Eric Holcomb, Governor
State of Indiana

Indiana Family and Social Services Administration
402 W. WASHINGTON STREET, P.O. BOX 7083
INDIANAPOLIS, IN 46207-7083

November 20, 2020

Rachel Nichols
Project Officer
Division of Medicaid Expansion Demonstrations
State Demonstrations Group
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Acceptance of 1115(a) Healthy Indiana Plan (Project Number 11-W-00296/5)

Dear Ms. Nichols,

I am pleased to accept the award of approval for the 1115(a) Healthy Indiana Plan (HIP) as outlined in your letter dated October 26, 2020, authorizing HIP to operate through December 31, 2030. The state of Indiana looks forward to continued work with CMS during this extension period. This acceptance letter also incorporates acknowledgement of the corresponding waiver, expenditure authority and special terms and conditions for the period of January 1, 2021 through December 31, 2030, contingent upon revisions to include the technical corrections contained in Attachment 1 and included in the revised version of the STCs also attached.

Thank you for your thoughtful consideration of the HIP renewal package. We look forward to continuing to work with CMS during the course of the demonstration. If you have questions or need any information, please contact Angela Todd at 1-317-234-8030 or Angela.Todd@fssa.in.gov.

Sincerely,

[redacted]

Allison Taylor
Medicaid Director
Office of Medicaid Policy and Planning
Indiana Family and Social Services Administration

Special Terms and Conditions: Technical Changes Healthy Indiana Plan Project #11-W- 00296/5

#	STC # and Original Language	Changed Language	Reason
1	General edit	**Original:** POWER Account and Copayments Operational Protocol OR Operational Protocol, SUD/SMI Implementation Protocol, SMI Monitoring Plan **Modified:** Changed all references to the Implementation Plan for HIP and SUD where appropriate, or to the Monitoring Protocol where appropriate.	Implementation plan will be the current document where operational detail will reside.
2	General edit	Where applicable changed references from the 12-month benefit period, or benefit period to calendar year benefit period.	Since 2018 HIP has operated on a calendar year benefit period for POWER accounts and MCO assignments.
3	VI. COMMUNITY ENGAGEMENT PROGRAM	In program description removed the word requirement. Left in state assurances.	Since this is not active and is pending supreme court decision the word requirement removed from program description sections where possible.
4	VII. HIP POWER ACCOUNT 2.c.	**Original:** In HIP Basic, the beneficiary would then be responsible for paying co-payments in accordance of amounts specified in the state plan, but not monthly POWER account contributions. **Modified:** In HIP Basic, the beneficiary would then be responsible for paying co-payments in amounts allowable under the State Plan and specified in this	HIP Basic copayments are not state plan copayments, but specified in the waiver.

		waiver but not monthly POWER account contributions.	
5	VII. HIP POWER ACCOUNT 3.c.	**Original:** '... and that payment of a POWER Account contribution means an individual can now only change plans for cause and how enrollment broker can help. **Modified:** '... and that once a payment is made there is an annual health plan lock-in, and the member may only change plans for cause outside of the annual selection period-;- and how enrollment broker can help.	Modified language to adds clarity around calendar year lock in.
6	VII. HIP POWER ACCOUNT 3.d.	Removed language specifying that the MCO identifies tobacco users.	MCO does not identify tobacco users for the purpose of the tobacco surcharge.
7	VII. HIP POWER ACCOUNT 3.e.	Added language before table with POWER account contribution amounts: Tiers may be modified over the course of the demonstration as described in STC VII.4.	Added to clarify that amounts may change over the course of the demo.
8	VII. HIP POWER ACCOUNT 10 Contributions from other third parties	**Original Language:** There are no limits on the amounts third parties can contribute to a beneficiary's POWER account except that the contribution must be used to offset the beneficiary's required contribution only —not the state's contribution. **Modified language:** A third party's contribution must be used to offset the beneficiary's required contribution only—not the state's contribution—and	There are limits on third party contributions as specified in modified language.

		thus may not be greater than the beneficiary's expected annual contribution amount.	
9	VII HIP Cost-sharing 3. Table 5.	Modified copayment amount for ER use to $9.40.	Per the CFR ER copayments can also be increased for inflation. Modified to align with other original $8 amount.
10	IX Redetermination and MCO Enrollment 1.	**Original Language:** In the event a loss of eligibility is implemented following a Supreme Court decision... **Modified Language:** In the event a loss of eligibility occurs following a Supreme Court decision allowing for non-eligibility periods...	Updated as disenrollment may occur for failure to renew, but the non-eligibility period is pending the Supreme Court decision.
11	IX Redetermination and MCO Enrollment 2.c.	**Original Language:** reenroll, consistent with an effective date consistent with the beneficiary's eligibility category. **Modified Language:** reenroll, consistent with the coverage effective date for the beneficiary's eligibility category.	Updated to clarify effective date language.
12	IX Redetermination and MCO Enrollment 3.a.	**Original Language:** ...for at least twelve months prior to implementation of the demonstration. **Modified Language:** ...for at least twelve months prior to implementation of the policy.	Changed to policy as the demonstration is implemented but the policy is not in effect.
13	IX Redetermination and MCO Enrollment 3.a.d.v.	**Original Language:** Was residing in a county subject to a disaster declaration made in accordance with IC 10-14-3-12	Changed language so reference for the non-eligibility period is to the redetermination policy instead of payment policy.

		at the time the member was terminated for non-payment or at any time in the 60 calendar days prior to date of member termination for non-payment; **Modified Language:** Was residing in a county subject to a disaster declaration made in accordance with IC 10-14-3-12 at the time the member was terminated for failure to complete annual redetermination;	
14	XI Serious Mental Illness 2.b.i.E	**Original Language:** ...state requirement that participating psychiatric hospitals screen enrollees for co-morbid physical health conditions... **Modified Language:** ...state requirement that participating psychiatric hospitals screen enrollees who have been diagnosed with an SMI or SED for comorbid physical health conditions...	Added clarifying language around SMI/SUD diagnosis requirement.
15	XII Delivery System 4	**Removed:** Except in cases of presumptive eligibility, auto-assignment may occur after the date in which the state determined their eligibility.	Removed reference to presumptive eligibility, PE is no longer managed care so does not impact auto assignment. Other language captures the auto assignment policy.
16	XII Delivery System 6.g.	**Original Language:** If a beneficiary is transferred from the MCO, the MCO, must return the remaining balance of the individual's POWER account to the state within 120 days of the last date of participation with the MCO. The state shall then provide the entire remaining	Operational detail is not precisely correct on the POWER account transfer procedures, recommend specifying that it is documented in the implementation plan.

		POWER account balance-to the new MCO with the information needed to properly track the individual's contribution. **Modified Language:** If a beneficiary is transferred from the MCO, the MCO must return the remaining balance of the individual's POWER account to the state as specified in the implementation plan. The state shall provide a POWER account to the new MCO with the information needed to properly track the individual's contribution as specified in the implementation plan.	
17	XVI. Evaluation of the Demonstration 3.b. & 4	Removed requirements related to including non-emergency copayment in the evaluation design and hypotheses.	There is no longer a waiver granted for the ER copay, the copayment is at the state plan allowable amounts.