CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST

NUMBER: **No. 11-W- 00296/5**

TITLE: **Healthy Indiana Plan (HIP) 2.0**

AWARDEE: **Indiana Family and Social Services Administration (FSSA)**

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the demonstration populations.

The demonstration will operate under these waiver authorities beginning February 1, 2015. The waiver will continue through January 31, 2018, unless otherwise stated.

The following waivers shall enable Indiana to implement the HIP Medicaid section 1115 demonstration.

Title XIX Waivers

1. Premiums **Section 1902(a)(14) and Section 1916**

To enable the state to charge premiums in HIP Plus at levels not more than two percent of household income. Total cost-sharing for a household is subject to a quarterly aggregate cap of five percent of household income, except that all HIP Plus households at or below five percent of the federal poverty level (FPL) will be required to contribute, at a minimum, monthly one dollar ($1.00) POWER account contributions. Individuals at or below 100 percent of poverty will not have premiums as a condition of eligibility.

2. Freedom of Choice **Section 1902(a)(23)(A)**

To the extent necessary to enable Indiana to restrict the freedom of choice of providers for HIP Link enrollees to a choice of providers participating in the network of the HIP Link plan. No waiver of freedom of choice is authorized for family planning providers.

3. Reasonable Promptness **Section 1902(a)(8)**

To the extent necessary to enable Indiana to start enrollment in HIP Plus on the first day of the month in which an individual makes their initial contribution to the POWER account, or, for members under 100 percent FPL who fail to make an initial POWER account payment within 60 days following the date of invoice, the first day of the month in which the 60 day payment period expires, except for individuals who apply through presumptive eligibility.

To the extent necessary to enable Indiana to prohibit reenrollment for 6 months for individuals with income over 100 percent of the FPL who are disenrolled for failure to make POWER Account premium contributions, subject to the exceptions and qualifying events described in the terms and conditions.

No waiver of reasonable promptness applies to individuals who are AI/AN.

4. Methods of Administration **Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53**

To the extent necessary to relieve Indiana of the requirement to assure transportation to and from medical providers for HIP 2.0 demonstration populations. No waiver of methods of administration is authorized for pregnant women, individuals determined to be medically frail, and Section 1931 parents and caretaker relatives. This waiver authority will expire January 31, 2016 unless explicitly renewed under the conditions described in the terms and conditions.

5. Comparability **Section 1902(a)(17)**

To the extent necessary to enable the state to vary cost sharing requirements for individuals from cost sharing to which they otherwise would be subject under the state plan such that beneficiaries who are in HIP Plus will be charged only one co-payment (for non-emergency use of the emergency department) and individuals who are in HIP Basic will be subject to copayments at Medicaid permissible levels except for non-emergency use of the emergency department, as described in the terms and conditions.

7. Retroactivity **Section 1902(a)(34)**

To the extent necessary to enable Indiana not to provide medical coverage to HIP members in the HIP Plus plan for any time prior to the first day of the month in which an individual pays the first contribution to the POWER account or fast track prepayment.

To allow Indiana not to provide medical coverage to HIP members under 100 percent FPL who failed to make an initial POWER account payment or fast track payment, as applicable, within 60 days following the date of invoice, for any time prior to the first day of the month in which the 60 day payment period expired.

8. Cost sharing for Non-emergency Use of the Emergency Department **Section 1916(f)**

To the extent necessary to enable Indiana to require a graduated co-payment up to $25 for all HIP 2.0 demonstration populations, for non-emergency use of the emergency department as described in 42 CFR 447.54. This waiver authority will end two years from the effective date of the demonstration.

9. Payment to Providers **Section 1902(a)(13) and Section 1902(a)(30)**

To the extent necessary to permit Indiana to provide for payment to providers that is not more than the rates paid by an employer sponsored insurance (ESI) plan providing primary coverage for services to the HIP Link population, such that payment by the ESI Plan (plus any payment from the individual's POWER account and remaining cost sharing due from the individual under the ESI plan from the beneficiary) serves as payment in full and the state has no further payment obligation to the provider.

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Medicaid Costs Not Otherwise Matchable

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below (which would not otherwise be included as matchable expenditures under section 1903 of the Act) shall, for the period beginning February 1, 2015, through January 31, 2018, unless otherwise specified, be regarded as matchable expenditures under the state's Medicaid state plan:

1. Expenditures under contracts with managed care entities that do not meet the requirements in section 1903(m)(2)(A) of the Act specified below. Indiana's managed care plans participating in the demonstration will have to meet all the requirements of section 1903(m) except the following:

   a. Section 1903(m)(2)(A)(vi) of the Act insofar as it requires compliance with requirements in section 1932(a)(4) of the Act and 42 CFR 438.56(c)(2)(i) that enrollees be permitted an initial period to disenroll without cause, as described in the terms and conditions.

2. Expenditures related to individuals who are receiving services in a presumptive eligibility period that lasts longer than the month after the month of a presumptive eligibility determination.

3. Expenditures related to services provided to eligible section 1931 related HIP members in the three months prior to their effective date of eligibility in HIP 2.0.