and health care coverage to over 377,000 individuals.

I am truly grateful for your time on the phone last week, Ms. Wachino, and I look forward to continuing to work with you.

Regards,



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