DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DEC 14 2018

Nancy Smith-Leslie
Director, Medical Assistance Division
New Mexico Human Services Department
State Capitol
Room 400
Santa Fe, NM 87501

Dear Ms. Smith-Leslie:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) is approving New Mexico's (the state's) request to extend the section 1115 Medicaid demonstration project, newly entitled "Centennial Care 2.0 1115 Medicaid Demonstration" (Project Number 11W-00285/6), in accordance with section 1115(a) of the Social Security Act (the Act).

This approval is effective January 1, 2019 through December 31, 2023. CMS's approval is subject to the limitations specified in the attached waiver authorities, expenditure authorities, Special Terms and Conditions (STCs), and subsequent attachments. The state may deviate from the Medicaid state plan requirements only to the extent those requirements have been listed as waived or as not applicable to expenditures or individuals covered by expenditure authority.

Objectives of the Medicaid Program

Under section 1901 of the Act, the Medicaid program provides federal funding to participating states "[f]or the purpose of enabling each state, as far as practicable under the conditions in such state, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care."

As this statutory text makes clear, a basic objective of Medicaid is to enable states to "furnish … medical assistance" to certain vulnerable populations (i.e., payment for certain healthcare services defined at section 1905 of the Act, the services themselves, or both). By paying these costs, the Medicaid program helps vulnerable populations afford the medical care and services they need to attain and maintain health and well-being. In addition, the Medicaid program is supposed to enable states to furnish rehabilitation and other services to vulnerable populations to help them "attain or retain capability for independence or self-care," per section 1901 of the Act.

We are committed to supporting states that seek to test policies that are likely to improve beneficiary health, because we believe that promoting independence and improving health outcomes is in the best interests of the beneficiary and advances the fundamental objectives of

the Medicaid program. Healthier, more engaged beneficiaries may also consume fewer medical services and have a lower risk profile, making the program more Policies designed to improve beneficiary health that lower program costs make it more practicable for states to make improvements and investments in their Medicaid program and ensure the program's sustainability so it is available to those who need it most. In so doing, these policies can promote the objectives of the Medicaid statute.

While CMS believes that states are in the best position to design solutions that address the unique needs of their Medicaid-eligible populations, the agency has an obligation to ensure that proposed demonstration projects are likely to promote the objectives of the Medicaid statute, including through measures designed to improve health and wellness and help individuals and families attain or retain capability for independence or self-care. Medicaid programs are complex and shaped by a diverse set of interconnected policies and components, including eligibility standards, benefit designs, reimbursement and payment policies, information technology (IT) systems, and more. Therefore, in making this determination, CMS considers the proposed demonstration as a whole.

Extent and Scope of the Demonstration

New Mexico's Centennial Care section 1115 Medicaid demonstration was approved by CMS on July 12, 2013. The demonstration became operational in January 2014 and expires December 31, 2018. The state's goals for the Medicaid demonstration were to modernize the program by enrolling most Medicaid and CHIP beneficiaries into pre-paid managed care, consolidating various pre-existing delivery system waivers into a single comprehensive managed care product, providing a comprehensive Community Benefit (personal care and home and community based services) to all participants with a nursing facility level of care need, and offering a beneficiary reward program to incentivize healthy behaviors. The demonstration also includes a hospital uncompensated care pool (UC Pool) and a Hospital Quality Improvement Incentive (HQII) pool.

The state is seeking a five-year demonstration extension, modifying the extension title to "Centennial Care 2.0." The state's extension proposal builds upon demonstration accomplishments and includes a number of program modifications, many of which require additional section 1115 waivers and expenditure authorities.

This approval authorizes the state to receive federal financial participation (FFP) for the continuum of services to treat addictions to opioids and other substances, including services provided to Medicaid enrollees diagnosed with a substance use disorder (SUD) who are short-term residents in residential and inpatient treatment facilities that meet the definition of an Institution for Mental Diseases (IMD). In addition, the state will implement two pilot programs, one for home visitation and the other for pre-tenancy and tenancy supports for individuals living with SMI. The state will also implement premiums and waive retroactive eligibility for some beneficiaries. Under the waiver of retroactive eligibility, individuals eligible for Institutional Care (IC) categories of eligibility, pregnant women (including during the 60-day postpartum period beginning on the last day of the pregnancy), infants under age 1, and individuals under age 19 will continue to be eligible for retroactive coverage starting as early as the third month before the month in which the member applies.

New Mexico also requested an additional five years of funding for the state's uncompensated care (UC) pool, with increased funding over the period of the demonstration extension. After reviewing the state's request pool funding, CMS will provide the state one additional year of UC funding, with the level of funding subject to the STCs. For the subsequent years of the demonstration, any UC funding will be based on updated CMS S-10 data provided by the state, as specified in the STCs. CMS has been working with states with UC pool funding to provide appropriate financial support. UC pool funds may be used to defray the actual uncompensated cost of medical services that meet the definition of "medical assistance" contained in section 1905(a) of the Act, that are incurred by hospitals, clinics, or other provider types, as agreed upon by CMS and the state in providing services to individuals as described in the STCs. As is consistent with federal policy priorities related to these pools, charity care costs may not include bad debt or Medicaid shortfall.

The state also requested an additional five years of HQII pool funding, with increased funding over the demonstration extension period. CMS recognizes the critical role that safety net hospitals play in providing charity care to the uninsured and the associated fiscal burden that hospitals bear for that care. CMS will provide New Mexico three years of HQII funding at $12 million per year for the first three years of the extension period. During this time, CMS will work with New Mexico on its plans to phase out the HQII program and/or transition to an alternative payment mechanism by December 31, 2021. In addition, the state will enhance the current HQII program by creating more accountability and improving quality associated metrics. HQII program funding is intended to be time-limited; CMS does not intend to authorize any further extensions.

Determination that the demonstration project is likely to assist in promoting Medicaid's objectives

In its consideration of the Centennial Care 2.0 Medicaid 1115 Demonstration proposal, CMS examined whether the demonstration was likely to assist in improving health outcomes, address health determinants that influence health outcomes, incentivize beneficiaries to engage in their own health care and achieve better health outcomes, and better enable New Mexico, "as far as practicable under the conditions in" the state, to furnish medical assistance, per section 1901 of the Act. CMS has determined the Centennial Care 2.0 Medicaid 1115 Demonstration is likely to promote Medicaid objectives, and the waiver and expenditure authorities sought are necessary and appropriate to carry out the demonstration. The following discusses individual aspects of the overall demonstration, and how they are likely to promote the objectives of the Medicaid program.

Continuing managed care in the state is likely to improve continuity of care, while making costs more predictable each year and lowering costs to the state

Continuing managed care in the state is likely to promote enhancements in continuity of care, leading to improved health outcomes. Ensuring beneficiaries continue with their coordinated health care provides a focus on beneficiary centered care, increases opportunities for preventive medicine, and is expected to result in higher beneficiary satisfaction leading to increased compliance with their plan of care.

In addition, continuing managed care will help ensure Medicaid's sustainability for beneficiaries over the long term, provide the state a more predictable annual budget and may slow the costs of the Medicaid program from growing year over year, which CMS expects will allow beneficiaries, including optional beneficiaries, to continue receiving Medicaid coverage over the long term, including for optional benefits. Implementing reevaluation standards for nursing facility level of care assessments related to members unlikely to have a status change as a result of their condition, such that these members will not be required to have an annual reevaluation, is similarly expected to decrease costs for the state and making the program more efficient for the state.

Approving the SUD program will allow the state to better address opioid use disorders and other SUDs, which are a serious public health concern in New Mexico.

The SUD program will improve access to high-quality addiction-related services and is critical to addressing SUD in the state. Under this program, all Medicaid beneficiaries will continue to have access to all current mental health and SUD benefits. In addition, all beneficiaries ages 19 through 64 will have access to additional covered services, authorized under section 1115(a)(2) of the Act, including SUD treatment services provided to individuals with SUD who are short-term residents in residential treatment facilities that meet the definition of an IMD. These services would otherwise be excluded from federal reimbursement due to the statutory restrictions on coverage of services provided to beneficiaries who are patients in an IMD setting.

New home visiting programs and pilots are likely to improve health outcomes for Medicaid beneficiaries who participate.

New Mexico will pilot a home visiting program with a focus on prenatal care, post-partum care, and early childhood development. Implementation of this program is projected to increase the likelihood of healthy pregnancies and improve birth outcomes, improve the health and development of children, increase school readiness and parental involvement in the child's care and education, and increase financial self-sufficiency for families. Beneficiary services in this pilot program will be provided to eligible pregnant and post-partum women, infants, and children under the age of 2 years old residing in state designated counties piloting the evidence based home visiting delivery model.

New Mexico will also provide pre-tenancy and tenancy support services to Medicaid beneficiaries living with Serious Mental Illness (SMI). This program will assist such individuals in acquiring and maintaining stable housing that we expect will lead to increased member involvement in their treatment plan, and improve the management of physical and mental health issues. The state expects the implementation of this program will have a positive impact on individuals with SMI, and the state will evaluate the extent to which provision of these services results in improved integration of all services, increased care coordination effectiveness, increased individual involvement in their care, improved health outcomes, and reductions in unnecessary or inefficient use of health care.

CMS has long recognized the importance of case management and connecting Medicaid beneficiaries to social services and other non-medical supports that enhance their health and well-being. Similarly, CMS recognizes that the social determinants of health, such as stable

housing, can influence health outcomes. The pre-tenancy and tenancy services being approved in this demonstration are designed to address housing instability by providing assistance designed to make the beneficiary a better tenant and linkages to other social services that will help these Medicaid beneficiaries acquire and maintain stable housing that meets their needs. Additionally, research supports the hypothesis that pre-tenancy and tenancy services will improve health outcomes. For example, the Kaiser Family Foundation has highlighted housing instability is a predictor of poor health outcomes and providing supportive housing programs optimizes available resources and may assist in advancing improvements to beneficiary care and population health while lowering per capita health care costs.[1] Given the potential health benefits of making the pre-tenancy and tenancy support services available to Medicaid beneficiaries with SMI, CMS believes that state Medicaid programs should be able to test the efficacy of these services in improving beneficiary health.

Incorporating the Family Planning eligibility requirements into the demonstration will assist with ensuring beneficiaries receive the appropriate care for their specific needs rather than being included in programs that will not provide beneficiary appropriate care.

The state will also incorporate new eligibility requirements under the state's optional Family Planning-Only program. The current Family Planning-Only program allows individuals applying for Medicaid, but not meeting financial eligibility standards to qualify for full Medicaid coverage, to be eligible for the Family Planning-Only program if their income is at or below 250 percent of the FPL. Under the demonstration extension, New Mexico is testing whether targeting this program specifically for individuals up to age 50 without health insurance and individuals under age 65 who have only Medicare coverage that does not include family planning services will encourage individuals to obtain appropriate, comprehensive coverage and reduce beneficiary confusion, while ensuring that individuals for whom the Family Planning-Only program is appropriate will continue to receive such coverage. The state is concerned that some beneficiaries who are ineligible for full Medicaid coverage, but who hold a card entitling them to Family Planning-Only coverage, may mistakenly believe they have comprehensive coverage and therefore forego an opportunity to obtain such coverage, such as subsidized insurance that may be available through the Health Insurance Exchange. This change will streamline the program to provide services to a targeted population that otherwise lacks coverage for family planning services, and for whom family planning-only coverage is more likely to be appropriate.

Incorporation of premium and cost sharing requirements incentivizes Medicaid beneficiaries to take an active role in their healthcare.

Through this demonstration extension, the state will have authority to implement premiums for beneficiaries in the adult expansion population who have a household income above 100 percent of the federal poverty level and are enrolled in managed care. For the first year of the demonstration extension, the state will impose a premium equal to one percent of household income (capped at $10/month), per member, with the option to increase premiums on an incremental basis, once per year after a public notice and comment process, up to no more than two percent of household income (capped at $20/month) during the demonstration term. These

[1] Kaiser Family Foundation, January 27, 2017

premium requirements are consistent with what would be permissible in the state plan. The state will implement hardship exemptions for beneficiaries who experience a hardship with respect to their ability to pay otherwise required premiums. A grace period of three months will be provided to individuals prior to suspension of coverage for nonpayment of premiums. Individuals failing to pay premiums after the grace period will be suspended from coverage and incur a three-month lockout period from the program. The individual may reenroll following completion of the lockout period and payment of owed premiums for coverage received prior to the suspension, as well as the first month's prospective coverage. Individuals will also incur co-payments, as specified in the state plan, for utilizing the emergency department for non-emergent issues and for non-preferred drugs when an equivalent preferred drug is available. Implementation of co-payments for inappropriate use of the emergency department or choosing to use higher cost prescription drugs when a lower cost alternative is available will encourage the individual to make responsible choices with respect to their use of healthcare services while preserving their ability to access needed care and services in the appropriate setting.

The demonstration promotes beneficiary health.

The waiver of retroactive eligibility, subject to specified exceptions, is designed to promote improved beneficiary health and wellness by encouraging continuity of coverage and care, including the receipt of preventive health services, or by encouraging beneficiaries to obtain health coverage as soon as possible after becoming eligible (e.g., if eligibility depends on a finding of disability or a certain diagnosis). New Mexico will phase out the Medicaid retroactive eligibility period for Centennial Care 2.0 members. In the first year of the extension period, the state will reduce the retroactive eligibility period from three months to one, except for beneficiaries to whom a premium requirement applies, whose coverage will be effective prospectively starting with the first month after the premium payment is received. The state will eliminate retroactive eligibility in the second year of the extension period, and coverage will be effective starting on the first day of the month in which the application is filed, except for beneficiaries to whom a premium requirement applies. The following populations are exempt from the waiver of retroactive eligibility: individuals eligible for IC categories of eligibility, pregnant women, women who are 60 days or less postpartum, infants under age one, and individuals under age 19. Additionally, no changes are being made to the hospital presumptive eligibility program in the state, so beneficiaries who are required to make a premium payment who experience an emergent medical situation before their coverage otherwise would take effect may receive coverage pursuant to a hospital presumptive eligibility determination.

As part of this demonstration, New Mexico will test whether this policy encourages Medicaid beneficiaries to obtain and maintain health coverage, even when healthy, or to obtain health coverage as soon as possible after becoming eligible (e.g., if eligibility depends on a finding of disability or a certain diagnosis). The state will evaluate whether the new policy increases continuity of care by reducing gaps in coverage that can occur when beneficiaries churn on and off Medicaid or sign up for Medicaid only when sick, and facilitates receipt of preventive services when beneficiaries are healthy. In circumstances where Medicaid eligibility depends upon a finding of disability or a certain diagnosis (e.g., of breast or cervical cancer), the state will evaluate whether the policy encourages beneficiaries to apply for Medicaid as soon as possible after the relevant finding or diagnosis. For example, for those who are aged, blind, or disabled,

or who may need long-term services and supports through Medicaid, the state will evaluate whether the policy encourages beneficiaries to apply for Medicaid expeditiously when they believe they meet the criteria for eligibility, to ensure primary or secondary coverage through Medicaid in case the need for services arises. By waiving retroactive eligibility for New Mexico Medicaid beneficiaries (with exceptions for pregnant women, women who are 60 days or less postpartum, infants under age one, and individuals under age 19), the demonstration will test the efficacy of measures that are designed to encourage eligible individuals to enroll as soon as possible, and, for certain populations, that are designed to encourage eligible individuals to maintain health coverage even while healthy. This feature of the demonstration is designed to encourage enrollment as soon as possible, to facilitate receipt of preventive care and other needed services, and to reduce Medicaid costs, with the ultimate objective of improving beneficiary health.

New Mexico will also evaluate the financial impacts of the waiver. The state expects that the new waiver authority will enable the state to better contain Medicaid costs and more efficiently focus resources on providing high quality health coverage, thereby promoting the sustainability of its Medicaid program. As described in the STCs, if monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, or if evaluation data indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. Further, CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Medicaid.

CMS is requiring the state's evaluation design to include hypotheses on the effects of the waiver on enrollment and eligibility continuity (including for different subgroups of individuals, such as individuals who are healthy, individuals with complex medical needs, prospective applicants, and existing beneficiaries in different care settings), as well as the effects of the demonstration on health outcomes and the financial impact of the demonstration (for example, an assessment of medical debt and uncompensated care costs).

Elements of the demonstration request CMS is not approving at this time

In the state's demonstration extension application, the state requested certain additional flexibilities that CMS is not approving at this time. CMS intends to continue discussing these flexibilities with the state.

The state requested to provide short-term behavioral health crisis services in the IMD setting for beneficiaries with behavioral health as a primary diagnosis. CMS has recently issued guidance on a new section 1115 demonstration opportunity to request expenditure authority for behavioral health services delivered in an IMD. CMS will continue discussing with New Mexico the state's request for flexibility for beneficiaries who require short-term behavioral health crisis services, and the approach described in the state Medicaid director letter issued on November 13, 2018; if approved, CMS expects that additional flexibility in this area may be incorporated into the Centennial Care 2.0 demonstration in the future.

New Mexico proposed to initiate care coordination for justice involved individuals prior to their release from incarceration. The state's program request would allow MCO care coordinators to work with justice involved individuals to establish appointments, referrals, and pharmacy services before these individuals are released to help ensure continuity of care once justice involved individuals leave a custodial setting. Consistent with CMS policy outlined in the April 28, 2016 State Health Official letter, CMS does not currently provide medical assistance or expenditure authority for care coordination for justice involved individuals who are inmates of a public institution (except as patients in a medical institution).

New Mexico requested waiver authority to cover adults in the mandatory Parent/Caretaker Relative category in the Alternative Benefit Plan (ABP). The state's current non-expansion Medicaid adults (Parent/Caretaker category) receive the standard Medicaid benefit package. Under the state's request, "medically frail" individuals would continue to receive the standard Medicaid benefit package. Under section 1931 of the SSA, individuals eligible in the parent/caretaker-relative eligibility group may not be mandatory enrolled in the ABP. CMS informed the state that this provision may not be waived under section 1115.

The state requested authority to develop a buy-in program for dental and vision services, to be implemented if the state were to determine that it does not have sufficient state funds to provide these services under the state plan for adults. Under this proposal, the state would eliminate or reduce optional dental and vision services for adults and develop supplemental dental and vision coverage (such as through riders to plans offered through MCOs) that adults would be able to purchase at an affordable premium. Implementation of this supplemental dental and vision coverage would be contingent upon state budget allocations. Following discussions of these services, New Mexico withdrew their request with respect to vision services. CMS has agreed to evaluate the state's request with respect to dental services, if and when the state identifies a need for this authority.

Consideration of Public Comments

CMS and the state received numerous comments throughout the federal and state comment periods. Consistent with federal transparency requirements, CMS reviewed all of the received public comments received during the federal comment period, along with the summarized public comments submitted by the state, when evaluating whether the demonstration is likely to promote the objectives of the Medicaid program, and whether the waiver and expenditure authorities sought are necessary and appropriate to implement the demonstration. In addition, public comments were considered in the development of the STCs that accompany this approval, and that will bolster beneficiary protections, including specific state assurances around these protections to further support Medicaid beneficiaries.

Comments on the waiver of retroactive eligibility

Many of the commenters expressed concerns with the state's request to waive retroactive eligibility as part of the demonstration extension. In New Mexico's state comment period, the state initially requested an immediate waiver of retroactive eligibility with the extension. The state received numerous recommendations not to eliminate the three-month retroactive eligibility period. Following review of these comments, New Mexico chose to phase out the

retroactive eligibility period by reducing it to one month in demonstration year 6 (the first year of the extension) for beneficiaries who are not subject to a premium requirement, then eliminate the retroactive eligibility period in demonstration year 7, to allow time for the delivery system to develop the necessary processes and for the state otherwise to conduct outreach and education to beneficiaries, providers, and potential applicants regarding the waiver. Additionally, the state is moving toward an environment in which Medicaid eligibility, both initial determinations and renewals, will be streamlined to the greatest extent possible. A real-time eligibility system is scheduled to roll-out by the end of 2018, meaning that many individuals will receive an eligibility determination at the time of application.

During the federal comment period, CMS also received comments expressing concerns about New Mexico's phasing out, then elimination, of retroactive eligibility. Comments expressed concern that the eventual elimination of retroactive eligibility will lead to individuals losing coverage and lacking access to care. Additional concerns addressed by the public included gaps in coverage leading to beneficiaries going into debt when diagnosed with a costly illness. During the first year of the extension period, the state will be working to ensure the delivery system will have the necessary processes in place to meet the needs of beneficiaries. Furthermore, the state will ensure that it will abide by all Medicaid regulations related to beneficiary notices, fair hearings and appeals to ensure all requirements are met.

Commenters also asserted that there is no experimental purpose associated with the waiver of retroactive eligibility. However, this demonstration is designed to test whether eliminating retroactive coverage will encourage beneficiaries to obtain and maintain health coverage as early as possible, regardless of whether they are sick, disabled or healthy, without increasing the rate of churn in and out of the program. This feature of the amendment is intended to increase continuity of care by reducing gaps in coverage when beneficiaries churn on and off of Medicaid or sign up for Medicaid only when sick, and to increase the uptake of preventive services by continuously covered beneficiaries, with the ultimate objective of improving beneficiary health.

Commenters also expressed concern that waiving retroactive eligibility does not promote the objectives of the Medicaid program. As discussed above, the waiver of retroactive eligibility is intended to incentivize beneficiaries to maintain coverage regardless of health status, promote continuity of coverage, and encourage the receipt of preventive care, with the overall goal of improving health outcomes for beneficiaries. To increase awareness of this waiver authority and help ensure that it promotes the objectives of the Medicaid program as intended, New Mexico will provide outreach and education to the public and to providers about how to apply for and receive Medicaid coverage. The state will also evaluate the financial impacts of the waiver on beneficiaries and providers.

Comments on premiums

Commenters expressed concern with the state's proposal to implement premiums as part of the demonstration extension. Many commenters stated the proposed changes will decrease access to care for low income individuals already living near the poverty level and concerns with imposing a three month period of suspended eligibility for non-payment following a three month grace period. CMS discussed the concerns raised in the federal comment period around the eligibility suspension period, and the state agreed to develop hardship criteria for

individuals facing difficulties paying premiums. Under the approved STCs, hardship criteria include, but are not limited to, bankruptcy, death of a close family member, and unpaid medical expenses that result in substantial debt.

Commenters also argued that premiums are inconsistent with the objectives of the Medicaid program, and do not have research value. CMS disagrees with this assertion. CMS has authorized premiums in several states and is currently evaluating these premium requirements; there is not sufficient evidence to assert that premium requirements do not advance the objectives of Medicaid or that there is no research value in further studying the role of premiums in the Medicaid program. On the contrary, interim evaluation findings regarding premiums in one state found that beneficiaries who paid premiums are more likely to obtain primary care and preventive care, have better prescription drug adherence, and rely less on the emergency room for nonemergent treatment, compared to those who do not pay premiums.[2] New Mexico will evaluate the premium requirement, and CMS reserves the right to withdraw its authority if CMS determines that the premium requirements are not promoting the objectives of Medicaid or are otherwise not in the public interest.

Comments on Cost-Sharing

Comments expressed concern about the state's initial proposal to charge more than nominal co-payments. The more than nominal co-payments were proposed for non-emergent use of the emergency department and for a beneficiary who chooses a brand prescription drug over a generic drug. The commenters suggested that these co-payments would deter access to care and the state is shifting the cost from the Medicaid program to the beneficiary.

During discussions with CMS, the state opted to charge only the nominal co-pays as allowed under the Medicaid state plan for non-emergent use of the emergency department and for pharmacy benefits. The state opted not to seek a waiver of cost sharing requirements under section 1916(f) of the SSA.

Other Information

CMS' approval of this demonstration is conditioned upon compliance with the enclosed list of waiver and expenditure authorities and the STCs defining the nature, character and extent of anticipated federal involvement in the project. The award is subject to our receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter. Your project officer for this demonstration is Ms. Sandra Phelps. She is available to answer any questions concerning your demonstration project. Ms. Phelps' contact information is as follows:

---

[2] The Lewin Group, Indiana Healthy Indiana Plan 2.0 Interim Evaluation Report (2016), available at: https://www.in.gov/fssa/files/Lewin_IN%20HIP%202%200%20Interim%20Evaluation%20Report_FINAL.pdf.

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-1968
E-mail: Sandra.Phelps@cms.hhs.gov

Official communications regarding this demonstration should be sent simultaneously to Ms. Phelps and Mr. Bill Brooks, Associate Regional Administrator (ARA) in our Dallas Regional Office. Ms. Roberts' contact information is as follows:

Centers for Medicare & Medicaid Services
Dallas Regional Office
1301 Young St.
Room 833
Dallas, TX 75202
Telephone: (214) 767- 4461
E-mail: Bill.Brooks@cms.hhs.gov

If you have any questions regarding this approval, please contact Mrs. Judith Cash, Director, State Demonstrations Group, Center for Medicaid and CHIP Services at (410) 786-9686.

Sincerely,

Seema Verma