Exhibit F

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

January 27, 2015

Joseph Moser
Medicaid Director
Indiana Family and Social Services Administration
402 W. Washington St., Room W461
Indianapolis, IN 46204

Dear Mr. Moser:

The Centers for Medicare & Medicaid Services (CMS) is approving Indiana's application for a three-year Medicaid demonstration entitled, "Healthy Indiana Plan 2.0" (Project Number 11-W-00296/5). The demonstration is approved in accordance with section 1115(a) of the Social Security Act (the Act) and is effective on the date of this signed approval. Through this demonstration and associated state plan amendments, the state will provide coverage to adults in Indiana with incomes through 133 percent of the Federal poverty level (FPL) beginning February 1, 2015.

The terms of the demonstration have been incorporated into the accompanying waiver and expenditure authorities, which can be exercised only as described and as set forth in the Special Terms and Conditions (STCs). The unique design of HIP 2.0 builds on the existing HIP demonstration with modifications to address new features proposed by the state and provisions and objectives established by the Affordable Care Act.

Two primary routes to coverage are established under the demonstration: HIP Plus for those who contribute to the Personal Wellness and Responsibility (POWER) account, and HIP Basic for those who do not make such contributions. The state shall make contributions to POWER accounts for individuals enrolled in HIP Plus and HIP Basic. The POWER Account will be used to pay for some of beneficiaries' health care expenses covered under the demonstration. Through the use of such accounts the state intends to promote the efficient use of healthcare, including encouraging preventive care and discouraging unnecessary care.

The demonstration authorizes the state to collect monthly premiums (contributions to the POWER account) from individuals up to 133 percent of the FPL in an amount not to exceed 2 percent of household income, except that the POWER account contributions from individuals with income below 5 percent of the FPL will be no more than $1 per month. POWER account contributions are required as a condition of eligibility for individuals with incomes above 100 percent of the FPL but not for individuals with lower incomes, who will enroll in HIP Basic if they do not make POWER account contributions.

Individuals covered under the demonstration, regardless of income, who make POWER account contributions shall be enrolled in HIP Plus. Those enrolled in HIP Plus will not be subject to cost sharing, with the exception of a copayment for non-emergency use of emergency department services, as discussed below. Adults with incomes at or below 100 percent of the FPL who do not choose to make contributions will be enrolled in HIP Basic and will be subject to co-payments at levels permitted under federal Medicaid rules.

Individuals with incomes above 100 percent of the FPL, who begin but subsequently cease making POWER account contributions will, after a 60 day grace period, be disenrolled from HIP 2.0 coverage and disqualified from such coverage for six months. Exceptions to this "lock out," which applied to all beneficiaries in the existing HIP demonstration, will be afforded to individuals who are medically frail and those with specific circumstances as described in the special terms and conditions. Because payment of premiums (contributions to the POWER account) is not a requirement for coverage for individuals with incomes at or below 100 percent of the FPL, if such individuals begin but cease making payments, they will not lose coverage (or be subject to a lock out) but will be automatically enrolled, without a new application or gap in coverage, into HIP Basic (instead of HIP Plus).

Also reflecting the unique design of HIP 2.0, coverage will be effective: 1) the first day in the month in which an individual makes a POWER account contribution; or, for those with incomes at or below 100 percent of the FPL who do not make a POWER account contribution, coverage will start 2) the first of the month in which the 60 days payment period expires. Expanded access to presumptive eligibility processes will be available at qualified entities throughout the state for individuals seeking immediate coverage, and a "fast track" method for billing and paying POWER account contributions will be available to all individuals under the demonstration to expedite coverage.

Both HIP Plus and HIP Basic will provide coverage of a full alternative benefit plan (ABP) for individuals in the new adult group, authorized through an amendment to the state plan. Individuals in the HIP Plus ABP will have access to additional benefits not available in the HIP Basic (ABP) although all individuals, whether enrolled in Plus or Basic, will receive all essential health benefits required by law. The demonstration provides authority for the state to not offer non-emergency medical transportation (NEMT) for the new adult group during the first year of the demonstration; this authority may be extended subject to evaluation regarding the impact of this policy on access to care.

Under the demonstration, all beneficiaries will be subject to a copayment for non-emergent use of the Emergency Department (ED). We have granted the state authority to demonstrate whether a graduated co-payment – $8 for the first instance and $25 for recurrent non-emergent use of the ED, with education and referrals to primary care providers – will reduce unnecessary ED use and improve beneficiaries' use of health care in the most appropriate setting. Per Federal law regarding experimental approaches to cost sharing, this authority requires a control group for evaluation and is granted for a period of two years.

Under the demonstration, the state will also offer a voluntary premium assistance program called HIP Link for individuals above age 21 with access to cost effective health care coverage through

employer sponsored insurance (ESI) that has met qualification criteria specified in the STCs. Individuals electing the HIP Link program will receive full ABP coverage, but their ESI plan will pay primary to Medicaid for all such services; individuals will be able to use POWER account funds to cover any out-of-pocket costs above Medicaid permissible limits.

In addition, outside this demonstration, the state aims to encourage employment through a work search and job training program called Gateway to Work, for Healthy Indiana Program 2.0 beneficiaries who choose to participate. Health coverage provided by the Medicaid program and this demonstration will not be affected by this state initiative.

CMS approval of this section 1115 demonstration extension is subject to the limitations specified in the approved waiver authorities and compliance with the enclosed STCs defining the nature, character, and extent of Federal involvement in this project. The state may deviate from the Medicaid state plan requirements only to the extent those requirements have been specifically listed as waived, consistent with the STCs. The approval is subject to CMS 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. Andrea Casart. She is available to answer any questions concerning your section 1115 demonstration. Ms. Casart's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-0742
Facsimile: (410) 786-5882
E-mail: Andrea.Casart@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Casart and to Mr. Alan Freund, Associate Regional Administrator for the Division of Medicaid & Children's Health in the Chicago Regional Office. Mr. Freund's contact information is as follows:

Mr. Alan Freund
Associate Regional Administrator
Division of Medicaid and Children Health Operations
233 North Michigan Avenue, Suite 600
Chicago, IL 60601
Email: Alan.Freund@cms.hhs.gov

If you have questions regarding this approval, please contact Mr. Eliot Fishman, Director, Children and Adults Health Programs Group, Center for Medicaid & CHIP Services, at (410) 786-5647.

Thank you for your work with us, as well as stakeholders in Indiana, over the past several months on developing this demonstration, and congratulations on its approval.

Sincerely,

/s/

Marilyn Tavenner
Administrator

Enclosures

cc: Verlon Johnson, ARA, Region VI

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.

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)**

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.