March 17, 2017

The Honorable Thomas Price, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W. Washington, DC 20201

Dear Secretary Price:

The undersigned organizations appreciate the opportunity to comment on Indiana's request to extend the Healthy Indiana Plan (HIP) 2.0 demonstration project, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on January 31, 2017. We fully support Indiana's decision to continue to accept federal Medicaid funding to provide coverage to low-income adults as well as the state's proposal to expand substance use disorder treatment. However, we have concerns, as outlined further below, with specific aspects of the demonstration request that should be addressed during the approval process.

Support for Indiana's Request to Expand Substance Use Disorder Treatment

We are pleased that Indiana is taking advantage of CMS' July 2015 guidance by extending substance use disorder coverage to all Medicaid and Children's Health Insurance Plan (CHIP) beneficiaries. It is important that all people, including young adults and those in HIP Basic, have access to SUD treatment should they need it.

Indiana proposes to add detoxification services, intensive outpatient treatment and addiction recovery management services to its Medicaid program. All these services are important, but we are particularly pleased by the addition of the addiction recovery management services as they enable beneficiaries to focus on their recovery. These recovery services are emerging as best practices and are especially vital to maintain recovery after an immediate crisis is addressed or to allow people to more quickly rebound from relapses, which are common for people recovering from substance use disorders. We do, however, recommend that CMS require Indiana to include recovery oriented measures in its evaluation plan described on pages 38 –to 41 as the current evaluation methodology only measures engagement in treatment.

We also support Indiana's proposal to cover residential treatment for up to 30 days. Residential treatment is part of the continuum of standard care for individuals with substance use disorders, and without Medicaid coverage for residential treatment, beneficiaries have limited options for care and recovery. Low-income individuals with a substance use disorder need the same access to residential treatment as those with moderate and high incomes who can afford to pay for residential treatment or whose insurance covers it.

While these additional benefits will be helpful, we have concerns about the proposal to subject these services subject to cost-sharing. We encourage CMS to require that the state not apply cost-sharing, such as co-payments, to this category of service. Cost sharing can create unnecessary barriers to care, and timing is everything when seeking substance use disorder treatment. Cost-sharing could act as a deterrent and make the difference between continued substance use and getting help.

CMS Should Not Extend Certain Policies without More Evaluation

As stated above, we support Indiana's decision to expand Medicaid to all low-income adults below 138 percent of the poverty line. However, we have significant concerns with several provisions in the HIP 2.0 demonstration that the state seeks to extend. Findings in the HIP 2.0 interim evaluation report show these policies are affecting participation in the program and making it harder for people to obtain care:

- **Premiums are keeping enrollment low and deterring people from care.** Indiana is proposing to continue to require HIP 2.0 enrollees to make monthly contributions to their POWER accounts. Monthly contributions are set at 2 percent of an individual's income except monthly contributions for individuals with little to no income are set at $1. These monthly contributions are considered to be premiums under section 1916(a)(1) of the Social Security Act.

  Evidence from the HIP 2.0 interim evaluation suggests that monthly premiums are deterring people from enrolling into the program. Specifically, about one-third of individuals who apply for Medicaid coverage under HIP 2.0 and are found eligible are not enrolled, because they don't make a premium payment.[1] According to the evaluation, in any given month, as many as 30,000 people are in a "conditional eligibility status" — i.e., have been found eligible within the past 60 days but are not enrolled because they haven't made premium payments. Of those, only two-thirds enroll by the end of their 60-day payment period.

  On top of that, Indiana's non-payment of premium policy is denying coverage as well as important benefits to individuals. In HIP 2.0's first year, 2,677 individuals with incomes above the poverty line who had been enrolled in HIP Plus — that is, 5.9 percent of such individuals — had their coverage terminated for falling behind for 60 days on their premiums and were then locked out of coverage for six months. In addition, 21,445 HIP-Plus enrollees with incomes below the poverty line (8 percent of such individuals) were moved to the more-limited HIP Basic due to non-payment of premiums.

  Until more evaluation data is available, we recommend CMS not extend Indiana's authority to charge premiums and lock individuals out of coverage for non-payment of premiums. Current data suggests that these policies are denying individuals coverage, which doesn't further the objectives of the Medicaid.

- **Enrollees in HIP Basic are experiencing significant barriers to care.** One of the hypotheses HIP 2.0 is testing is whether providing better benefits to people who pay premiums will advance the goal of increasing personal responsibility for healthy behaviors and awareness of their health care costs. Throughout the demonstration

[1] The Lewin Group, "Indiana Healthy Indiana Plan 2.0: Interim Evaluation Report," July 6, 2016, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/ByTopics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-interim-evl-rpt- 07062016.pdf.

about one-third of HIP enrollees have been enrolled in the Basic plan, and evidence shows they are less likely to get the care they need.

According to the interim evaluation of HIP 2.0, HIP Plus enrollees used more preventive, primary, and specialty care and prescription drugs than enrollees in HIP Basic. Basic enrollees were more likely to use the emergency room, with 1,034 visits per 1,000 members per year compared to 775 visits for Plus enrollees. Basic members were also more likely to visit the emergency room for non-emergency reasons, with 263 visits per 1,000 members per year compared to 183 per 1,000 members for Plus. When coupled with lower rates of primary care use (31 percent of enrollees in Plus but only 16 percent in Basic had at least one primary care visit) and preventive care use (64 percent in Plus and 45 percent in Basic had a visit qualifying them for a rollover of POWER Account payments), the greater reliance on the emergency room for non-emergency care among HIP Basic enrollees suggests that they were more likely to lack adequate access to ordinary health care, likely due in part to the co-pays charged in Basic or other factors.

Basic members also have lower rates of adhering to their prescription drug regimens for certain chronic conditions such as asthma, arthritis, and heart disease. This isn't surprising, because Basic members must refill their prescriptions every month and make a co-payment, while Plus members can obtain a 90-day supply of maintenance medications without a co-pay. This is of particular concern because access to maintenance medications can affect health outcomes and ultimately drive up costs. It's also of concern because, compared to other groups, African Americans are more likely to be in the Basic plan; fully half of African Americans enrolled in HIP 2.0 are in Basic rather than Plus.

Indiana's proposal to extend HIP 2.0 focuses on the fact that Plus enrollees are getting more needed care. But nothing in the interim evaluation of HIP 2.0 proves that they're doing so because they're paying premiums. It's at least as likely that they're getting more care because they *don't* have to pay the co-payments that Basic enrollees must pay. CMS should not allow Indiana to continue penalizing people who can't pay premiums, because it is keeping them from getting the care they need. As such, it is not a proper use of demonstration authority.

- **Co-payments for non-emergent use of the emergency department (ED) needs further review.** Indiana is the only state to receive CMS approval for special cost-sharing waiver authority under section 1916(f) of the Social Security Act. Indiana is currently approved to implement a graduated copayment amount ($25) for HIP Plus enrollees who use the ED for non-emergent purposes.

  To obtain this special waiver, certain conditions had to be met, such as testing a previously untested use of copayments, limiting the experiment to 2 years, and establishing a control group to test the waiver's effect. The state's request to extend this waiver on a permanent basis doesn't meet several of these conditions – most notably the requirements that the waiver last no more than two years, and that the waiver test a previously untested use of copayments.

Moreover, Indiana acknowledges that the independent evaluation of this policy hasn't yet been completed as of their extension request submission. Because of this, and a 2015 study showing co-payments for non-emergency use of the ED didn't change beneficiaries' use of the ED, it is questionable whether such a co-pay promotes the objectives of Medicaid.[2] As with the use of premiums, there is a large body of research – including evidence from Indiana's own interim evaluation – that demonstrates the harmful effects cost sharing has on utilization of care for low-income people, including the impact on appropriate uses of care and health outcomes. Cost-sharing also poses significant financial strain on individuals that have limited resources.

We urge CMS to not approve Indiana's request to extend its section 1916(f) cost-sharing waiver until it can provide findings from its required evaluation.

- **HIP 2.0's transportation waiver is preventing people from getting care.** When CMS approved the HIP 2.0 waiver in January 2015, it granted Indiana a waiver of the non-emergency medical transportation (NEMT) benefit for one year so an evaluation could be conducted to determine whether waiving NEMT created or exacerbated an unmet need for transportation for HIP 2.0 beneficiaries. Indiana was subsequently granted short-term extensions to December 2016 and, more recently, through January 2018. The state was granted short-term extensions because the data was inconclusive as to whether beneficiaries were negatively impacted by the lack of transportation benefit, and because the state had not published all of the evaluation data.

  We believe the data released by the Lewin Group in November 2016[3] again demonstrates that transportation is an obstacle to care for the expansion population. The state says the waiver should be extended because those without the transportation benefit missed fewer scheduled appointments than those with the benefit. But the survey also shows that transportation was the most cited reason for missing a scheduled appointment. Further, people with incomes below the poverty line were much more likely to cite transportation difficulties as a reason for missing an appointment.

  The state has already received a waiver of the NEMT benefit through January 2018. We see no reason why it should be extended any further at this time.

CMS Should Not Approve Changes that Create More Complexity and Barriers to Care

Indiana is requesting approval of changes to the HIP 2.0 demonstration that when coupled with its existing problematic features will create more complexity and barriers to care for HIP 2.0 enrollees. We are particularly concerned with the following proposed changes to the demonstration:

---

[2] Mona Siddiqui, Eric T. Roberts, Craig E. Pollack, "The Effect of Emergency Department Co-payments for Medicaid Beneficiaries Following the Deficit Reduction Act of 2005," JAMA Internal Medicine, January 26, 2015.

[3] The Lewin Group, "Indiana HIP 2.0: Evaluation of Non-Emergency Medicaid Transportation (NEMT) Waiver," November 2, 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-nemt-final-evl-rpt-11022016.pdf

- **Implementing an "open enrollment" period with a 6-month lockout of coverage.** Indiana proposes to lock people out of coverage if they don't complete their annual redetermination of coverage in a timely manner. Individuals would be locked out of coverage for six months, unless they come back within the three-month period following the date their coverage is terminated, for failure to complete the renewal process.

  We believe that this is an overly punitive approach that will result in some of the most vulnerable Medicaid beneficiaries losing coverage when they need it the most. These would include persons experiencing a mental health and/or substance abuse crisis, and families and individuals who are homeless or living doubled or tripled up. Indiana's own data suggests that a very high percentage of HIP enrollees have very very low incomes – these populations are known to experience high degrees of residential instability.

  In a July 2016 letter to Indiana, CMS determined that this request is not consistent with the objectives of the Medicaid program. CMS rightly recognized that many low-income individuals face challenges in completing the renewal process such as language access and problems getting mail. CMS also found that mental illness or homelessness can make completing the renewal process difficult and that gaps in coverage that would result from a lockout could lead to harm. In addition, CMS noted that based on state data, 5 percent of enrollees in HIP 2.0 population don't complete the renewal process, which means that approximately 18,850 people would be locked out from coverage each year.[4]

  Indiana has not provided any new information or justification in its request that demonstrates to CMS how implementing an "open enrollment" period with a 6-month coverage lockout furthers the objectives of the Medicaid. Indiana's proposal would keep beneficiaries from obtaining access to necessary health care and should be rejected.

- **Imposing tobacco surcharge on smokers.** We support Indiana's tobacco cessation goals as quitting tobacco is the single best change a person can make to improve their health, and we support the state's recent efforts to enhance benefits for tobacco cessation as well as its proposal to raise awareness of these benefits. However, we are concerned that Indiana's proposal to charge tobacco users a premium surcharge of an additional one percent of annual income will not have the desired effect of encouraging people to quit. Evidence shows that a tobacco surcharge does not reduce tobacco use; rather, it has negative side effects. For example, a study in *Health Affairs*[5] found that smokers in states with a surcharge had a lower take-up of available coverage than their non-smoking counterparts.

---

[4] July 29, 2016 letter from CMS to Indiana, available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-lockouts-redetermination-07292016.pdf.

[5] Abigail Friedman, William Schpero, and Susan Busch, "Evidence Suggests That The ACA's Tobacco Surcharges Reduced Insurance Take-Up and Did Not Increase Smoking Cessation," *Health Affairs*, July 2016, http://content.healthaffairs.org/content/35/7/1176.abstract

Under Indiana's proposal, enrollees would get a reprieve from the surcharge for one year. Yet research shows it can take an individual 5-30 times to quit for good.[6] Thus, even if an enrollee made a quit attempt in year one, they could still have to pay the penalty in year two.

If smokers forgo healthcare due to the inability to pay an increased premium, they will miss out on more than just tobacco cessation services; they also won't get the care that could detect a tobacco-related cancer at an early stage, or treat a tobacco-caused illness, such as COPD. Indiana's proposed tobacco surcharge should be denied.

- **Ending the prior claims program.** Indiana is required to pay for medical claims incurred up to three months prior to enrolling in HIP 2.0 for certain parents. In 2016, CMS notified the state that it would need to continue its prior claims program until it could demonstrate that only 5 percent of eligible adults were utilizing the program. At that time, data from Indiana showed that nearly 14 percent of eligible adults were utilizing the program, incurring costs averaging $1,561 per person.[7]

  In its extension request, Indiana requested to terminate the prior claims program. However, it didn't include any prior claims program data in its application, making it unclear as to whether the state has met the 5 percent threshold required by CMS. As such, we urge CMS to continue the prior claims program until such time as the state can demonstrate it has met the established threshold.

- **Expanding HIP Link should not occur without more clarity on cost-effectiveness and what is being waived for whom.** On page 33, the state requests authority to consider high deductible plans cost effective for family members of HIP Link enrollees, although there is no explicit request for a waiver of the cost-effectiveness test overall. This is a concern as high deductible plans are less likely to prove cost-effective.

  The state requests an amount, duration, scope and comparability waiver to allow choice of an employer plan with a wrap-around coverage provided by Indiana. The application states the intent of this request is to extend the program to children with family members who are accessing coverage through their employer. It is unclear what the state is seeking to waive if all benefits are being provided. Moreover, states can already do premium assistance and even mandate participation if benefits are fully provided and the approach proves cost-effective under section 1906 of the Social Security Act (or section 1906A if enrollment is voluntary). We appreciate that the state is committed to providing all benefits to children as the state expands its premium assistance program, but we would encourage the state to monitor access to EPSDT if this approach moves forward. We urge CMS to seek more clarity on the state's request, and to ensure that any

---

[6] Michael Chaiton, Lori Diemert, Joanna Cohen, et al., "Estimating the number of quit attempts it takes to quit smoking successfully in a longitudinal cohort of smokers," BMJ Open, May 2016, http://bmjopen.bmj.com/content/6/6/e011045

[7] July 29, 2016 letter from CMS to Indiana.

agreement reached ensures that the approach is cost-effective and full access to benefits and cost-sharing provisions.

Ensure Indiana's Proposed Incentives are an Appropriate Use of Medicaid Resources.

While we support Indiana's objective of improving individuals' health and reducing health care costs through healthy behavior incentives, we are concerned that the proposed Healthy Incentive Initiative, which is based on workplace wellness programs, may not meet the unique needs of the Medicaid population and would not be an efficient use of Medicaid funds. Moreover, the proposal provides little detail on how the program would actually work. While behavior incentives or rewards are not as harmful as penalties that limit access to needed services, such as premiums and cost-sharing requirements, rewards have not been shown to improve health outcomes or reduce costs in the long-term. Short-term incentives provided at the point of service may be effective in increasing the likelihood that an individual attends a diabetes prevention class, for example, but there is little evidence showing the effectiveness of incentives provided after the fact, such as funds added to a POWER Account.[8]

Offering the Healthy Incentive Initiative is likely to prove costly for Indiana. Other states that have implemented incentive programs have incurred significant costs in implementing and administering these programs. Rewards above and beyond the cost of services can be costly to provide, and offering them requires up-front funds and staff time[9]

Before approving this aspect of Indiana's proposal, CMS should require that the state provide specific information on how the programs would work, information on the administrative costs the state expects to incur, and expected outcomes based on research on the use of healthy behavior incentives

Thank you for your willingness to consider our comments. If you would like any additional information, please contact Joan Alker (jca25@georgetown.edu) or Judy Solomon (Solomon@cbpp.org).

CC: Seema Verma, Tim Hill, Eliot Fishman

American Congress of Obstetricians and Gynecologists
American Heart Association/American Stroke Association
American Lung Association
Center for Law and Social Policy (CLASP)
Center on Budget and Policy Priorities
Children's Defense Fund
Community Catalyst
Community Transportation Association of America

[8] Hannah Katch and Judith Solomon, "Are Medicaid Incentives an Effective Way to Improve Health Outcomes?" Center on Budget and Policy Priorities, January 2017. http://www.cbpp.org/research/health/are-medicaid-incentives-an-effective-way-to-improve-health-outcomes

Families USA
First Focus
Georgetown University Center for Children and Families
HIV Medicine Association
National Association of Community Health Centers
National Health Law Program
National Multiple Sclerosis Society