STATE OF INDIANA
OFFICE OF THE GOVERNOR
State House, Second Floor
Indianapolis, Indiana 46204

Eric J. Holcomb
Governor

January 31, 2020

The Honorable Alex Azar
Secretary U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Washington, D.C. 20201

Re: Healthy Indiana Plan §1115 Demonstration Extension Request (Project No. 11-W-00296/5)

Dear Secretary Azar,

I am pleased to submit Indiana's application to extend the Healthy Indiana Plan (HIP) Section 1115 demonstration waiver.

A fixture of Indiana's health care system since 2008, today HIP provides coverage to more than 400,000 Hoosiers each year. This waiver extension preserves HIP as a core component of health care in Indiana by seeking continued authority to operate the program for a 10-year period through December 31, 2030.

In addition to authorizing HIP, the existing waiver includes authority to operate a Substance Use Disorder (SUD) demonstration to provide greater access to SUD services for all Hoosiers that receive coverage through Indiana Medicaid. Through this demonstration, over 65,000 members have been able to receive needed SUD treatment, and I am dedicated to working with you to continue support of those overcoming addiction.

This extension requests to continue to operate the SUD demonstration and incorporate the recently approved Serious Mental Illness waiver amendment for a 5-year period through December 31, 2025. The extension also incorporates the pending HIP Workforce Bridge waiver amendment for operation through the waiver's next 10-year period, to support members transitioning to commercial coverage.

I look forward to continued collaboration to ensure access to quality healthcare for Hoosiers. Thank you for your consideration of this proposal.

Sincerely,

Eric Holcomb

Eric J. Holcomb
Governor of Indiana

Indiana Family and Social Services Administration

Renewal Request for the
Healthy Indiana Plan (HIP)
Section 1115 Waiver
(Project Number 11-W-00296/5)

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Section 1: Summary of HIP Renewal Request

The Healthy Indiana Plan (HIP) has been a feature of Indiana's Medicaid program since 2008. The current approval to operate HIP expires December 31st, 2020. This document requests to renew the HIP program with no substantive changes. Based on the long-tenure and demonstrated success of HIP, the State requests renewal for a ten-year period through December 2030.[1]

This 1115 waiver renewal requests authority to continue to operate HIP, as approved and operating in Indiana today, and to incorporate the HIP Workforce Bridge amendment into the renewed program.

Today, HIP provides coverage each year to approximately 570,000 non-disabled Hoosier adults age 19 to 64 who have income at or below 133 percent of the federal poverty level.[2] HIP enrollees have access to different benefits and cost-sharing based on factors such as income, health status, and eligibility as a low-income parent and caretaker, as described below:[3]

- Every HIP enrollee has a $2,500 **POWER Account** to fund the $2,500 deductible. Members and the State contribute to this account.
- **HIP Plus** offers a commercial coverage package including vision, dental and chiropractic services. To receive HIP Plus benefits, HIP members make contributions to their POWER Account. Member contributions to the POWER Account are refunded if a member leaves the program without spending the funds on health care services. HIP Plus is an option for coverage for all HIP enrollees. For members who have income over the poverty level, HIP Plus is the only benefit option. Members can lose coverage for HIP Plus if they fail to pay, and those with income over the poverty level are subject to a 6-month coverage exclusion for non-payment. HIP Plus also incorporates a surcharge for members who continue to use tobacco following a year of cessation opportunities.
- **HIP Basic** members have copayments instead of POWER Account contributions. HIP Basic offers a commercial coverage package that includes all of the essential health benefits but does not include vision, dental, or chiropractic services. Additionally, there are some service limits that are lower than those available under HIP Plus. Members with income at or below the poverty level who do not contribute to their POWER Accounts receive HIP Basic benefits.
- **HIP State Plan** benefits are available to members who are (1) pregnant, (2) medically frail, or (3) low-income parents and caretakers. Pregnant members have no cost sharing. Medically frail and low-income parents and caretakers receive the full Medicaid benefit

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[1] The renewal incorporates the inclusion of the HIP Workforce Bridge Amendment as proposed to be effective in the final year of the demonstration.

[2] $17,422 per year for an individual, or $35,860 for a family of four in 2019, inclusive of the 5% of income disregard.

[3] All HIP benefits are approved Alternative Benefit Plans (ABPs) in the Medicaid State Plan. HIP Basic copayments are within the federally allowable limits. All HIP cost-sharing is subject to a maximum 5% of income quarterly limit.

package but may choose to make contributions to the POWER Account or have HIP Basic copayments.[4]

- **Gateway to Work** started in 2015 as a voluntary referral of HIP members to employment services. In 2019, the program expanded with the goal of increasing community engagement and connecting members to gainful employment. The program is designed to improve physical and mental health, and overall enrollee financial stability and well-being.
- **HIP Workforce Bridge** will support individuals who transition off HIP coverage to enroll in and maintain commercial coverage. If approved as requested in the amendment, beginning in 2020, qualified individuals will access the HIP Workforce Bridge Account. This account leverages unspent POWER Account dollars to fund up to $1,000 of health care costs following disenrollment from HIP and helps ensure individuals disenrolling from HIP have sufficient time to enroll into other coverage.

This renewal requests to continue the existing HIP program with the incorporation of the HIP Workforce Bridge amendment, without substantial changes to policy. The primary modification requested is the extended renewal period of ten years. The State is committed to scientific and evidence-based approaches to program oversight, monitoring and evaluation, and to continued involvement and meaningful consultation with stakeholders on program policy and operations. The ongoing cycle of three-year renewals creates unnecessary administrative burdens for the State and federal government, and does not meaningfully enhance the oversight or transparency of the demonstration. The STCs allow for withdrawal of waiver authority at any time that it is determined that the approved waiver or portions of the waiver are not meeting the objectives of the Medicaid program. In addition, the State solicits public comment prior to submitting any proposed amendment for any needed change, meaning that frequent renewal requirements do not provide an enhancement to federal authority over the demonstration.[5]

With this request to renew HIP, Indiana continues its commitment to providing innovations in the provision of public health care coverage. A ten-year renewal will give HIP members confidence that HIP will continue to be a resource for accessing quality health care, and will also allow state and federal staff to dedicate resources to continually improving HIP and ensuring the program meets its ongoing goals.

Section 2: Historical Narrative

HIP first passed the Indiana General Assembly in 2007 with bipartisan support. Indiana pioneered the concept of medical savings accounts in the commercial market and became the first state to apply the consumer-driven model to a Medicaid population. Provided by private health insurance carriers, HIP offers its members a high-deductible health plan paired with the POWER Account, which operates similarly to a health savings account. Following CMS approval, HIP began enrolling working-age, uninsured adults in coverage on January 1, 2008.

[4] As discussed in the HIP program components section, a minority of medically frail individuals that have income over the poverty level may have copayments and required contributions.
[5] Healthy Indian Plan Special Terms and Conditions, III -12.

In 2011, with the passage of the Patient Protection and Affordable Care Act (ACA), the Indiana General Assembly reinforced its support for the program by calling for HIP to be the coverage vehicle for Medicaid expansion in the State. The legislature passed Senate Enrolled Act 461 (codified at Indiana Code §12-15-44.2), to codify this requirement as well as to make several conforming changes to the HIP program related to the ACA.

In 2014, following several one-year extensions of the original HIP waiver, Governor Mike Pence opted to seek expansion of Indiana's successful HIP program to cover individuals in the new adult group. Following a historic agreement with the Indiana hospitals that secured funding for the costs of expansion beyond the existing cigarette tax revenue, the State submitted a fiscally sustainable waiver to expand its existing HIP demonstration waiver. The HIP 2.0 waiver built on the early HIP experiences and outcomes to improve the program and strengthen the core values of personal responsibility and consumer driven healthcare. In January 2015, CMS approved the HIP 2.0 program through a three-year waiver expiring in January 2018. Following implementation of HIP 2.0 on February 1, 2015, the Indiana General Assembly codified HIP 2.0 at Indiana Code §12-15-44.5. Through the 2016 codification efforts, the state legislature once again reinforced its support of HIP by expressly prohibiting the continuation of Medicaid expansion in the State except through HIP, operated in a manner consistent with the statutory provisions.

Immediately upon receiving a three-year approval for HIP on January 27, 2015, the State began accepting applications for the program. Services began just days later, as the enhanced HIP program launched on February 1, 2015. In addition to processing new program applications, the launch of HIP 2.0 included the conversion of members previously enrolled in the original HIP program as well as all non-pregnant adults enrolled in Hoosier Healthwise—Indiana's traditional Medicaid managed care program. Over 222,000 individuals were enrolled in HIP by the end of the first quarter of operations. Program enrollment stabilized with approximately 400,000 enrollees in the program on a month-to-month basis.

HIP 2.0 enhancements included the fast track prepayment option, which allows individuals to pre-pay their POWER Account contribution either by credit card on their application or an invoice received during application processing. The State also rolled out enhancements to presumptive eligibility for HIP, adding new providers that can make presumptive eligibility determinations, including county health departments, federally qualified health centers, rural health centers, and community mental health centers. In addition, at the direction of the Indiana General Assembly, the State implemented a program to provide presumptive eligibility to prison inmates who are being treated in inpatient settings while incarcerated. The State has leveraged this program to ensure that HIP applications are filed for inmates prior to release in order to improve continuity of care and continued access to prescriptions in order to reduce recidivism. A program called HIP Link, which helped individuals connect with and enroll in their employer insurance, was also established during the initial three-year approval period.

In January 2017, after two-years of program operations and 12-months prior to the expiration of the initial three-year approval, Indiana submitted the required request to renew the HIP program. This request was to renew the existing program, incorporate additional, eligible populations, and

implement new policies. Specifically, under the request, pregnant women were proposed to be included in HIP to prevent confusing coverage transitions during pregnancy. Additionally, a tobacco surcharge was proposed to support the State's initiatives around decreasing tobacco use, and the State proposed to reestablish the non-eligibility period for failure to renew coverage. The renewal request also documented State policy initiatives around encouraging MCEs to develop member incentive and engagement programs, enhancing HIP Plus benefits with chiropractic services, and technical changes requested to the STCs. In addition, the renewal included the request to add a substance use disorder (SUD) component, to ensure access to comprehensive SUD services for all Indiana Medicaid enrollees.

Prior to the renewal request being approved, in July 2017, an amendment was submitted to the original renewal application. This amendment requested additional changes to the preceding renewal request. First, the State requested to change the HIP Plus contribution schedule from two percent of income each month, to one of five set amounts which are approximately two percent of household income. This change allowed for more consistent POWER Account contribution amounts for individuals with variable income. Second, the State requested to enhance the existing voluntary Gateway to Work initiative to include a requirement that individuals who do not have an exemption, already work at least 20 hours per week, are enrolled as a full-time student, or participate in Gateway to Work for eight out of 12 months of the calendar year. The amendment to the pending renewal request also included technical corrections and the request to phase out the HIP Link program due to low enrollment.

HIP was authorized for an additional, three-year approval period on February 1, 2018. The authorization included approval for ongoing program operations and provided authority to implement the requested program changes. The change to the tiered POWER Account contribution was implemented in January 2018, following written guidance from CMS. The remaining waiver changes were implemented over the course of 2018, with Gateway to Work and the tobacco surcharge first taking effect in January 2019. Gateway to Work operates on a calendar-year basis. The program has member community engagement hours that gradually increase over the first 18-months post-implementation; the requirement will be fully phased in at the 20-hour per week level in July 2020. Effective October 2019, the enrollment penalty for not complying with Gateway to Work was temporarily suspended pending results of a lawsuit filed in federal court.

In May 2019, the state posted for public comment the HIP Workforce Bridge Amendment. This amendment proposes to add in the final year of the demonstration program components to help individuals who are no longer eligible for HIP due to increasing income successfully transition to commercial market coverage. The HIP Workforce Bridge Amendment includes a $1,000 account, funded with remaining POWER Account dollars, that helps support the cost of commercial coverage following HIP disenrollment and modifications to Gateway to Work exemptions. Following public comment, this request was submitted to CMS in July 2019.

This renewal request is to continue the HIP program as established, with the incorporation of HIP Bridge Amendment.

2.1 Historical and Current and Program Objectives

Since the initial approval in 2008, HIP has included three different sets of program objectives. The program objectives from 2008 to 2018 were relatively consistent, and progress towards these objectives has been summarized in prior waiver submissions, monitoring, and evaluation reports (see Figure 1). The objectives stipulated by the approval for the current program include a focus around (1) determining the impact of changes to the HIP Plus contribution amounts from a two percent of income amount for each individual to one of five set amounts based on income; (2) the impact of implementing a community engagement initiative; and (3) the impact of implementing the tobacco surcharge. In addition, the evaluation plan for the current demonstration period includes alignment where possible with the CMS 1115 evaluation guidance and includes three additional objectives. First, to improve health care access, appropriate utilization, and health outcomes among HIP members; and second, to evaluate member experience with the program and ensure that HIP policies approximately align with commercial market policies and promote a positive member experience; and finally, to assess the costs of implementing and operating the HIP demonstration aligned the CMS guidance around evaluating program sustainability.[6]

Figure 1: Objectives of the HIP program, 2008 to 2020

HIP (Jan. 2008 – Jan. 2015)	HIP 2.0 (Feb. 2015 to Jan. 2018)	HIP STCs (Feb. 2018 to Dec. 2020)
1. Reduce the number of uninsured low-income Hoosiers	**1. Reduce the number of uninsured low income Indiana residents and increase access to healthcare services**	The State did not request change to goals from HIP 2.0. The new HIP STCs include the following new goals:
2. Improve Statewide Access to Health Care Services for Low-Income Hoosiers	**2. Promote value-based decision making and personal health responsibility**	1. Moving the monthly payment obligation to a tiered structure will result in more efficient use of health care services, be easier for beneficiaries to understand, and increase compliance with payments
3. Promote value-based decision making and personal health responsibility by participants in the HIP Program	**3. Promote disease prevention and health promotion to achieve better health**	2. Implementing a community engagement requirement will lead to sustainable employment and improved health outcomes among HIP beneficiaries
4. Promote primary prevention for HIP Participants	4. Promote private market coverage and family coverage options to reduce network and provider fragmentation within families	3. Charging beneficiaries an increased monthly contribution for tobacco use will discourage tobacco use and increase the utilization of tobacco cessation benefits.
5. Prevent Chronic Disease Progression with Secondary Prevention	5. Provide HIP members with opportunities to seek job training and stable employment to reduce dependence on public assistance	
6. Provide Appropriate Quality-Based Health Care Services	**6. Assure State fiscal responsibility and efficient management of the program**	
7. Assure State Fiscal Responsibility and Management of the Program		

[6] HIP Evaluation goals for 2018 to 2020 include: (1) Improve health care access, appropriate utilization, and health outcomes among HIP members; (2) Increase community engagement leading to sustainable employment and improved health outcomes among HIP members; (3) Discourage tobacco use among HIP members through a premium surcharge and the utilization of tobacco cessation benefits; (4) Promote member understanding and increase compliance with payment requirements by changing the monthly POWER account payment requirement to a tiered structure; (5) Ensure HIP program policies align with commercial policies, encourage members understanding, and promote positive member experience; and (6) Assess the costs to implement and operate HIP and other non-cost outcomes of the demonstration.

2.1.1 Tiered POWER Account Contributions

Effective January 1, 2018, member POWER Account contribution amounts changed from a two percent of income amount to one of five tiered amounts. The current tiered amounts are seen in Table 1.

Table 1: POWER Account Tiers Effective 1-1-2018

FPL	Monthly POWER Account Contribution: Single Individual	Monthly POWER Account Contribution: Spouses
<22%	$1.00	$1.00
23-50%	$5.00	$2.50
51-75%	$10.00	$5.00
75%-100%	$15	$7.50
101-133%*	$20.00	$10.00

**With 5% of income disregard*

This change is expected to have reduced the number of times a member's payment amount might change during the year and increase compliance with payments. Preliminary data for 2018 shows that this may be the case. In December 2017, 66 percent of individuals made contributions for HIP Plus coverage, and by December 2018, this had increased to 75 percent.[7] This increase may be due to the change in the contribution policy; however, other factors such as members taking advantage of rollover incentives could also be a factor. Analysis of this objective is a focus of the independent interim evaluation report, included with this renewal request.

2.1.2 Community Engagement

The 2018 HIP renewal provided authority to enhance the existing Gateway to Work program, which provided referrals to employment and job training opportunities. The changes require up to 80 hours of work or community engagement activities per month for non-exempt individuals. The Gateway to Work program rolled out in January 2019 and will be fully phased in July 2020 in alignment with the schedule seen in Table 2.

Table 2: Gateway to Work Phase In Schedule

Date Range	Required Hours
January 1, 2019 – June 30, 2019	0 hours per month (0 hours per week)
July 1, 2019 – September 30, 2019	20 hours per month (5 hours per week)
October 1, 2019 – December 31, 2019	40 hours per month (10 hours per week)
January 1, 2020 – June 30, 2020	60 hours per month (15 hours per week)
July 1, 2020 – Ongoing	80 hours per month (20 hours per week)

The program is implemented on a calendar-year basis, with the requirement applying to individuals for eight out of 12 months of the calendar year. Processes to act on non-compliant individuals were temporarily suspended in October 2019 pending results of a

[7] FSSA HIP dashboard, December 2017 & 2018 HIP Plus enrollment percentages. Accessed 2-21-2019

lawsuit filed in federal court. Due to the recent program implementation, preliminary data is available on Gateway to Work as reported in the independent interim evaluation posted and submitted concurrently with this request.

2.1.3 Tobacco Surcharge

The tobacco surcharge was authorized in 2018 and was implemented through a phased-in approach. Starting in 2019, individuals that had reported smoking and continued to smoke after 12 months were subject to an increased HIP Plus contribution amount.

The independent interim evaluation provides an overview of use of tobacco and use of cessation services in HIP and a preliminary look at individuals assessed a tobacco surcharge in 2019.

2.2 Independent Interim Program Evaluation

In addition to the three goals above, the interim program evaluation analyzes member service utilization, access to services, and health outcomes in addition to preliminary analysis on member's experiences and satisfaction with HIP. The interim evaluation also incorporates CMS evaluation guidance around assessing enrollment impacts and costs of operating the demonstration. This evaluation report is available concurrent with this renewal request. The final evaluation for the current three-year renewal period (through December 2020) will be submitted in July 2022 as required in the current program STCs.

2.3 Renewal Program Goals

Under this renewal request, HIP will continue to operate under goals that are in alignment with the prior goals of the demonstration. These goals are targeted to the following realms: Health Care, Economic and Social, Public Health, and improved Policy and Process.

Table 3: Renewal Program Goals

Realm	Factor	Policy	Program Goal
Health Care	Access	HIP members are able to see a doctor in a timely manner without traveling too far to seek care.	Provide timely and geographically appropriate access to healthcare services.
	Utilization	HIP members get the care they need from the most appropriate setting.	Promote appropriate utilization of healthcare by maintaining low inappropriate use of the emergency department and supporting utilization of needed services from qualified non-emergency providers.
	Outcomes	Access and appropriate utilization support positive health outcomes. HIP members are able to control chronic conditions, receive needed care, and have an overall increase in health and wellbeing.	Promote control of chronic conditions, delivery of needed care, and increase in member health and wellbeing.
Economic and Social	Work and community engagement	Through increased educational attainment, connection with community resources, and promotion of sustainable employment community engagement will increase income and self-sufficiency of HIP members.	Increase community engagement leading to increased educational attainment, sustainable employment and member self-sufficiency.

	Insurance rates; Coverage gaps	HIP members may have gaps in coverage when they leave HIP for having income over the HIP limit. HIP promotes increased uptake of commercial insurance when HIP coverage is lost and support individuals in their ability to maintain HIP coverage while they remain eligible.	Reduce the number of uninsured Hoosiers, decrease gaps in coverage, and promote uptake of commercial insurance when leaving HIP.
Public Health	Tobacco use	HIP should encourage access of tobacco cessation services and decrease member tobacco use.	Meaningfully increase use of tobacco cessation services and meaningfully decrease tobacco use status for HIP members.
	Prevention and wellness	HIP members should use preventive services and adopt healthy behaviors.	Encourage healthy behaviors and appropriate care, including early intervention, prevention, and wellness
Policy and Process	HIP Policy	HIP policies ensure continuous coverage and promote health care access, utilization, and improved health outcomes.	HIP policies support the goals of HIP by promoting continuous coverage and improved health outcomes.
	Social determinants of health	Barriers prevent HIP members from achieving health and financial stability. To support ongoing innovation in HIP, member barriers and needs will be identified.	Generate actionable information on social determinants of health needs.

Section 3: HIP Eligibility, Benefits, and Cost Sharing

HIP coverage is targeted to non-disabled adults between 19 and 64 years of age and encompasses the following eligibility groups: (1) the adult group, (2) low-income parents and caretakers, (3) transitional medical assistance, (4) pregnant women with income that would otherwise make them eligible for HIP, and (5) for limited benefit HIP Bridge coverage starting in 2020, specified former HIP enrollees that lost coverage due to increases in income over the HIP income limit.

Table 4: HIP Eligibility

#	Eligibility Group	Social Security Act and CFR Citations	Income Level	Waiver Criteria
1	Adult group	1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119 including individuals who meet the definition of medically frail consistent with 42 CFR Section 440.315(f).	133 percent of the FPL including a 5 percent of income disregard	Non-medically frail individuals over 100% FPL are eligible for HIP Plus enrollment only
2	Parents & caretaker relatives	42 CFR 435.110	Parents and caretakers with income under the State's AFDC payment standard in effect as of July 16, 1996 (section 1931 parents and caretaker relatives), converted to a MAGI-equivalent amount by household	
3	Adult Transitional Medical Assistance beneficiaries	1902(a)(52) and 1925 of the Act including individuals who are medically frail	No income limit for first 6 months of eligibility. 185% FPL for the second 6 months of eligibility	Individuals with household income over the adult group income level are designated as TMA
4	Pregnant women, age 19 and older	42 CFR 435.116	133 percent of FPL	Waiver of retroactive coverage does not apply.

5	Individuals with MAGI-based income above 133 percent FPL	1902(a)(10)(A)(ii)(XX) 42 CFR 435.218	None	Limited to those that have lost HIP coverage due to increase in income. Coverage begins in 2020 following approval of the HIP Workforce Bridge.

Enrolled HIP members qualify for one of three cost-sharing models based on eligibility factors and whether they buy into the HIP Plus package. These cost sharing packages are as follows:

1. HIP Plus cost-sharing which allows individuals to make a monthly contribution to their POWER Account. For those who make a monthly contribution, there are no copayments, with the exception of non-emergency use of the emergency room. A waiver to offer the contribution option for HIP-enrolled individuals is provided; the copayment for non-emergency use of the emergency room is within Medicaid allowable limits. Monthly contributions are a set amount for specified income levels, and with the exception of some individuals with a tobacco surcharge, the amounts are below two percent of enrollee income on average, with a minimum amount of $1 per month.
2. HIP Basic cost sharing which assesses copayments on most services within the Medicaid allowable limits. The copayment model only applies to eligible individuals who do not contribute to their POWER Account.
3. For pregnant HIP members, all cost sharing is suspended.

In addition to the three cost-sharing models in HIP, there are four separate benefit options. HIP Plus, HIP Basic, the HIP State Plan benefits, and the limited HIP Workforce Bridge benefit that will begin in 2020 based on authorization of the HIP Workforce Bridge amendment. All individuals who are medically frail or low-income parents and caretakers receive the HIP State Plan benefits. HIP Plus and HIP Basic benefits are available to newly eligible adults, and individuals eligible for Transitional Medical Assistance. HIP Plus and HIP Basic are based on commercial market benefit packages and are approved Alternative Benefit Plans in the Medicaid State Plan and both offer all of the essential health benefits. Aligned with commercial market benefits, neither HIP Plus nor HIP Basic offer coverage for non-emergency medical transportation. HIP Plus has additional enhanced services such as vision, dental, and chiropractic services. Individuals receive HIP Plus and HIP Basic benefits based on income and payment of monthly POWER Account contributions.

Table 5: HIP Benefit and Cost Sharing Options

	Benefits	Cost Sharing	HIP Eligible Member Characteristics	Members Enrolled Jul 2019[8]
Healthy Indiana Plan – Cost Sharing and Benefit Options by HIP Member Characteristics	Medicaid State Plan Benefits	No cost sharing	Pregnant	18,283
		Monthly Contributions	Low-income parents and caretakers, the medically frail, and individuals eligible for Transitional Medical Assistance	123,578
		Copayments	Low-income parents and caretakers and the medically frail at or below the poverty level who do not make monthly contributions	42,456
		Contributions and Copayments	The medically frail with income over the poverty level who are 60 days past-due on their monthly contribution	315
	HIP Plus-ABP	Monthly Contributions Copayment for non-emergency ED use	Able-bodied adults	153,118
	HIP Basic-ABP	Copayments	Able-bodied adults with income at or below the poverty level	48,490
	HIP Bridge-Limited $1,000 Benefit	Contribution deducted from premium reimbursement	Previously enrolled in HIP, but disenrolled due to over income.	N/Ae– 2020 Implementation
Total fully eligible HIP members				386,240

Every enrolled HIP member has a $2,500 POWER Account which is used to cover the $2,500 deductible that applies to all HIP enrollees. For all plans, maternity services and preventive services, such as annual examinations, smoking cessation programs, and mammograms, are covered without charge to the members and are not included in the deductible amount of $2,500. After the plan deductible is met and covered by the $2,500 POWER Account, all benefits in the applicable benefit package continue to be covered for HIP members.

[8] FSSA HIP dashboard, July 2019 Monthly enrollment. Accessed 9-30-2019.

Section 4: HIP Components and Operations

HIP is composed of distinct program elements that integrate to achieve the program goals. Many of these elements were established in the initial HIP implementation in 2008 or incorporated when HIP expanded coverage in 2015 to all non-disabled adults with income below 133 percent of the poverty level. The HIP program continues to innovate and since 2018 has designed, developed and implemented changes such as a calendar year period for MCE enrollment, deductibles, and POWER Accounts, a tobacco surcharge, and the Gateway to Work community engagement initiative. The HIP Workforce Bridge initiative incorporated in the waiver amendment request is the most recent example of the evolution in ongoing program innovation.

4.1 POWER Accounts

HIP leverages innovations from the commercial market. Unlike traditional Medicaid, HIP coverage is based on a high-deductible model. HIP enrollees by definition are low-income, and this high-deductible plan pairs with a unique health savings-like account, the POWER Account, to fund the cost of the deductible. The POWER Account has been the central component of the HIP design since program initiation in 2008. In current operations, the POWER Account operates in alignment with original design, and provides a health-savings 'like' account that funds member deductibles. The POWER Account provides funding for the first $2,500 in health care services and holds both state and member contributions. The State contributes all dollars that are beyond the member contribution amount, up to the full $2,500, to the account.

The POWER Account promotes transparency around the costs of care and provides members incentives to engage with the health care system to help to control health care costs. As an incentive to receive preventive care, the cost of preventive services is fully covered outside of the POWER Account. Members receive monthly account statements showing account debits and credits, and members who do not use their entire account during the year may earn rollover incentives that reduce the costs of future enrollment. Receipt of preventive services can increase the member's rollover incentive.

Over 10 years of member experience with POWER Accounts has been documented by quarterly and annual reporting, independent evaluations, and required additional POWER Account reports.

The first HIP member survey, conducted in 2010, found that 95 percent of members were satisfied with the program, 97 percent of members knew their monthly contribution amount; over half (63 percent) of members knew their POWER Account balance; and nearly half (44 percent) of members checked their POWER Account balances at least once a month.[9]

The most recent HIP member survey, conducted in 2016, found that 86 percent of contributing members were satisfied with the program, with 95 percent reporting that they would re-enroll in HIP if they left and became eligible again, and 42 percent reporting that

[9] 2010 Mathematica Survey of HIP members

they are checking their POWER Account balances at least once a month.[10] FSSA internal monitoring has found that high member satisfaction with HIP continues through the current demonstration year.

The most recent POWER Account data indicate that 65 percent of members used less than half of their POWER Account balances while 44 percent of members qualified for rollover. Of the members who qualified for the State discount percent (HIP Basic members eligible for HIP Plus), the vast majority (79 percent) qualified for the maximum rollover discount rate of 50 percent.[11]

There is no specific waiver granted to operate the POWER Account under the HIP approval, and reporting on accounts is incorporated into the required CMS-64 reporting in alignment with the current HIP approval. This HIP renewal does not request any changes to the POWER Account, and solely seeks authorization to continue POWER Account operations for the requested renewal period through 2030.

4.2 Member Contributions

Members make monthly payment deposits to the POWER Account. When service costs are deducted from the POWER Account, the payment is deducted proportionally from the state and member funds in the account. In this way, for all services that are applied to the deductible, HIP member contributions are paying a portion of the cost. Members who do not spend their full account on health care during the year get to keep contributions as a rollover towards the next year of enrollment. For members who leave the program, their remaining contributions can be refunded. This design, where all services applied to the deductible are paid with member and state contributions, and where members can count on their contributions rolling over or being returned to them, gives members "skin in the game." Members engage as consumers with financial incentives to avoid unnecessary care and make value-based healthcare choices.

In the initial HIP program, the contribution was up to 4.5 percent of member annual income. The 2015 approval set contributions at two percent of income with a minimum contribution of one dollar. Starting in 2018, member contributions changed from a certain percent of income to one of five set amounts. The change to the set amount reduces the changes in contribution amounts that a member might experience during the benefit year if they have slight changes in income. Contribution amounts established for the current program are displayed in Table 6.

[10] 2016 Lewin Survey of HIP members
[11] 2018 FSSA Member Data

Table 6: HIP Member Contributions 2018 to 2020

FPL	2019 Monthly Income: Individual Estimates	2019 monthly Income: Family of Four Estimates	Monthly Power Account Contributions: Single Individual	Monthly Power Account Contributions: Spouses
<22%	<$229	<$472	$1[illegible]00	$1[illegible]00
23-50%	$229-$520	$472-$1,073	$5.00	$2.50
50-75%	$521-$780	$1[illegible]074-$1,609	$10.00	$5.00
75%-100%	$781-$1[illegible]041	$1,610-$2,146	$1[illegible]5.00	$7.50
100-133%* FPL	$1[illegible]042-$1,453	$2,147-$2,996	$20.00	$10.00

**With 5% of income disregard*

Since 2008, initial enrollment in the program has been contingent on making a payment. In the 2015 approval, this requirement continued with HIP Plus enrollment requiring an individual to make an initial contribution, and then an ongoing monthly contribution to maintain enrollment. Individuals have 60 days to make their initial and ongoing monthly payments.

Following application, the start date for coverage is the first of the month in which a member makes their initial contribution to their POWER Account.

Members may make an initial contribution, or fast track pre-payment, towards HIP Plus when they file their application or during application processing. If the member completes the eligibility process and is found eligible, the fast track payment is put towards the required contribution amount. When applicants are found ineligible, the fast track contribution is refunded.

In HIP, the majority of enrollees, across all income levels, have made their required contributions; since the first quarter following the expansion of HIP in 2015, 65 to75 percent of members have enrolled in HIP Plus in any given month, meaning these members are making regular contributions. The first HIP member survey, conducted in 2010, found 75% of members indicating that POWER Account contributions were affordable; this was when contributions were up to 4.5 percent of income.[12] In the most recent HIP member survey, conducted in 2016, 80% of members indicated that they would pay more to stay in the program.[13]

In this renewal, no substantial changes are requested to the member contribution component of the HIP program. To allow flexibility to adjust contributions, Indiana requests that a ceiling based on three percent of household income be established for POWER Account contribution amounts, and that any variation from the current amounts but below this threshold require member and CMS notice, but no formal waiver amendment. This

[12] 2010 Mathematica Survey of HIP members
[13] 2016 Lewin Survey of HIP members

flexibility would allow for adjustments to the contribution tier amounts without requiring an amendment submission and approval process with CMS.

4.2.1 Tobacco Surcharge

The 2018 approval incorporated a tobacco surcharge component where members who report tobacco use and continue to use after a full year of enrollment are assessed a surcharge. The tobacco surcharge increases the member POWER account contribution amount by 50 percent.

In this renewal, no changes are requested to the tobacco surcharge.

4.3 HIP Plus and HIP Basic

Members who make an initial POWER Account contribution enroll into HIP Plus with coverage effective the first day of the month in which their contribution is made. Other than the monthly contribution, the members in HIP Plus have no additional cost sharing responsibility except for a copayment for non-emergency use of the emergency room. The copayment for non-emergency use of the emergency room is within the Medicaid allowable limits and is currently set at $8.00. Members who pay their contribution receive the full Medicaid benefit package if they qualify as a Section 1931 low-income parent and caretaker, or if they are medically frail. They receive the HIP Plus alternative benefit plan, which includes all the essential health benefits and adds vision, dental and chiropractic coverage.

In the initial HIP program established in 2008, individuals that did not make their required contribution were not enrolled. Beginning in 2015, the HIP Basic plan was implemented for individuals with income below the poverty level who do not make their required contribution. Like HIP Plus, HIP Basic is both a benefit package and a cost-sharing schedule. The HIP Basic benefit package is an approved, alternative benefit plan that includes all of the essential health benefits but does not have coverage for vision, dental, or chiropractic services. HIP Basic benefits are available to adults with income under the poverty level who do not complete enrollment into HIP Plus and are not otherwise qualified for the Medicaid State Plan benefits. The HIP Basic cost-sharing schedule includes copays within the Medicaid allowable limits for most services as outlined in Table 7. All HIP-enrolled individuals who do not complete enrollment into HIP Plus and who are not otherwise exempt from cost sharing pay the HIP Basic copayment amounts when accessing care.

Table 7: HIP Plus and HIP Basic Contribution and Copayment Amounts

Category	HIP Plus	HIP Basic
Monthly Contribution	$1-$20	$0
Copayment- Outpatient services - including office visits	$0	$4
Copayment- Inpatient services - including hospital stays	$0	$75
Copayment- Preferred drugs	$0	$4
Copayment- Non-preferred drugs	$0	$8
Copayment- Non-emergency ER visit	$8	$8

Members enroll into HIP Basic when they do not pay for HIP Plus within 60 days and the member income is under the poverty level. At initial application, members' enrollment into HIP Basic is effective the first of the month in which their 60 days to pay for HIP Plus expire. For members enrolled in HIP Plus who stop making monthly payments for 60 days, HIP Basic enrollment starts the month following the end of the 60-day payment period following notification to the member of the change from HIP Plus to HIP Basic.

Regardless of income level, all members enrolled in other Medicaid categories who transfer to HIP, including those moving from presumptive eligibility, enroll directly into HIP Basic. This ensures that members who currently have Medicaid coverage do not experience coverage gaps while waiting to enroll in HIP Plus. For these initial enrollments in HIP Basic, members have a 60-day payment period while in HIP Basic to make a payment and move to HIP Plus. For members who make a payment, HIP Plus coverage begins the first of the month in which the payment is made.

Members who have income over the poverty level are not eligible for ongoing HIP Basic coverage. A member with income over the poverty level may be enrolled in HIP Basic when (1) the member transitions from another Medicaid category as noted in Table 8, or (2) the member had income at or below the poverty level and enrolled in HIP Basic, and income then increased over the poverty level. Members with income over the poverty level enrolled in HIP Basic have a 60-day period to transition to HIP Plus. Following this 60-day period, these members are disenrolled from HIP if they have not made a payment for HIP Plus since HIP Basic is not available as an ongoing coverage option for individuals with income over the poverty level.

On an annual basis, all ongoing HIP Basic enrollees receive an opportunity to move to HIP Plus by making their required contribution. This occurs following the individual's annual renewal of HIP coverage. HIP Basic members that receive preventive services and have a balance remaining in their POWER Account receive an additional opportunity to transfer to HIP Plus by a rollover incentive which provides a discount off the member's required HIP Plus contribution. Members enrolled in HIP Plus always have any of their remaining member contributions rollover, and these contributions are matched by the state when the member received preventive care. Since 2015, approximately 40 to 45 percent of HIP members who complete a full benefit period have qualified for a rollover incentive to reduce the ongoing cost of HIP Plus coverage, and in 2018 the average amount rolled over was approximately $50.

In this renewal, no substantial changes are requested to HIP Basic or HIP Plus or the rollover incentive. In the waiver approval, Indiana requests flexibility to vary HIP Basic copayment amounts within the Medicaid limits with proper notification to CMS, members and stakeholders, but without requiring a waiver amendment.

4.4 Non-Payment

Not paying monthly contributions within 60 days results either in enrollment in HIP Basic, disenrollment from HIP Plus, or failure to complete enrollment into HIP Plus. Members who

complete enrollment into HIP Plus and have income over the poverty level are subject to a six-month, non-eligibility/lockout period where they may not reenroll into HIP unless the member experiences a qualifying event.

Table 8: Results of Non-Payment by Member Characteristics

Member Characteristics	Action after 60-days with no payment	Subject to Non-eligibility period?
Approved applicant below the poverty level	Enrolled in HIP Basic.	No
Approved applicant above the poverty level	Not enrolled in HIP. No lockout applied, may reapply.	No
HIP Basic member with income above the poverty level	Disenrolled from HIP. No lockout applied, may reapply.	No
HIP Plus member with income below the poverty level	Enrolled in HIP Basic.	No
HIP Plus member with income above the poverty level	Disenrolled from HIP. Member is locked out of HIP coverage for six-months unless member experiences qualifying event.	Yes
Medically frail HIP member with income above the poverty level	Member remains enrolled but copayments are added for services received.	No

HIP members disenrolled from HIP Plus for non-payment and subject to the six-month coverage lockout may not reenroll in HIP until the six-month period expires, or the member has a qualifying event. Qualifying events include:

- Obtained and subsequently lost private insurance coverage
- Had a loss of income after disqualification due to increased income
- Took up residence in another state and later returned
- Is a victim of domestic violence
- 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 non-payment or at any time in the 60 calendar days prior to date of member termination for non-payment
- Is medically frail

HIP has incorporated a lockout period for non-payment since initial implementation in 2008. The initial lockout period was for 12 months. This period was decreased to six months in 2015. The HIP lockout period is aligned with commercial market coverage policies, where individuals who fail to maintain coverage during the year must wait to re-enroll unless they have a special enrollment event or until the annual open enrollment opportunity.

In 2018, as reported by the Interim Evaluation Report 5,500 members were subject to a HIP lockout for non-payment.[14] Since the initiation of the program, the rates for applying the non-payment lockout as a proportion of individuals that could be subject to the lockout have remained relatively low and stable on an annual basis ranging from a low of three percent to a high of 8.5 percent.

In this renewal request, no changes are requested the non-payment policy.

4.5 Retroactive Coverage

Since initiation in 2008, HIP has included a waiver of retroactive coverage. As discussed in the proceeding sections, following application, HIP benefits do not become effective until the first of the month in which payment is made, or the 60-day payment period expires. This requirement to make a payment to initiate coverage, or to wait for 60-days for coverage to start is aligned with commercial market enrollment policies. In HIP, pregnant women that are within the HIP income eligibility receive coverage that is retroactive up to three months from the date of application. All other populations covered by HIP are not eligible for coverage prior to the month of application, and have a coverage start date in accordance with the payment date or the expiration of the 60-day payment period.

In this renewal request, no changes are requested to the retroactive coverage policy.

4.6 Gateway to Work

Gateway to Work began in 2015 to promote the connection between employment and health by integrating the State's various work-training and job-search programs with HIP. Through this initiative, all eligible HIP members who were unemployed or working less than 20 hours per week were referred to available employment, job search and training programs to assist in securing gainful employment. This voluntary referral program had few members take advantage of the job search and training opportunity; only 580 Gateway to Work orientations were attended during the first 15 months of the voluntary program.

One of the goals of the HIP demonstration as approved in 2015 was to provide HIP members with opportunities to seek job training and stable employment to reduce dependence on public assistance. To meet this goal, the Gateway to Work program was modified from a voluntary to a mandatory initiative in the 2018 approval.

Beginning in 2019, members that are not exempt and not currently working at least 20 hours per week must complete qualified activities for eight out of 12 months of the calendar year to

[14] HIP Interim Evaluation, Draft for Public Comment. November 6th, 2019. Exhibit F.4.4a, pg. 150.

maintain their benefits. The required hours phase in from zero to 20 hours over the course of 18-months, following the below schedule.

Table 9: Gateway to Work Phase In Schedule

Date Range	Required Hours
January 1, 2019 – June 30, 2019	0 hours per month (0 hours per week)
July 1, 2019 – September 30, 2019	20 hours per month (5 hours per week)
October 1, 2019 – December 31, 2019	40 hours per month (10 hours per week)
January 1, 2020 – June 30, 2020	60 hours per month (15 hours per week)
July 1, 2020 – Ongoing	80 hours per month (20 hours per week)

Compliance with the Gateway to Work requirement is designed to be checked at the end of the calendar year. To be compliant, members must have eight out of 12 months of the year where they are exempt from the requirement or have completed qualifying activities. Months in which members are not enrolled in HIP count compliant months. Effective October 2019, eligibility suspension for failure to complete the requirement was temporarily removed pending the resolution of a lawsuit challenging the approval of the Gateway to Work program.

4.6.1 Exemptions

All HIP members may participate in Gateway to Work, but members that have an exemption do not have any requirement to participate.[15] Members meeting the following criteria are considered exempt from the Gateway to Work requirement:

- Pregnant
- Primary Caregiver of Children under 13
- Medically Frail
- Full- or Part-Time Student
- Homeless
- Recently Incarcerated or Institutionalized
- Temporary Certified Illness or Incapacity
- Participating in Substance Use Disorder (SUD) treatment
- Kinship Caregivers of Abused or Neglected Children
- Primary Caregiver of Disabled Dependent
- SNAP and TANF Recipients
- Age 60 or older
- Exemptions for Good Cause
- Member of Federally Recognized Tribe

Member exemptions are applied prospectively where the exemption is already known to the State; for example, SNAP and TANF recipients. For exemptions that are not applied prospectively, members may report any exemptions for past, current and future months.

[15] In the HIP Workforce Bridge Amendment submitted in July 2019, the dependent age for caretakers was increased from under 7 to under 13 and the exemption for federally recognized tribes was added.

Member requested exemptions are reported to MCEs and documented in the Gateway to Work tracking system.

4.6.2 Qualified Activities

Members that have a requirement for Gateway to Work may meet the requirement by completing any of the following qualified activities:

- Employment and self-employment
- Homeschooling
- Job search activities
- Education related to employment
- College education
- English as a second language
- General education
- High school equivalency
- Job skills training and vocational education
- Caregiving services
- Community and public service
- Volunteer work
- Other miscellaneous non-prohibited activities

Activities that do not count for Gateway to Work include:

- Illegal activities
- Medical treatment, such as doctor's appointments, medical tests or treatment
- Taking care of own pets
- Behavioral health counseling or case management, such as therapy appointments or time billed by an entity providing case management services
- Support groups (anger management, behavior awareness, PTSD, cancer support group)
- Activities directly related to the health improvement of the member rather than their community engagement
    - Examples: swimming classes, participating in a 5k, exercise classes and smoking cessation classes

Members that have verified employment of at least 20 hours per week, for the purposes of HIP eligibility, are considered to meet the Gateway to Work requirement; these enrollees are not required to report community engagement hours. For members required to report activities, multiple modes of reporting are available, including online or by phone via the MCEs. All online tools and resources are designed to be mobile device compatible. Members may report activities for the current month or any past month during the calendar year. Member activity reports are accepted based on member self-attestation. Both MCEs and OMPP review a sample of the reported activities to verify that the member attestation is reasonable and compatible with known information about the member using a reasonable compatibility methodology.

4.6.3 Member Supports

Gateway to Work is designed to ensure member success. All members receive notification of their requirements for completing Gateway to Work. Specifically, on a monthly basis, along with the POWER Account statement, members receive an update of their status towards meeting their requirements. Gateway to Work status is also documented in FSSA's online benefits portal. Additionally, multiple options are available for members that need help understanding the requirement, identifying if they are exempt, or finding activities.

For example, members may complete an initial online assessment. This assessment will inform members if they may be exempt or are already completing activities that meet the requirement. Referrals to Gateway to Work partner resources are also provided through this process. Members who cannot complete the assessment online may call their MCE and complete the same assessment telephonically with an MCE representative.

Additionally, members who need support beyond referrals and general information have the option of completing a more in-depth assessment with their MCE. This process builds off the information provided in the initial assessment to help support identification of a more concrete plan to meet the Gateway to Work requirements. Further, members that need additional help beyond completing assessments, may receive ongoing Gateway to Work assistance through their MCE. This ongoing assistance will support members in development and monitoring of a plan to achieve Gateway to Work compliance.

In addition to MCE supports, organizations across the state have stepped up as Gateway to Work partners. Gateway to Work partners may provide many levels of support including: computer terminals where members can log their information, access state-funded job training and adult education classes, comprehensive education and support in meeting the requirements, or volunteer opportunities where members can complete activities.

4.6.4 Eligibility Suspensions

Effective October 2019, eligibility suspensions for Gateway to Work are not active pending resolution of a federal lawsuit. As designed, members that have a requirement to report but are non-compliant will have their benefits suspended if they do not meet the Gateway to Work requirement eight out of 12 months of the calendar year. Members that are not on track to meet the annual requirement by October of the calendar year will have the opportunity to go back and report earned hours for previous months and/or complete pre-suspension courses that will help count towards member compliance with the requirement. Members are evaluated for suspension in December and all existing information, including member reported hours and exemptions during the calendar year, will be considered. Members that are not exempt and do not meet the requirement to complete Gateway to Work activities for eight out of 12-months of the calendar year, inclusive of participation in pre-suspension courses, will be suspended from HIP benefits effective January 1st of the subsequent calendar year. All suspended members can have their benefits restored quickly without having to reapply. After January 1st, all suspended members will work directly with the Gateway to Work Unit to resolve their suspension. Suspension resolution can occur by the member reporting hours and meeting the current month's hours requirements, gaining an

exemption, gaining full or part-time work, or enrolling in full or part-time post-secondary training.

4.6.5 Current Gateway to Work Operations

The Gateway to Work requirement began in January 2019. Members were not required to report activities until July 2019. In July 2019, out of approximately 380,000 fully enrolled HIP members 73 percent of members were exempt, 8 percent who are not exempt meet the requirement with current reporting of employment, and the remaining 19 percent were required to report either hours or an exemption.[16] Since initial implementation, members have been reporting exemptions and hours by calling their MCEs and by accessing the online reporting tool. More detailed description of the first six months of Gateway to Work is included in the Interim Program Evaluation available concurrent with this renewal request.

Effective October 2019, the enrollment suspension for not meeting the requirement was temporarily removed pending the resolution of a lawsuit. In this renewal no changes are requested to the existing Gateway to Work approval.

4.7 HIP Workforce Bridge Account

The State requests the HIP Workforce Bridge Account be authorized as a component of the renewal, consistent with the waiver amendment submitted in July 2019.[17]

The HIP Workforce Bridge Account will provide $1,000 to pay for health care expenses that occur during a transition to commercial coverage. This will include payment for premiums, deductible costs, copayments, and co-insurance incurred through enrollment on the commercial plan. HIP members who lose eligibility for HIP due to increased income will be qualified for the Account. This Account will help to bridge the gap between the costs of HIP and costs of commercial insurance.

The HIP Workforce Bridge Account is targeted for implementation in Spring of 2020, the final year of the current HIP demonstration. It is estimated that approximately 27,000 HIP members may qualify for the account on an annual basis.

4.8 Managed Care Entity Selection Periods

In HIP, a member's MCE is the main point of contact for coverage. Beyond coordinating access and payment for health care services, HIP MCEs monitor the member deductible and POWER Account, provide member incentives, and, starting in 2019, support members with Gateway to Work. Similar to selection of coverage during commercial market enrollment periods, HIP members have an opportunity to select their plan prior to making their initial POWER Account contribution payment. Following enrollment into an MCE, members receive an opportunity to change plans once per year, during the annual open enrollment period. The open enrollment period occurs each fall, with the selection of the new MCE

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[16] FSSA Data provided August 15th, 2019 via e-mail. Gateway to Work allows for retroactive reporting of exemptions, so exemption percentage for July 2019 may increase throughout the year.

[17] The HIP Workforce Bridge Account Amendment is available at: https://www.in.gov/fssa/hip/files/BridgeAmendmentRequest2019_SubmissionFINAL.PDF

taking effect on January 1 of the following calendar year. Members continue to have the opportunity to change plans for cause, in accordance with 42 CFR §438.56.

In this waiver request no changes are requested to the current process for selecting, maintaining and changing enrollment in MCEs.

4.9 HIP Maternity Coverage

Beginning in 2018, all HIP members who become pregnant and any new applicants who are pregnant and are within the HIP income level are enrolled in HIP Maternity coverage. HIP Maternity coverage provides the HIP State Plan benefit package and has no cost sharing. Pregnant women remain eligible for retroactive coverage when enrolled in HIP. All pregnancy services are considered to be covered outside of the member POWER Account, and pregnant women that complete preventive care, including prenatal visits, can qualify for rollover and reduce their costs of future enrollment in HIP Plus. In addition to the ability to earn rollover incentives while pregnant, continued enrollment in HIP during pregnancy eliminates the coverage transition between HIP and Hoosier Healthwise at pregnancy onset and the end of the 60-day post-partum period. This provides greater coverage continuity for members.

No changes are requested to the HIP Maternity policy applicable to pregnant women with income under the HIP income limit.

4.10 Non-emergency Transportation

The HIP Basic and HIP Plus alternative benefit plans are based on commercial market benefits and do not include coverage for non-emergency transportation. A waiver of non-emergency transportation has been a component of HIP since initial implementation in 2008. Pregnant members, medically frail members, and members who qualify as Section 1931 low-income parents and caretakers qualify for the full Medicaid benefit package and receive non-emergency transportation.

In this waiver renewal, no changes are requested to the non-emergency transportation policy.

4.11 Eligibility Renewal Requirements

Similar to commercial market coverage, HIP incorporates requirements that encourage members to maintain coverage. These requirements include the HIP POWER Account contribution policy, as well as the policy around HIP renewals. In the 2008 implementation, HIP excluded individuals who did not renew their HIP coverage from reenrolling in coverage for a set period of time. This policy to require renewal of HIP coverage and to exclude individuals who do not renew coverage for a period of up to six months was reauthorized in the 2018 approval and also exists in Indiana Code at 12-15-44.5-4.9(b). Individuals who fail to complete their HIP coverage renewal on time have a grace period of three months where they can complete the renewal without a penalty. Following the grace period, there is a three-month period where members are excluded from HIP enrollment. Members who do not successfully complete a renewal during enrollment, or in the grace period, are eligible to reenroll after six months from the expiration of their HIP coverage. Members who are

medically frail, pregnant, or Section 1931 low-income parents and caretakers are exempt from the exclusion period for failure to renew coverage.

While authorized in the current approval, this policy is not currently in effect. Continued authorization to implement this policy is requested.

4.12 Presumptive Eligibility

The HIP waiver currently includes the authorization for additional provider types, including Federally Qualified Health Centers, Rural Health Centers, Community Mental Health Centers and Health Department sites, to complete presumptive eligibility (PE) for HIP members. Through 2017, HIP has received over 340,000 PE applications, and has enrolled over 265,000 individuals in coverage through PE since 2015.[18] No changes to this waiver component are requested.

4.13 Medically Frail with Income Above the Poverty Level

Members in HIP who are medically frail but who have income over the poverty level are not subject to disenrollment from HIP if they fail to make their POWER Account contribution within 60 days. Medically frail members with income over the poverty level continue to owe POWER Account contributions, but also become subject to copayments when they fail to pay the required monthly POWER Account contribution. As with all HIP members, total cost sharing is limited to five percent of quarterly income. Medically frail members subject to copayments and contributions have an annual opportunity at eligibility renewal to eliminate their copayments by making a required contribution.

In this waiver renewal request, no changes are requested for the medically frail with income over the poverty level.

4.14 Transitional Medical Assistance

In the 2018 approval, Transitional Medical Assistance (TMA) was authorized as continued coverage for Section 1931 low-income parents and caretakers who had income increase over the HIP eligibility threshold. Individuals who have income that increases over the Section 1931 low-income parent and caretaker limit, but remain under the HIP income level, maintain their HIP enrollment but are not designated as TMA, as HIP provides continued comprehensive coverage. Low-income parent and caretakers who earn income over the HIP limit and designated as TMA. For these individuals, coverage is provided for six months for all income levels, regardless of the individual's payment of the HIP Plus monthly contribution. Individuals designated as TMA receive the full Medicaid benefit package with HIP Plus cost sharing. For the first six months of enrollment, TMA individuals are not disenrolled for failure to pay for HIP Plus in alignment with TMA rules. Following the initial six-month TMA period, TMA members are eligible for an additional six months of enrollment where income is below 185 percent of the federal poverty level, and the TMA member maintains HIP Plus enrollment through making the required contribution amount.

[18] HIP Annual Reports, 2015 – 2017

TMA members who do not make their POWER account payments in the second six months of enrollment will be disenrolled for non-payment.

In this waiver renewal request, no changes are requested to the TMA policy.

4.13 Substance Use Disorder

The 2018 approval included a waiver to implement enhanced benefits for substance use disorders. The request to renew the SUD waiver and the components added via the approved SMI amendment is included as part of this renewal request and detailed further in the document.

Section 5: Summary of Requested HIP Program Changes

No substantive changes are requested, with the exception of the request to incorporate the HIP Workforce Bridge Amendment requested in 2019 into the approved waiver renewal. A summary of requested non-substantive changes to the approved waiver include:

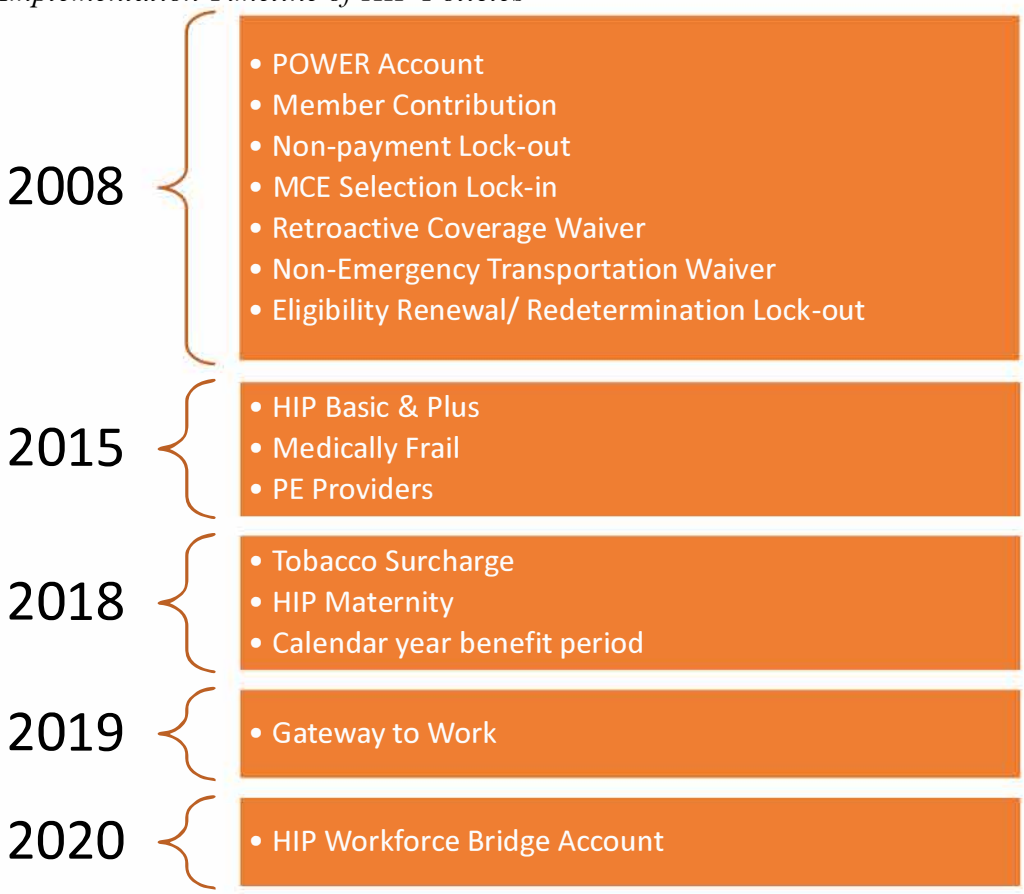
- The State requests the flexibility to modify the POWER Account contribution tiers below average limit of three percent of member income, with appropriate notice to members, stakeholders and CMS, but without requiring the submission of a waiver amendment. Modifications could include increasing or decreasing the amounts of the base contribution or the tobacco surcharge or introducing POWER Account contribution waivers such as a waiver of the contribution requirement for individuals that are also enrolled in employer sponsored coverage.
- The State requests the flexibility to modify the HIP Basic copayment amounts within the Medicaid allowable limits, with appropriate notice to members, stakeholders and CMS, but without requiring the submission of a waiver amendment. These modifications may include increases in copayment amounts within limits allowed for cost of living increases, decreases in copayment amounts, or implementation of copayment waivers on target services.

While not a change to the content approval, the substantive request of this renewal is to allow the program to be reauthorized in entirety for a period of 10 years.

5.1 10-year Approval Request

HIP is established as the Indiana program that provides coverage to low-income, non-disabled adult Hoosiers. The foundation of the HIP program, providing consumer directed coverage options that leverage commercial market policies for a Medicaid program, have been operational since 2008. When initially approved and subsequently authorized as the vehicle to cover the Medicaid expansion population in 2015, HIP pioneered innovations in Medicaid including POWER Accounts, member contributions, benefit-plan and cost-sharing variations, and commercial market policies around required monthly payment and eligibility renewals. Today, these policy innovations have been approved and implemented in Medicaid demonstration programs across the country.

Figure 2: Implementation Timeline of HIP Policies



The CMCS Informational Bulletin from November 6, 2017 covering 1115 Demonstration process improvements acknowledges that the 1115 demonstration approval process can be cumbersome and time consuming. The opportunity to renew routine and successful demonstrations for a period of up to 10 years is proposed as a solution to increase efficiency and reduce the burden associated with operating demonstrations.

From its long-term experience with HIP, Indiana knows that short approval periods requiring waiver renewal every three years do not serve to further the goals of the Medicaid program, or meaningfully enhance transparency, stakeholder input, or the federal oversight process.

As part of standard program operations, there are monthly, quarterly, and annual program reports as well as extensive program evaluation reporting completed for the 1115 demonstration. In addition, a public forum discussing the demonstration with stakeholders is held annually, and input is documented in program reporting. Further, the waiver STCs require amendments and public comment for any substantial changes to the waiver, and allow for CMS to withdraw approval for the entire demonstration or for any component of the demonstration at any time, negating the need for short approval periods. All of these activities are opportunities for meaningful transparency and stakeholder input.

Three-year renewal cycles create administrative complexity. A program may only be in effect for 12–18 months before drafting of the renewal must begin. Because renewal applications are due up to one year before the waiver authority expiration, a state must begin waiver drafting and public notice at least 18–24 months before the end of the three year-approval period. Where data on program elements is required as a component of the renewal submission, the short approval period prohibits the ability to provide meaningful data on progress and results of demonstration policies.

Indiana is committed to transparency around the demonstration, continual improvement, and support of scientifically rigorous methods to evaluate the demonstrations impacts. Renewing the long-term, core components of HIP for a 10-year period through 2030 relieves the State and CMS from the administrative requirements associated with supporting the renewal cycle, and allows for these resources to instead focus on understanding the impacts of the demonstration, and continually improve demonstration operations and monitoring. This longer approval period will also give HIP members confidence that HIP coverage is here to stay; and it will allow the State to reallocate resources from supporting the ongoing renewal process to focusing on making HIP the best program possible, and continuing to develop cutting-edge program innovations.

Section 6: HIP Program Evaluation

The Lewin Group was selected via Indiana's procurement process to complete the interim and summative independent evaluation reports for the current demonstration period (2018 to 2020). The Lewin Group and FSSA have coordinated with CMS in development of a comprehensive evaluation plan for this demonstration period. The current draft of this evaluation plan is available for review with this renewal request and incorporates the 2019 CMS 1115 evaluation guidance. The interim evaluation report is posted and submitted with this renewal request. The summative evaluation will be available by July 2022, in alignment with federal requirements in the current STCs.

For this renewal request, the State proposes that, in addition to comprehensive quarterly and annual monitoring, three separate evaluation reports be submitted covering the 10-year approval period.

- First, an initial report on the first three years of the demonstration expected to be complete in 2025
- Second, an interim report on the first eight years of the demonstration, expected to be complete in 2029 and
- Third, a final report covering the full 10-year demonstration period submitted 18-months following the expiration of the waiver in 2032. For the 10-year approval period, the state proposes to continue the currently approved evaluation design, with modifications as necessary to ensure alignment of program operations and the current program objectives detailed in Section 2.2.

Section 7: HIP Quality Reporting

Indiana has a robust quality oversight plan for continually monitoring the performance of the MCEs serving the HIP population: Anthem, CareSource, MDwise, and MHS. The Office of Medicaid Policy and Planning's (OMPP) Quality and Outcomes section is responsible for oversight of the MCEs, including managing compliance with contract requirements, monitoring program data, and reviewing required reporting documents from each MCE.

The State conducts numerous monitoring activities to assure quality and consistent delivery of healthcare services to Medicaid and HIP members. Specifically, the monitoring activities include quality management and improvement program work plans (QMIPs); data analysis; enrollee hotlines operated by the State's enrollment broker; geographic mapping for provider networks; external quality review (EQR); network adequacy assurance submissions; monthly on-site monitoring reviews; recognized performance measure reports; and surveys.

7.1 Managed Care and State Quality Assurance Monitoring

Each year, OMPP prospectively identifies priorities for improving the delivery of healthcare to Medicaid and HIP members and improving operations. These priorities are included in the State's Quality Strategy Plan (QSP). The State's QSP includes an overall framework for continuous quality improvement that utilizes several quality committees related to key agency priorities. Representation on these committees includes state agencies, including the Indiana State Department of Health, MCE staff, and other health industry experts. The 2017 and 2018 QSPs[19] contained the HIP-specific objectives and goals for quality improvement in the tables below.

Table 10: 2017 QSP HIP-Specific Goals and Objectives

	Objective	Goal
1.	HIP members shall have access to primary care within a maximum of 30 miles of the member's residence and at least two providers of each specialty type within 60 miles of member's residence.	90% of all HIP members shall have access to primary care within a minimum of 30 miles of member's residence and at least two providers of each specialty type within 60 miles of member's residence
2.	HIP members shall have access to dental and vision care within a maximum of 60 miles of the member's residence and at least two providers of each specialty type within 60 miles of the member's residence.	90% of all HIP members shall have access to dental and vision care within a minimum of 60 miles of member's residence and at least two providers of each specialty type within 60 miles of the member's residence.
3.	HIP members who obtain a preventive exam during the measurement year receive power account roll-over.	Achieve at or above 85% of the number of members who receive a preventive exam during the year.

[19] The 2019 QSP has been posted for public comment and is in the process of being finalized. Please see https://www.in.gov/fssa/files/2019%20QSP%20Plan%20-%20public%20comment%20draft%20.pdf

4.	ER admissions per 1000-member months	Achieve at or below 75 visits per 1000-member months.
5.	Percentage of members who received follow-up within 7 days of discharge from hospitalization for mental health disorders	Achieve at or above the 90th percentile for members who receive follow-up within 7 days of discharge from hospitalization for mental health disorders.
6.	Number of outpatient and emergency department visits per member months	Achieve at or above the 90% percentile of outpatient visits (HEDIS) Achieve at or below the 10th percentile of emergency department visits (HEDIS)
7.	Increase the referral of pregnant women who smoke to the Indiana Tobacco Quitline for smoking cessation services.	Achieve an increase in the percentage who are referred to and have one contact with the Indiana Tobacco Quitline.
8.	Right Choices Program (RCP)	A minimum of 90% of the findings of appeals filed by members to be removed from RCP will be upheld because the member was correctly assessed as requiring RCP services.
9.	Provide quality health care to members identified as medically frail.	Identify individuals who meet the medically frail criteria and offer access to enhanced services.

Table 11: 2018 QSP HIP-Specific Goals and Objectives

	Objective	**Goal**
1.	HIP members shall have access to primary care within a maximum of 30 miles of the member's residence and at least two providers of each specialty type within 60 miles of member's residence.	90% of all HIP members shall have access to primary care within a minimum of 30 miles of member's residence and at least two providers of each specialty type within 60 miles of member's residence.
2.	HIP members shall have access to dental care within a maximum of 30 miles of the member's residence and vision care within a maximum of 60 miles of the member's residence.	90% of all HIP members shall have access to dental care within a maximum of 30 miles of the member's residence and vision care within a maximum of 60 miles of member's residence.
3.	HIP members who obtain a preventive exam during the measurement year receive power account roll-over.	Achieve at or above 85% of the number of members who receive a preventive exam during the year.
4.	ER Admissions per 1000-member months	Achieve at or below 75 visits per 1000-member months.
5.	Percentage of members who received follow-up within 7 days of discharge from hospitalization for mental health disorders	Achieve at or above the 90th percentile for members who receive follow-up within 7 days of discharge from hospitalization for mental health disorders.

6.	Percentage of members who had a preventive care visit	Achieve at or above the 90th percentile for the percentage of members who had a preventive care visit.
7.	Frequency of prenatal and post-partum care	Achieve at or above the 90th percentile for the frequency of prenatal care and at or above the 90th percentile for the frequency of post-partum care.
8.	Increase the referral of pregnant women who smoke to the Indiana Tobacco Quitline for smoking cessation services.	Achieve an increase in the percentage who are referred to and have one contact with the Indiana Tobacco Quitline.
9.	Right Choices Program	A minimum of 90% of the findings of appeals filed by members to be removed from RCP will be upheld because the member was correctly assessed as requiring RCP services.

The QSP framework also includes MCE-led quality improvement projects (QIPs) that promote innovation and health outcomes improvement. These QIPs are submitted to OMPP and reviewed for performance.

Additionally, each of the contracted health plans are required to develop and maintain a QMIP that incorporates and addresses data from the plans' Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys and quality metrics obtained from the Healthcare Effectiveness Data and Information Set (HEDIS) collected by the National Committee for Quality Assurance (NCQA). The QMIPs also must address any opportunities for improvement identified in the EQR, which is further discussed below.

The MCEs serving the HIP population are required to submit reports to OMPP on a monthly and quarterly basis, which are reviewed by staff for compliance with contractual requirements. Additionally, OMPP also conducts a monthly on-site meeting at each of the MCEs' offices to discuss focus areas, observe process demonstrations, and address concerns from the monthly and quarterly reports. The contracted plans report on various operational and programmatic factors, including member access to primary medical providers, dentists, behavioral health providers, and specialists. The reports for 2017 indicated the following HIP access statistics for Indiana's 92 counties:

- Primary medical providers: HIP members statewide largely resided in counties in which the average mileage from a member's home address to an available primary medical provider is fewer than 30 miles. The MCEs ranged from a low of 25 counties where the distance from a member to an available provider was more than 30 miles to a high of 37 counties.[20]
- Dentists: HIP members statewide largely resided in counties in which the average mileage from a member's home address to an available dentist is fewer than 30 miles.

[20] https://www.in.gov/fssa/files/Website_Report_4A_Primary_Care%5b1%5d.pdf

The MCEs ranged from a low of seven counties where the distance from a member to an available provider was more than 30 miles to a high of 16 counties.[21]

- Behavioral health providers: HIP members statewide largely resided in counties in which the average mileage from a member's home address to an available behavioral health provider is fewer than 45 miles. The MCEs ranged from a low of six counties where the distance from a member to an available provider was more than 45 miles to a high of 10 counties.[22]
- Specialists: HIP members statewide largely resided in counties in which two providers in each identified specialist category were within 60 miles of the member's home address. Category-specific details are available on OMPP's website at https://www.in.gov/fssa/files/Website_Report_4E_Specialists_HIP%5b1%5d.pdf.

In addition to monitoring of member access to healthcare services, the State strives to ensure that the care provided to HIP members is of the highest quality. CAHPS surveys of members in 2017 and 2018 indicate that across all MCEs[23], an average of 79.7 percent of members were satisfied with their personal doctor in 2017 and 80.4 percent of members were satisfied with their personal doctor in 2018, as indicated by a ranking of 8-10 on a 1-10 scale.[24] Additionally, 75.7 percent and 77.4 percent of members were satisfied with their personal healthcare in 2017 and 2018, respectively.[25]

7.2 External Quality Review

The State utilizes Burns & Associates, Inc. to conduct an annual EQR of each of the MCEs. The EQR includes all of Indiana's Medicaid managed care programs, including HIP, Hoosier Healthwise, and Hoosier Care Connect. In addition to validating general performance measures and the performance improvement projects, the 2017 EQR for the 2016 calendar year (CY) focused on validation of performance measures, validation of performance improvement projects, and focus studies on lead testing and related outreach efforts, medication adherence, potentially preventable readmissions, and claims processing. Of note specific to HIP, the EQR includes an evaluation of the rate of potentially preventable readmissions (PPRs). This evaluation found that the PPR rate for HIP dropped from 8.8 percent in CY 2014 to 6.7 percent in CY 2016.[26] EQR reports can be reviewed online at: https://www.in.gov/fssa/ompp/5533.htm

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[21] https://www.in.gov/fssa/files/Website_Report_4B_Dentist%5b1%5d.pdf
[22] https://www.in.gov/fssa/files/Website_Report_4C_Behavioral_Health%5b1%5d.pdf
[23] Anthem, MDwise, and MHS for CY2017; Anthem, CareSource, MDwise, and MHS for CY2018.
[24] https://www.in.gov/fssa/files/Website_Report_6D_HIP_CAHPS%5b1%5d.pdf
[25] *Id.*
[26] https://www.in.gov/fssa/files/FINAL%20REPORT%20External%20Quality%20Review%20of%20Indiana%27s%20Health%20Coverage%20Programs_Review%20Year%202016.pdf

Section 8: Requested Waivers

The State requests a renewal of all currently approved waivers with minor, non-substantive changes. The state also requests incorporation of the waivers granted for the HIP Workforce Bridge Amendment in the renewal. The waivers requested for the renewal period include the below.

1. Health Plan Enrollment

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 organizations (MCO) 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, except as described in the terms and conditions.

b. 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(g) that automatic MCO reenrollment occur only if the beneficiary's disenrollment was due to a Medicaid eligibility lapse of two months or less, as described in the terms and conditions.

2. Premiums Section 1902(a)(14) insofar as it incorporates Section 1916 and 1916A

To enable the state to charge monthly contributions for HIP Plus at a minimum amount of one-dollar per month and not to exceed a maximum amount of three-percent of member income.

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

To enable 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 individuals with incomes at or below 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 are found eligible through presumptive eligibility.

4. Provision of Medical Assistance Section 1902(a)(8) and 1902(a)(10)

To the extent necessary to enable Indiana to suspend eligibility for, and not make medical assistance available to, beneficiaries who fail to comply with community engagement requirements, unless the beneficiary is exempted.

5. Eligibility Section 1902(a)(10) and 1902(a)(52)

To the extent necessary to enable Indiana to prohibit reenrollment, and deny eligibility, for up to six months, for individuals with income over 100 percent of the FPL who are disenrolled for failure to make POWER Account premium contributions within 60 days of the date of invoice, subject to the exceptions and qualifying events.

To the extent necessary to enable Indiana to prohibit reenrollment, and deny eligibility, for up to three months following the end of the 90-day reconsideration period for individuals who are

disenrolled for failure to provide the necessary information for the state to complete an annual redetermination, subject to the exceptions and qualifying events.

To the extent necessary to enable Indiana to make a determination of ineligibility, and terminate eligibility for, beneficiaries who are in a suspension of coverage for failure to meet the approved community engagement requirements on their redetermination date, unless the beneficiary meets the requirement or is exempted as described in the STCs during the month of redetermination.

6. 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 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.

7. Comparability and Amount, Duration and Scope of Services Sections 1902(a)(17) and 1902(a)(10)(B)
To the extent necessary to enable the state to vary cost sharing requirements for beneficiaries for 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 copayment (for non-emergency use of the emergency department) and individuals who are in HIP Basic will be subject to copayments within Medicaid permissible levels.

To the extent necessary to enable Indiana to vary contribution requirements, for different HIP Plus program beneficiaries based on income and on tobacco use, and in a manner consistent with all otherwise applicable law. To allow for variations or waivers of POWER Account contribution requirements, within established limits, based on target initiatives such as encouraging uptake of employer insurance.

To allow the HIP Workforce Bridge Account to be available solely to defined eligible individuals that are disenrolled from HIP due to an increase in income.

To allow the state to provide only a limited defined benefit via the HIP Bridge Account, that is limited to cost-sharing assistance up to an amount of $1,000, regardless of health care costs incurred by the member. To allow any balance payable in excess of $1,000, to be assigned to member responsibility without regard to cost-sharing limitations.

8. Retroactivity Section 1902(a)(34)
To enable the state not to provide three months of retroactive eligibility for beneficiaries receiving coverage through the HIP program as described in the STCs, except for pregnant women.

Section 9: Demonstration Financing and Budget Neutrality

The HIP component of the demonstration does not include Budget Neutrality Component and all financing allocations are assumed to exist both with and without the waiver, no changes requested in this submission are expected to have an impact on waiver financing. Budget Neutrality is incorporated in the SUD/SMI component of this waiver renewal and is included as a component of this submission.

Section 10: Public Notice and Comment

Public notice of the HIP and SUD Renewal request was provided November 6th, 2019 and can be accessed at https://www.in.gov/fssa/hip/. Two public hearings were held:

1) Tuesday November 19th at 2:00 pm at the Indiana State Library, History Reference Room 211, 315 W. Ohio St., Indianapolis, IN 46202. This hearing was a special session of the Medical Advisory Commission.
2) Wednesday November 20th at 10 am at Indiana Government Center South, Conference Room 18, 302 W Washington St, Indianapolis, IN 46204. This hearing was accessible via web conference at https://Indiana.AdobeConnect.com/indiana.

Oral testimony was recorded via court reporter during these hearings. Written comments were received via mail at 402 West Washington Street, Room W374, Indianapolis, Indiana 46204, and via electronic mail at hip@fssa.in.gov through December 6th, 2019.

Copies of the public notice documents are provided in Attachment A. In addition to the formal public notice, FSSA also sent an e-mail to a stakeholder communication list that includes over 1,600 e-mail addresses providing information on the start of the comment period, the hearing dates, and the location of the posted documents.

In total, a combined 32 oral and written comments and a report were received. All 32 comments and the report received addressed elements of HIP, while six of these comments also addressed the SUD/SMI renewal request and are summarized separately in the SUD/SMI document. Comment sources included provider associations, community organizations, advocacy groups, health plans, a university, and HIP members. Organizations that commented both orally during the hearing, and submitted written comment were considered as one comment.

Section 10.1 Summary of Public Comments

Comments received for HIP included comments with overarching support or opposition, and comments specific to member required contributions, POWER Accounts, co-payments, Gateway to Work, retroactive coverage waiver, non-emergency transportation waiver, the process to enroll in and renew HIP coverage, and the 10-year extension request.

Many of the comments received were overall supportive of Medicaid Expansion, but not supportive of the elements of HIP that can result in coverage restrictions for HIP members. Comments supported HIPs promotion of preventive care and the programs ability to be more than just health insurance with linking of individuals to other needed services. Some comments called for the elimination of HIP and the implementation of a traditional Medicaid

expansion. Other commenters were in full support of HIP, and all requested elements of this HIP extension request.

Commenters frequently cited the independent interim evaluation report posted concurrently with the renewal for public comment. Continued rigorous evaluation, reporting and data sharing was requested by provider groups and community organizations.

POWER Account Contributions

Eighteen comments received specifically were in opposition to required POWER account contributions requesting that the policy be eliminated or changed. Commenters noted that POWER Account contributions create financial and administrative barriers and prohibit access to care. Medicaid members commented that not receiving accurate communication about their contributions made it hard to know what to pay and when and that making the payment could be a financial challenge. One comment noted that specifically for rural Hoosiers without checking accounts, cell or internet access, that getting to the store to get stamps and mail payments was a barrier. Changes in contribution amounts during the year were noted as problematic and concerns were raised about the impact of POWER Account contributions on increasing member churn. One commenter noted that due to the POWER Account contributions, many individuals may not enroll in HIP, or only enroll in HIP Basic coverage which prohibits care access. Two commenters cited studies showing that adding or increasing premiums for low income individuals results in a decrease in the number of people covered. Commenters cited the draft interim evaluation report noting the racial disparities in disenrollment from HIP Plus as a reason for not supporting POWER Account contributions. Multiple commenters requested that research be conducted into the root cause of this disparity.

Two commenters requested that the required contribution be eliminated for individuals under the poverty level, and one noted that if eliminating the requirement under the poverty level was not a possibility that making the contribution be the same amount for the entire year or eliminating it for individuals only under 50 percent of the poverty level was requested.

Comments from health plans and provider associations were received that supported HIP's incorporation of personal responsibility including required contribution and that it resulted in increased engagement of HIP Plus members.

Tobacco Surcharge

Five comments received included comments on the HIP's tobacco surcharge. Four advocacy groups commented in opposition to the tobacco surcharge, noting that there is no evidence-based support for tobacco surcharges decreasing tobacco use and increasing utilization of cessation services. A provider association commented in support of the tobacco surcharge noting that it promoted efficient use of the health care system and positively impacted public health.

POWER Accounts

Eight comments received specifically commented on POWER Accounts. Six of these commenters including advocacy groups and one Medicaid member noted that the POWER

Account structure created confusion and barriers for patients to access care. The report submitted as a comment noted that POWER Accounts generate statements with health care cost information, but that interviews and focus groups with members did not reveal that the statement was understood by members or used to inform purchasing decisions. An education gap was also noted, in that members did not know about rollover. One comment was received from a provider association noting support for the preventive care incentive present in the accounts.

HIP Basic Copayments

Five comments received noted that HIP Basic copayments were prohibitive to members receiving needed care. One commenter noted the increased price sensitivity of low-income individuals to even nominal copayments. Commenters citied the reduced utilization or primary care and increased utilization of emergency care observed from HIP Basic members in the interim evaluation report. Copayments discouraging visits to primary care and filling prescription medications were noted as areas of concern.

Non-emergency ER use Copayment

Six comments were received that referenced the non-emergency ER copayment. Five advocacy organizations commented in opposition to this policy as it can deter people from seeking needed care in an emergency. One provider organization commented in support of the non-emergency ER copayment.

Gateway to Work

Twenty-four comments were received relating to Gateway to Work. The majority of these comments requested that the program requirement be discontinued in the waiver renewal and expressed concern about potential coverage losses resulting from the program, additional administrative burden on members and the state, member's ability to comply with the reporting requirement if they do not have phone or email, concerns about members understanding the requirement and the exemption process. Related to exemptions, one commenter requested that cystic fibrosis be added as an exemption type. A member commented that the mail received regarding GTW was confusing, sometimes received late, and that the medical exemption process was confusing to navigate. The Interim Evaluation report was cited noting that through June 2019 only 1 percent of individuals had reported activities for Gateway to Work. Commenters also expressed concern about the costs of operating the program.

Comments received in support of the program applauded the focus on social determinants of health, building life skills and promoting completion high-school equivalency and technical certifications. One commenter noted that the education, training, and employment promoted by Gateway to Work will help HIP members to take advantage of the expected need for additional workers Indiana's economy over the next 10-years. One commenter specifically requested that the use of Gateway to Work infrastructure developed to connect individuals to resources and opportunities continue to be maximized even though the requirement is on hold, as HIP members benefit from being connected to resources, education, training and employment.

Retroactive Coverage Waiver

Eight comments were received specific to HIP's waiver of retroactive coverage. These comments noted that the Medicaid application process is lengthy and complicated and that there is substantial burden on individuals in gaining and maintaining Medicaid. Individuals may lose coverage due to administrative reasons that result in coverage gaps without availability retroactive coverage. Individuals may also not apply for coverage until they are sick and without retroactive coverage, they may incur Medical debt. Specific to HIP, the coverage start date of HIP Basic, following sixty days of non-payment for Plus was cited as creating coverage gap issues exacerbated by the retroactive coverage waiver.

HIP Workforce Bridge

Nine comments were received regarding the pending HIP Workforce Bridge initiative which is incorporated as an element of the requested renewal. All comments received were in support of this initiative. One of the comments requested that the amount of the account be increased, and an additional comment requested that limits be established on the types of plans that premiums can be reimbursed for from the account.

Non-Emergency Medical Transportation

Eight comments were received regarding non-emergency transportation (NEMT) and the NEMT waiver applicable to non-medically frail individuals in the adult group in HIP. All comments made the case for the importance of NEMT to the HIP population and opposed the NEMT waiver. Commenters made noted that individuals were more likely to keep medical appointments with access to NEMT, that NEMT was becoming a more common benefit in commercial plans specially Medicare Advantage plan options, and that transportation to medical appointments was specifically challenging for individuals managing multiple chronic conditions. Suggestions were also received for improving the current NEMT system in Indiana.

Enrollment and Renewal Processes

Eight comments were received regarding the processes to enroll in HIP coverage, maintain HIP coverage, and renew HIP coverage. Medicaid members, community organizations and a University provided examples of cases where there were challenges in collecting, submitting, and having documentation processed. Members provided comments relating to confusing and delayed communication. Commenters noted that the start of coverage was delayed by administrative issues with submission of required paperwork, and the delay in coverage resulted in members not being able to go to the doctor. The burden of managing the documentation and verifications required is a challenge for HIP members. One commenter requested that HIP allow a continuous 1-year eligibility period without requiring mid-year verifications related to changes.

10-Year Renewal Request

Ten comments were received opposing the 10-year renewal requests. Three of these comments requested that HIP be discontinued entirely and replaced with a traditional Medicaid expansion. One comment indicated that they did not see the NEMT waiver as routine or noncomplex, and other commenters added that Gateway to Work, POWER Account contribution tiers and the tobacco surcharge changed in the 2018 approval and

information on their efficacy is not yet available to support a 10-year approval. The existing legal challenge of the current HIP approval was noted by one commenter. Six of the comments opposing a 10-year approval supported a 5-year approval of HIP.

Comments from Health Plans and provider associations noted support of the long-term extension of the HIP program.

Section 10.2 Response to Comments & Changes Made as a Result of Public Comment

FSSA appreciates the comments received on the HIP extension request and notes the substantive content and evident thoughtfulness of commenters. The engagement of stakeholders is a defining feature of the HIP program and the comments received during the extension period comment opportunity clearly demonstrate the value of this engagement.

POWER Accounts, Required Contributions, Retroactive Coverage, Non-Emergency Transportation, and Non-emergency ER Copayment

Commenters' concerns related to coverage losses and barriers to accessing coverage presented by HIP policies including required contributions, the retroactive coverage waiver and HIP Plus and Basic enrollment timelines, confusing around the complexity and efficacy of POWER Accounts, and the Non-Emergency ER Copayment are appreciated. In particular, providing examples of specific challenges and barriers presented to members as a result of these policies provide valuable information to support continued program improvement. FSSA is committed to ensuring members understand HIP policies minimizing administrative barriers to compliance. Where commenters noted barriers specifically for rural members in making payments due to not receiving a pre-paid postage envelope to mail their payment, FSSA will move to address this barrier and require pre-paid postage envelopes be provided for submission of payments. This will not require a change to the waiver extension application.

Policies covering POWER Accounts, required contributions, retroactive coverage, non-emergency transportation and non-emergency ER copayments as described in this waiver extension are drafted to align with state law authorizing the HIP program. In Indiana Code, at IC 12-15-44.5 these policies are established. Due to the requirements present in Indiana Code concerning these policies, there are no changes made to this application as a result of public comments received.

HIP Basic Copayments

FSSA appreciates comments noting that members with HIP Basic found the copayments a disincentive to seeking appropriate care, particularly in filling prescriptions and getting primary care. As noted by commenters, negative utilization differences between HIP Basic and HIP Plus members are reported in the independent interim evaluation. Like commenters FSSA is concerned about the utilization difference between HIP Basic and HIP Plus and the potential that HIP Basic copayments are contributing to this difference. The existing request present in this waiver extension application to allow for modification of copayments without submission of a waiver amendment but with appropriate notification would allow for FSSA to adjust or waive HIP Basic copayments to address utilization concerns. As such, no changes are made to this application based on comments received.

Gateway to Work

FSSA acknowledges commenters concerns that Gateway to Work will result in coverage losses, that it increases administrative burden for individuals, and is costly to the state. The purpose of Gateway to Work is to connect individuals to educational, training, work and volunteer opportunities and to resources that support member success. FSSA is committed to minimizing any coverage loss resulting from this program. Comments highlighting the administrative challenges of Gateway to Work and specifically the exemption process and monthly reporting will be taken into consideration in improving the program. As designed, while monthly reporting is encouraged, HIP members have until the end of each calendar year to correct any non-compliant months prior to compliance actions being taken in following year – so members that cannot report monthly or only learn they need an exemption later in the year are not subject to penalties. In addition, related to the request to add cystic fibrosis as an exemption type, FSSA is not adding new exemption types, as the requested exemption type proposed by commenters would be eligible for a medical exemption under current policy.

At this time, no changes related to the design of Gateway to Work are made to the extension request as a result of public comment.

Tobacco Surcharge

FSSA appreciates comments related to the tobacco surcharge. Based on program design, the first year the tobacco surcharge applied was in 2019. At this point there is not enough information to provide evidence of the efficacy or inefficacy of the policy. As such, no changes are made related to the tobacco surcharge.

10-year request

FSSA appreciates comments in support of a long-term renewal of HIP. Some commenters noted that due to the inclusion of policies that started in 2018 and 2019, that a 10-year renewal of those policies seems premature. Most commenters opposed to a 10-year extension supported a 5-year extension of HIP. Due to the long standing and proven core features of HIP and the minimal changes made in the 2018 approval, no changes are made to the request for a 10-year approval of the HIP demonstration at this time.

Support for the HIP Workforce Bridge

FSSA appreciates comments of support related to the HIP Workforce Bridge. One commenter that requested that HIP Workforce Bridge be limited to only reimburse ACA compliant plans, FSSA supports access to comprehensive coverage on leaving HIP, however realizes that all individual situations are different and so is committed to linking individuals who receive accounts with qualified Navigators to support individuals in the best coverage decision. Related to the request to increase the value of the account, current funding allocation for HIP Bridge accounts do allow for an increased account value. No changes are requested to the HIP Workforce Bridge component in this extension request as a result of public comment.

Administrative Issues and Commenter Recommendations

A major theme of the comments received both in writing and via testimony at the hearings, related to administrative challenges with applying for, enrolling in, and maintaining HIP coverage. Commenters requested consideration of continuous eligibility policies. FSSA notes that the application, verification and redetermination processes are not unique to HIP. Minimizing barriers to individuals gaining and maintaining coverage is a key goal and the causes of the administrative issues reported will be investigated to target improvement. This process does not require changes to this extension request.

Commenters also recommended continued reporting and rigorous program evaluation and stakeholder engagement, as well as further investigation of the underlying causes of the racial disparities noted in the interim evaluation report. While no changes are made to this extension request as a result of these comments, FSSA agrees with commenter suggestions and is committed to ongoing reporting and stakeholder engagement and identifying and addressing root causes of barriers to disparities and barriers to coverage.

Section 11: Tribal Notice

Notice of the waiver renewal request was provided to Indiana's federally recognized tribe, the Pokagon Band of Potawatomi Indians, on November 1, 2010. The notice and opportunity for consultation was provided in accordance with 42 CFR 431.408(b).

No tribal comment or request to meet was received during the tribal notice period.

Section 12: HIP Demonstration Administration

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ATTACHMENT A: Public Notices

OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES
ADMINISTRATION
NOTICE OF PUBLIC HEARING

In accordance with 42 CFR §431.408(a)(2)(ii), the Indiana Family and Social Services Administration (FSSA) will be holding public hearings on a proposed extension of the Healthy Indiana Plan Section 1115 demonstration waiver (HIP Waiver) that will be submitted to the Centers for Medicare and Medicaid Services (CMS). Through this The Healthy Indiana Plan (HIP) has been a feature of Indiana's Medicaid program since 2008. The current approval to operate HIP expires December 31, 2020. FSSA is seeking a ten year extension of the HIP Waiver with no substantive changes. The extension request includes incorporation of the HIP Bridge Account amendment, which was submitted to CMS on July 25, 2019. FSSA will be requesting the following non-substantive, technical changes through the extension request:

- Flexibility to modify the POWER Account contribution tiers below average limit of three percent of member income, with appropriate notice to members, stakeholders and CMS, but without requiring the submission of a waiver amendment. Modifications are not currently proposed but could, for example, include increasing or decreasing the amounts of the POWER Account base contribution or the tobacco surcharge.
- Flexibility to modify the HIP Basic copayment amounts within the Medicaid allowable limits, with appropriate notice to members, stakeholders and CMS, but without requiring the submission of a waiver amendment. Modifications are not currently proposed but these modifications may include increases in copayment amounts within limits allowed for cost of living increases, decreases in copayment amounts, or implementation of copayment waivers on target services.

Additionally, through this waiver extension application, FSSA is seeking federal approval for a five-year extension of the substance use disorder (SUD) and requested serious mental illness (SMI) components of the HIP Waiver. This includes authority to reimburse institutions for mental disease (IMDs) for short term stays for individuals diagnosed with SMI or SUD.
Hearings will be held as follows:

1) Tuesday November 19th at 2:00 pm at the Indiana State Library, History Reference Room 211, 315 W. Ohio St., Indianapolis, IN 46202. This hearing will be a special session of the Medical Advisory Commission.
2) Wednesday November 20th at 10 am at Indiana Government Center South, Conference Room 18, 302 W Washington St, Indianapolis, IN 46204. This hearing will be also be accessible via web conference at https://Indiana.AdobeConnect.com/indiana.

All information regarding the submission, including the public notice, the HIP Waiver extension, and other documentation regarding the proposal are available for public review at the FSSA, Office of General Counsel, 402 W. Washington Street, Room W451, Indianapolis, Indiana 46204. The full Public Notice and HIP Waiver documents are also available to be viewed online at https://www.in.gov/fssa/hip/.
Written comments may be sent to the FSSA via mail at 402 West Washington Street, Room W374, Indianapolis, Indiana 46204, Attention: Natalie Angel or via electronic mail at hip@fssa.in.gov through **December 6th, 2019**.

OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES ADMINISTRATION

NOTICE OF PUBLIC COMMENT PERIOD TO EXTEND THE HEALTHY INDIANA PLAN 1115 DEMONSTRATION

Pursuant to 42 CFR § 431.408(a), notice is hereby given that the Indiana Family and Social Services Administration (FSSA) will provide the public the opportunity to review and provide input on a proposed extension of the Healthy Indiana Plan Section 1115 demonstration waiver (HIP Waiver). This notice provides details about the waiver amendment submission and serves to open the 30-day public comment period, which closes on December 6, 2019.

In addition to the 30-day public comment period in which the public will be able to provide written comments to the FSSA via US postal service or electronic mail, the FSSA will host two public hearings in which the public may provide verbal comments. Hearings will be held at the following dates, times, and locations:

1) Tuesday, November 19th at 2:00 pm at the Indiana State Library, History Reference Room 211, 315 W. Ohio St., Indianapolis, IN 46202. This hearing will be a special session of the Medical Advisory Commission.
2) Wednesday, November 20th at 10:00 am at the Indiana Government Center South, Conference Room 18, 302 W. Washington St., Indianapolis, IN 46204. This hearing will be also be accessible via web conference at https://Indiana.AdobeConnect.com/indiana.

Prior to finalizing the proposed HIP Waiver extension, the FSSA will consider all the written and verbal public comments received. The comments will be summarized and addressed in the final version to be submitted to the Centers for Medicare and Medicaid Services (CMS).

EXTENSION PROPOSAL SUMMARY AND OBJECTIVES

The Healthy Indiana Plan (HIP) has been a feature of Indiana's Medicaid program since 2008. The current approval to operate HIP expires December 31, 2020. Based on the long-tenure and demonstrated success of HIP, FSSA is seeking a ten year extension of the HIP Waiver with no substantive changes. The extension request includes incorporation of the HIP Bridge Account amendment, which was submitted to CMS on July 25, 2019. FSSA will be requesting the following non-substantive, technical changes through the extension request:

- Flexibility to modify the POWER Account contribution tiers below average limit of three percent of member income, with appropriate notice to members, stakeholders and CMS, but without requiring the submission of a waiver amendment. Modifications are not currently proposed but could, for example, include increasing or decreasing the amounts of the POWER Account base contribution or the tobacco surcharge.
- Flexibility to modify the HIP Basic copayment amounts within the Medicaid allowable limits, with appropriate notice to members, stakeholders and CMS, but without requiring the submission of a waiver amendment. Modifications are not currently proposed but these modifications may include increases in copayment amounts within limits allowed for cost of living increases, decreases in copayment amounts, or implementation of copayment waivers on target services.

Additionally, through this waiver extension application, FSSA is seeking federal approval for a five-year extension of the approved substance use disorder (SUD) and requested serious mental illness (SMI) components of the HIP Waiver. This includes authority to reimburse institutions for mental disease (IMDs) for short term stays for individuals diagnosed with SMI or SUD.

BENEFICIARIES & ELIGIBILITY

All current HIP eligibility limits and requirements will remain unchanged. HIP continues to target non-disabled adults between the ages of 19 and 64 with a household income less than 133% of the federal poverty level (FPL) with a 5% of income disregard, including individuals eligible for the adult group, low- income parents and caretakers eligible under Section 1931 of the Social Security Act (Section 1931), pregnant women with income within the HIP limit, and individuals eligible for transitional medical assistance.

HIP includes Gateway to Work a community engagement initiative that connects HIP members with ways to look for work, train for jobs, finish school and volunteer. While eligibility suspensions for not completing Gateway to Work are on hold, this HIP Waiver extension requests the ability to continue the Gateway to Work program.

Additionally, all Medicaid enrollees ages 21-64, eligible for full Medicaid benefits, and with a SMI or SUD diagnosis would be eligible for short term stays in an IMD under the SUD and requested SMI component of the waiver extension.

The HIP Waiver extension includes incorporation of the HIP Bridge Account amendment, currently under review by CMS, under which Indiana will adopt limited coverage for the group of adults who have income over the income eligibility level for the new adult group identified in § 1902(a)(10)(A)(ii)(XX) of the Social Security Act and in 42 CFR § 435.218. Individuals with MAGI-based income above 133 percent of the federal poverty level (FPL) who have lost HIP coverage solely due to an increase in income will be eligible for the defined benefit HIP Bridge Account for 12-months following HIP disenrollment. There will be no income limits on eligibility for the account.

ENROLLMENT & FISCAL PROJECTIONS

The HIP Waiver extension will have no impact on expected annual Medicaid enrollment as HIP is requested to be continued with no substantial changes. Further, it is expected to be budget neutral as outlined in the table below.

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	2021	2022	2023	2024	2025	
IMD Services MEG 1 (Fee-for-Service Inpatient)	$16,033,187	$16,987,010	$17,997,573	$19,068,244	$20,202,611	$90,288,625
IMD Services MEG 2 (Fee-for-Service Residential)	$5,130,495	$5,435,710	$5,759,076	$6,101,687	$6,464,681	$28,891,648
IMD Services MEG 3 (Managed Care)	$8,752,467	$9,273,174	$9,824,822	$10,409,288	$11,028,510	$49,288,261

TOTAL	$29,916,150	$31,695,893	$33,581,470	$35,579,219	$37,695,802	$168,468,534

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	2021	**2022**	**2023**	**2024**	**2025**	
IMD Services MEG 1 (Fee-for-Service Inpatient)	$16,033,187	$16,987,010	$17,997,573	$19,068,244	$20,202,611	$90,288,625
IMD Services MEG 2 (Fee-for-Service Residential)	$5,130,495	$5,435,710	$5,759,076	$6,101,687	$6,464,681	$28,891,648
IMD Services MEG 3 (Managed Care)	$8,752,467	$9,273,174	$9,824,822	$10,409,288	$11,028,510	$49,288,261
TOTAL	$29,916,150	$31,695,893	$33,581,470	$35,579,219	$37,695,802	$168,468,534

BENEFITS, COST SHARING, AND DELIVERY SYSTEM

The HIP Waiver extension does not propose any changes to benefits, cost sharing, or delivery system. However, it does incorporate the changes requested specific to the HIP Bridge Account amendment, currently under review by CMS, under which HIP members who qualify for the HIP Bridge Account will receive the benefits and cost sharing applicable to the HIP Bridge Account.

All HIP members will continue to receive a comprehensive benefit package, consistent with private market plans and compliant with all mandated essential health benefits as required by the Patient Protection and Affordable Care Act (ACA). The HIP benefit package does not include non-emergency transportation. Notwithstanding the foregoing, low-income parents and caretakers eligible under Section 1931, pregnant women, low-income 19 and 20-year-old dependents, individuals eligible for transitional medical assistance, and individuals identified as medically frail receive the same benefits as the Medicaid State Plan, including non-emergency transportation and other services not otherwise available to HIP members. Except for members receiving these HIP State Plan benefits, vision and dental services are only available through the HIP Plus plan. Participation in HIP Plus requires members to regularly contribute to their POWER account. The HIP Basic plan is only available to members below the federal poverty level who fail to make their monthly POWER account contributions. The HIP Basic plan does not cover vision and dental services and includes Medicaid allowable copayment amounts.

For all plans, preventive services, such as annual examinations, smoking cessation programs, and mammograms, are covered without charge to the members and are not included in the deductible amount. After the plan deductible is met by way of the $2,500 POWER account, the HIP program includes a comprehensive health plan benefits package.

All HIP medical benefits are currently provided through four (4) MCEs: Anthem, MDwise, Managed Health Services (MHS), and CareSource. Once an MCE has been selected, the member must remain in the MCE for 12 months, with limited exceptions. Members who do not select an MCE will be auto-assigned to an MCE have the opportunity to change the assigned MCE before the first POWER account contribution is made.

Enrollees receiving services under the SUD and requested SMI component of the waiver extension will continue to receive services through their current delivery system.

HYPOTHESES & EVALUATION

The HIP Waiver extension will not propose any changes to the evaluation design or hypotheses. Enhanced program goals, which include the below and will be incorporated into the existing evaluation design posted with the extension documentation, are proposed in the extension request. The enhanced program goals for the HIP extension include period the following:

- Provide timely and geographically appropriate access to healthcare services.
- Promote appropriate utilization of healthcare by maintaining low inappropriate use of the emergency department and supporting utilization of needed services from qualified non-emergency providers.
- Promote control of chronic conditions, delivery of needed care, and increase in member health and wellbeing.
- Increase community engagement leading to increased educational attainment, sustainable employment and member self-sufficiency.
- Reduce the number of uninsured Hoosiers, decrease gaps in coverage, and promote uptake of commercial insurance when leaving HIP.
- Meaningfully increase use of tobacco cessation services and meaningfully decrease tobacco use status for HIP members.
- Encourage healthy behaviors and appropriate care, including early intervention, prevention, and wellness.
- Leverage HIP policies to support the goals of HIP by promoting continuous coverage and improved health outcomes.
- Generate actionable information on social determinants of health.

WAIVER & EXPENDITURE AUTHORITY

FSSA requests an extension of all currently approved waivers and the waiver authority currently under review with CMS for the HIP Workforce Bridge amendment. As specified in the HIP Waiver extension, the requested waivers include:

1. **Premiums** **Section 1902(a)(14) insofar as it incorporates Section 1916 and 1916A**
   To enable the State to charge monthly contributions for HIP Plus at a minimum amount of one-dollar per month and not to exceed a maximum amount of three-percent of member income.

2. **Reasonable Promptness** **Section 1902(a)(8)**
   To the extent necessary to enable 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 individuals with incomes at or below 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 are found eligible through presumptive eligibility.

3. **Provision of Medical Assistance** **Sections 1902(a)(8) and 1902(a)(10)**
To the extent necessary to enable Indiana to suspend eligibility for, and not make medical assistance available to, beneficiaries who fail to comply with community engagement requirements, unless the beneficiary is exempted.

4. **Eligibility** **Sections 1902(a)(10) and 1902(a)(52)**
To the extent necessary to enable Indiana to make a determination of ineligibility, and terminate eligibility for, beneficiaries who are in a suspension of coverage for failure to meet the approved community engagement requirements, unless the beneficiary meets the requirement or is exempted as described in the STCs.

To the extent necessary to enable Indiana to prohibit reenrollment, and deny eligibility, for up to six months, for individuals with income over 100 percent of the FPL who are disenrolled for failure to make POWER Account premium contributions within 60 days of the date of invoice, subject to the exceptions and qualifying events.

To the extent necessary to enable Indiana to prohibit reenrollment, and deny eligibility, for up to three months following the end of the 90-day reconsideration period for individuals who are disenrolled for failure to provide the necessary information for the state to complete an annual redetermination, subject to the exceptions and qualifying events.

5. **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 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.

6. **Comparability and Amount, Duration and Scope of Services** **Sections 1902(a)(17) and 1902(a)(10)(B)**
To the extent necessary to enable the State to vary cost sharing requirements for beneficiaries for 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 copayment (for non-emergency use of the emergency department) and individuals who are in HIP Basic will be subject to copayments within Medicaid permissible levels.

To the extent necessary to enable Indiana to vary contribution requirements, for different HIP Plus program beneficiaries based on income and on tobacco use, and in a manner consistent with all otherwise applicable law. To allow for variations or waivers of POWER Account contribution requirements, within established limits, based on target initiatives such as encouraging uptake of employer insurance.

To allow the HIP Workforce Bridge Account to be available solely to defined eligible individuals that are disenrolled from HIP due to an increase in income.

To allow the State to provide only a limited defined benefit via the HIP Bridge Account, that is limited to cost sharing assistance up to an amount of $1,000, regardless of health care costs incurred by the

member. To allow any balance payable in excess of $1,000, to be assigned to member responsibility without regard to cost-sharing limitations.

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

To enable the State not to provide three months of retroactive eligibility for beneficiaries receiving coverage through the HIP program as described in the STCs, except for pregnant women.

FSSA also requests extension of the following expenditure authorities that are currently approved or pending approval by CMS:

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 organizations (MCO) 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, except as described in the terms and conditions.
    b. 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(g) that automatic MCO reenrollment occur only if the beneficiary's disenrollment was due to a Medicaid eligibility lapse of two months or less, as described in the terms and conditions.

2. Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental disease (IMD) and expenditures for otherwise covered services furnished to otherwise eligible individuals for short term stays for acute care in a psychiatric hospital that qualifies as an IMD.

REVIEW OF DOCUMENTS & SUBMISSION OF COMMENTS

All information regarding the submission, including the public notice, the HIP Waiver extension, and other documentation regarding the proposal are available for public review at the FSSA, Office of General Counsel, 402 W. Washington Street, Room W451, Indianapolis, Indiana 46204. The full Public Notice and HIP Waiver documents are also available to be viewed online at https://www.in.gov/fssa/hip/.

Written comments may be sent to the FSSA via mail at 402 West Washington Street, Room W374, Indianapolis, Indiana 46204, Attention: Natalie Angel or via electronic mail at hip@fssa.in.gov through **December 6, 2019**.

INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION
NOTICE OF TRIBAL COMMENT PERIOD FOR §1115 WAIVER EXTENSION

In accordance with 42 CFR § 431.408(b), notice is hereby given to the Pokagon Band of the Potawatomi that the Indiana Family and Social Services Administration (FSSA) will be seeking renewal of its Healthy Indiana Plan Section 1115 demonstration waiver (HIP Waiver) to the Centers for Medicare and Medicaid Services (CMS).

This notice also serves to open the **30-day tribal comment period, which closes December 1st at 5:00 pm.**

RENEWAL REQUEST SUMMARY

The Healthy Indiana Plan (HIP) has been a feature of Indiana's Medicaid program since 2008. The current approval to operate HIP expires December 31, 2020. Based on the long-tenure and demonstrated success of HIP, FSSA is seeking a ten year extension of the HIP Waiver with no substantive changes. The extension request includes incorporation of the HIP Workforce Bridge amendment, for which tribal notice was provided on May 15, 2019. FSSA will be requesting the following non-substantive, technical changes through the extension request:

- Flexibility to modify the POWER Account contribution tiers below average limit of three percent of member income, with appropriate notice to members, stakeholders and CMS, but without requiring the submission of a waiver amendment. Modifications are not currently proposed but could for example include increasing or decreasing the amounts of the POWER Account base contribution or the tobacco surcharge.
- Flexibility to modify the HIP Basic copayment amounts within the Medicaid allowable limits, with appropriate notice to members, stakeholders and CMS, but without requiring the submission of a waiver amendment. Modifications are not currently proposed but these modifications may include increases in copayment amounts within limits allowed for cost of living increases, decreases in copayment amounts, or implementation of copayment waivers on target services.

Additionally, through this waiver extension application, FSSA is seeking federal approval for a five-year extension of its substance use disorder (SUD) and requested serious mental illness (SMI) components of the HIP Waiver. This includes authority to reimburse institutions for mental disease (IMDs) for short term stays for individuals diagnosed with SMI or SUD.

TRIBAL IMPACT

As only technical changes related to POWER Account and cost sharing are proposed through this extension application, there will be no impact to tribal enrollees. Members of the Pokagon Band of the Potawatomi located in Indiana will continue to be eligible to obtain coverage under HIP when they meet the current criteria for eligibility. All eligible tribal members will also continue to receive HIP services in a manner consistent with federal regulations, including the American Recovery and Reinvestment Act of 2009, which in relevant part precludes states from imposing Medicaid premiums or other cost-sharing on members of federally-recognized Indian tribes. As occurs today, all eligible tribal members who participate in the demonstration will be enrolled in the HIP Plus plan with no POWER Account contribution or cost-sharing requirements. Further, tribal members will continue to have the option to voluntarily participate in HIP. If an enrollment option is not specified, members will be enrolled in a managed care entity (MCE) by default, and will be given the option to disenroll and receive benefits through the Medicaid fee-for-service program. Pending CMS approval of the HIP Workforce Bridge Amendment, for which tribal notice was provided on May 15, 2019, those who opt to participate will receive an exemption to any active Gateway to Work requirements in place of the current activity credit received for participation in the Pathways program. Exempt members do not have a Gateway to Work requirement when it applies but may still access Gateway to Work resources and participate on a voluntary basis. In addition, tribal members will be eligible to receive the HIP Bridge Account, if applicable.

Additionally, through extension of FSSA's IMD waiver, members of the Pokagon Band of the Potawatomi located in Indiana and enrolled in full Medicaid benefits will continue to have access to: (1) short term stays for acute care in a psychiatric hospital that qualifies as an IMD; and (2) treatment and withdrawal management services for SUD in IMDs.

REVIEW OF DOCUMENTS AND SUBMISSION OF COMMENTS

Written comments may be sent to the FSSA via mail at 402 West Washington Street, Room W374, Indianapolis, Indiana 46204, Attention: Amy Owens or via electronic mail at amy.owens@fssa.in.gov **through December 1st, 2019**. Additionally, we would be happy to schedule a phone or in-person consultation to discuss the program in further detail.

Indiana Family and Social Services Administration

Renewal Request for the Healthy Indiana Plan (HIP) Section 1115 Waiver –

Substance Use Disorder & Serious Mental Illness IMD Waiver (Project Number 11-W-00296/5)

January 31, 2020

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Section 1: Summary of IMD Waiver Renewal Request

The State of Indiana is requesting from the Centers for Medicare & Medicaid Services (CMS) approval of a five-year extension of its substance use disorder (SUD) and serious mental illness (SMI) components of the Medicaid demonstration entitled, "Healthy Indiana Plan (HIP)" (Project Number 11-W-00296/5) in accordance with sections 1115(a) and 1915(h)(2) of the Social Security Act (the Act). On September 1, 2015, then-Governor Mike Pence issued Executive Order 15-09, establishing the Governor's Task Force on Drug Enforcement, Treatment, and Prevention to identify best practices and make informed recommendations for policy makers. The task force included membership from the Indiana General Assembly, the Governor's Office, the Indiana State Department of Health, the Indiana Department of Correction, the Indiana Department of Child Services, the Indiana Family and Social Services Administration, and other organizations and associations throughout Indiana. Implementation of this 1115 SUD demonstration was one of several recommendations issued in the final report of the Task Force, and realized under Indiana's current Governor, Eric Holcomb.

On January 17, 2017, Governor Eric Holcomb introduced his "Next Level Legislative Agenda" representing five pillars designed to address key challenges facing the state, including the fourth pillar: "Attack the Drug Epidemic." During his speech he shared that deaths from drug overdoses had increased by 500 percent since 2000, and that Indiana was ranked 15th in the country in overdose fatalities. To provide impetus, direction and oversight to combat the crisis, he appointed Jim McClelland as the Executive Director for Drug Prevention, Treatment and Enforcement, and supported legislation to create the Indiana Commission to Combat Drug Abuse, comprising key community members, leadership from State agencies, and legislators. The Commission created a strategic approach to addressing substance abuse in Indiana that focused on the reduction of the incidence of individuals with substance use disorders (SUD); additional harms that can result from substance abuse; improved treatment for individuals with SUD; and supported community-based collaborations aimed on prevention, treatment and recovery.

The Indiana Family and Social Services Administration (FSSA) has leveraged this demonstration as part of an intense and integrated effort to mitigate the adverse impact of the opioid epidemic while continuing to monitor prevalence and access to treatment for other substances of abuse impacting the State of Indiana. FSSA is responsible for the administration and oversight of Indiana's Medicaid program and consists of six divisions including the Office of Medicaid Policy and Planning (OMPP), Division of Mental Health and Addiction (DMHA), Office of Healthy Opportunities (OHO), Division of Aging, Division of Family Resources, and Division of Disability and Rehabilitative Services. In addition to maintaining SUD services and supports that have been integrated into Medicaid's Indiana Health Coverage Program (IHCP) network for decades, the FSSA's OMPP has worked closely with the DMHA to add reimbursement for inpatient and residential services provided in Institutions for Mental Diseases (IMDs) under this demonstration; obtained a State Plan Amendment to offer intensive outpatient treatment (IOT) and peer recovery services for members; and removed barriers to Medication Assisted Treatment (MAT) for members. More recent efforts have introduced new providers into the IHCP network

by adding SUD services to long-standing practices in other specialties and making SUD services newly available to IHCP members.

Further, the provision of services in an IMD for individuals with SMI is part of broader efforts within the FSSA to ensure a comprehensive continuum of behavioral health services and is intended to improve access to acute care for Medicaid enrollees with SMI. This component of the waiver seeks to address the historical reliance on general hospital emergency rooms to handle individuals in acute psychiatric crisis.

Section 2: Historical Narrative Summary

On February 1, 2018, CMS approved an extension to Indiana's existing Section 1115 Medicaid demonstration waiver. The added goals of the waiver extension were aligned with the milestones outlined by CMS, as follows:

- Increased rates of identification, initiation, and engagement in treatment;
- Increased adherence to and retention in treatment;
- Reductions in overdose deaths, particularly those due to opioids;
- Reduced utilization of emergency departments and inpatient settings for treatment where utilization is preventable or medically inappropriate through improved access to other continuum of care services;
- Fewer readmissions to the same or higher level of care where the readmission is preventable or medically appropriate; and
- Improved access to care for physical health conditions among beneficiaries.

This waiver contributes to a comprehensive statewide strategy to combat SUD, including prescription drug abuse and opioid use disorders (OUD). The strategies within the waiver included the expansion of coverage for a full-range of SUD treatment services to Indiana Health Coverage Programs (IHCP) for members enrolled in Traditional Medicaid (full, fee-for-service coverage) or in any managed care program, including Healthy Indiana Plan (HIP), Hoosier Care Connect, and Hoosier Healthwise. Changes under the new SUD waiver included the following:

- Expanding coverage of inpatient SUD treatment provided in IMDs;
- Adding coverage for short-term residential SUD treatment; and
- Establishing a new provider type and specialty for residential treatment.

The waiver, currently approved through December 31, 2020, allows for Indiana Medicaid beneficiaries to continue to have access to all current mental health and SUD benefits. In addition, all beneficiaries, ages 21 through 64, gained access to expanded covered services provided while residing in an IMD for SUD short-term residential stays. The SUD program specifically allowed beneficiaries with SUD to access benefits that include SUD residential treatment, crisis stabilization and withdrawal management services provided in IMDs, which would otherwise be excluded from federal reimbursement. Under this demonstration, beneficiaries have access to high quality, evidence-based OUD and other SUD treatment services ranging from acute withdrawal management to on-going chronic care for these conditions in

cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions.

Indiana, as part of its evaluation plan, established six milestones for the SUD demonstration:

- Access to critical levels of care for SUD treatment;
- Use of evidence-based SUD-specific patient placement criteria; prior-authorization, providers, payers; matching need to capacity
- Use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities;
- Sufficient provider capacity at critical levels of care, including medication assisted treatment for OUD;
- Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD; and
- Improved care coordination and transition between levels of care.

In addition to the achievement of the metrics reported in the interim evaluation (attached to this extension application), the state took the following steps to support realization of these milestones.

1. Access to critical levels of care for SUD treatment.

Under the waiver, reimbursement for SUD inpatient stays for medically monitored detox in IMDs became available for all IHCP members in February 2018. Effective March 1, 2018, the IHCP began providing coverage for short-term low-intensity (American Society of Addiction Medicine [ASAM] Level 3.1) and high-intensity residential treatment (ASAM Level 3.5) for SUD in settings of all sizes, including facilities that qualify as IMDs.

FSSA requested this SUD waiver demonstration program as an outgrowth of recommendations made by the State's Taskforce on Drug Enforcement, Treatment, and Prevention. As such, the demonstration is one component of a broader strategy to address substance use disorders, including OUD within the State. Through a state plan amendment effective July 1, 2019, the IHCP modified the coverage of crisis intervention, intensive outpatient treatment (IOT), and peer recovery services to better serve IHCP members. For dates of service (DOS) on or after July 1, 2019, crisis intervention, IOT and peer recovery services will no longer be restricted to members eligible for the Medicaid Rehabilitation Option (MRO) benefit plan. In addition, all three services will no longer be carved out of managed care to support improved care coordination.

The State has also increased access to services, funded through other state and federal dollars, to compliment the new waiver services added to the SUD continuum of care for Hoosiers. Planning for use of State Targeted Response (STR) and State Opioid Response (SOR) federal funds considered the existing Medicaid service array and filling service gaps that remained. Indiana's DMHA is expanding access to four levels of recovery housing based on standards from the National Alliance for Recovery Residences' Oxford Model, including in rural areas of the state. In addition, SOR funding is being leveraged to expand the number of DATA-Waived Providers Across Indiana. DMHA is also committed to funding the addition of three additional training

tracks to the existing Indiana Opioid Addiction Treatment ECHO (I-ECHO) project that utilizes both didactic and case-learning approaches. The latter two initiatives will support existing Medicaid enrolled SUD providers as well as potentially expand the Medicaid SUD provider network.

2. Use of Evidenced-Based SUD-Specific Patient Placement Criteria

Prior authorization is required for all SUD residential stays, with medical necessity/admission criteria based on the ASAM Patient Placement Criteria Level 3.1 (Clinically Managed Low-Intensity Residential Services) and Level 3.5 (Clinically Managed High-Intensity Residential Services). In addition, DMHA is working to modify the Adults Needs and Strengths Assessment (ANSA) utilized by all contracted providers to incorporate ASAM criteria and develop the algorithms to recommend the level of treatment and services that incorporate the use of evidence-based practices.

In the fourth quarter of 2018, the SUD Work Group was created to engage stakeholders in a review of the strengths and challenges specific to the elements of 1115 Waiver implementation. The charge of this cross-collaborative group included examining concerns shared by stakeholders regarding access to the newly developed SUD residential treatment services. To date, the Work Group has examined issues pertaining to the prior authorization (PA) process, SUD treatment criteria interpretation and application, and transitions of care. Recommendations from this ongoing workgroup are being implemented through an FSSA project team. This core team meets biweekly. Quarterly SUD Work Group meetings continue as well as combined quarterly meetings with the Medicaid managed care plans and SUD providers. One outcome of this collaboration was the consensus that as of February 11, 2019, all plans will authorize a minimum length of stay of at least 14 days before re-evaluation/concurrent review, unless less than 14 days is requested by the provider.

Effective March 15, 2019, the IHCP began encouraging providers to use three new forms when requesting PA for inpatient and residential treatment for SUD. These forms provide prompts for information specific to residential and inpatient treatment and apply to these services rendered under both the fee-for-service (FFS) and the managed care delivery systems.

- Residential/Inpatient Substance Use Disorder Treatment Prior Authorization Request Form – This form is recommended for use to request PA for inpatient and residential SUD treatment services, rather than using the standard universal PA request form.
- Initial Assessment Form for Substance Use Disorder Treatment Admission – This assessment form can be completed and submitted as an attachment to the SUD residential and inpatient treatment PA request form for initial admissions.
- Reassessment Form for Continued Substance Use Disorder Treatment – This assessment form can be completed and submitted for requests to extend authorization for residential and inpatient SUD treatment.

These forms incorporate ASAM criteria associated with the specific member and requested service. Effective June 25, 2019, each of these substance use disorder PA request forms and any attachments can be submitted on the IHCP Provider Portal.

3. Use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities.

In an effort to raise the standards of care for addictions providers in Indiana, FSSA's OMPP partnered with the DMHA on an ASAM level of care designation process, beginning with ASAM Level 3.1 and 3.5 residential addiction treatment facilities. By July 1, 2018, all facilities seeking Medicaid reimbursement for residential SUD treatment were required to be enrolled as a new provider specialty, SUD Residential Addiction Treatment Facility (provider specialty 836, within provider type 35 [addiction services]). The first step in the enrollment process is to be certified as an *addiction treatment services provider, regular certification* and *residential sub-acute facility* by DMHA. To be certified and to maintain regular certification as an addiction treatment services provider, an entity must maintain accreditation from an approved accrediting agency.[1] After obtaining the required certifications from DMHA, each facility is required to obtain ASAM designation from DMHA. Once a provider has received certification as an *addiction treatment services provider, regular certification and residential sub-acute facility* with the applicable ASAM designation, the final step is enrollment as an IHCP provider. The State plans to expand the designation process to all ASAM levels of care. 116 individuals from the State, including SUD providers, managed care entities (MCEs) staff, and other stakeholder organizations attended ASAM training in early April 2019. DMHA is planning to provide additional training opportunities later in the calendar year.

4. Sufficient provider capacity at critical levels of care, including medication assisted treatment for opioid use disorder (OUD).

On February 19, 2019, the IHCP clarified billing guidelines for the SUD initial assessments; crisis intervention; and first dose induction of buprenorphine Observation. The guidance applied to enrolled IHCP providers, including affirmation that midlevel practitioners, such as licensed clinical addiction counselors, can provide these services within their scope of practice under the supervision of an enrolled IHCP provider.

In August 2019, the State applied for the Notice of Funding Opportunity under the Section 1003 Demonstration Project to Increase Substance Use Provider Capacity. The State received a notice of funding award in September 2019. Efforts under the planning phase of this opportunity align and will strengthen, as opposed to duplicate, waiver activities and goal achievement by providing a review of the existing Medicaid SUD full continuum provider network, including providers of new services under this waiver. Post-Planning Phase goals include: (1) increased access to SUD services through expanded provider participation; (2) increased access to services at each point in the prevention and treatment continuum (per ASAM levels of treatment and assessment criteria); (3) increased quality and positive outcomes through adoption of evidenced-based

[1] Current approved accreditation bodies include the Rehabilitation Accreditation Commission (CARF); Joint Commission on Accreditation of Healthcare Organizations; Council on Accreditation of Services for Families and Children (COA); and the National Committee for Quality Assurance (NCQA).

practices; and (4) increased quality and positive outcomes through provider technical assistance, monitoring, and reimbursement strategies.

5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD

Consider options for emergency responder reimbursement of naloxone-end of 2018

FSSA requested this SUD waiver demonstration program as an outgrowth of recommendations made by the State's Taskforce on Drug Enforcement, Treatment, and Prevention. As such the demonstration is one component of a broader strategy to address substance use disorders, including OUD within the State. Through a state plan amendment effective July 1, 2019, the IHCP modified the coverage of crisis intervention, intensive outpatient treatment (IOT), and peer recovery services to better serve IHCP members. For dates of service (DOS) on or after July 1, 2019, IOT and peer recovery services will no longer be restricted to members eligible for the Medicaid Rehabilitation Option (MRO) benefit plan. In addition, these two services will no longer be carved out of managed care in order to support improved care coordination. Further, a multiagency group with representation from behavioral health, Medicaid and public health has convened to pursue emergency responder reimbursement of naloxone.

DMHA is currently leveraging SOR funding to expand treatment service capacity by: (1) implementing an Addiction Provider Development and Sustainability (APDS) Program that provides funding for SUD-focused MA/MSW internships within community mental health center (CMHC) settings; (2) expanding SUD-specific Project ECHO curriculum and participation; and (3) partnering with academia to implement a Leadership and Organizational Change for Implementation (LOCI) intervention to develop and create an organizational change strategy to improve organizational leadership and create or enhance organizational climate for evidence-based practice (EBP) implementation. As part of the LOCI project, DMHA intends to pilot implementation of Motivational Enhancement Therapy-Cognitive Behavioral Therapy (MET/CBT). Creation of this framework could support a future DMHA/OMPP partnership to pilot other SUD-related EBPs and, if hypothesized outcomes are achieved, consider state plan amendments to add services or create incentives though reimbursement strategies for statewide adoption.

6. Improved care coordination and transition between levels of care.

In 2017, 77.1% of all Indiana Medicaid members were enrolled with a managed care entity (MCE). The OMPP requires all four contracted MCEs to provide care coordination across primary, behavioral and other specialty care. OMPP amended contracts to require that MCEs employ or contract with case managers with training, expertise and experience in providing case management services for members receiving behavioral health services. At a minimum, the MCE must offer to provide case management services to any member at risk for inpatient psychiatric or substance abuse hospitalization, and to members discharged from an inpatient psychiatric or substance abuse hospitalization, for no fewer than ninety (90) calendar days following that inpatient hospitalization. Case managers must also contact members during an inpatient hospitalization, or immediately upon receiving notification of a member's inpatient behavioral

health hospitalization, and schedule an outpatient follow-up appointment for within seven days of discharge.

As previously noted, access to peer recovery services was expanded through a state plan amendment to eliminate a restriction of these services to an individual ineligible for the MRO benefit plan. Peer recovery services are individual face-to-face services that provide structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills, including support through transitions in care. In support of the expansion and utilization by provider agencies, guidance was provided regarding peer recovery services, including the requirement that they must be delivered by individuals certified in peer recovery services per the DMHA standards and must be performed under the supervision of a licensed professional or a qualified behavioral health professional (QBHP).[2]

Section 2.1: SMI Waiver Amendment

On August 30, 2019, FSSA submitted an amendment to the SUD demonstration to request authority to reimburse for acute inpatient stays in IMDs for individuals diagnosed with SMI. This request was part of broader efforts within the FSSA to ensure a comprehensive continuum of behavioral health services and to improve access to acute care for Medicaid enrollees with SMI and serious emotional disturbance (SED). The amendment was approved on December 20, 2019, with an effective date of January 1, 2020.

The State's goals, through this waiver amendment included:

- Reduced utilization and lengths of stay in EDs among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings;
- Reduced preventable readmissions to acute care hospitals and residential settings;
- Improved availability of crisis stabilization services utilizing multiple service models to meet the unique needs across the state;
- Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care; and
- Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

As the waiver amendment has been recently implemented, evidence regarding the progress toward meeting these goals is not yet available.

[2] *BR201925* - IHCP bulletin clarified qualifications and supervision requirements for peer recovery specialist providers (June 18, 2019).

Section 3: Program Changes

In spring 2016, the Indiana General Assembly passed Senate Enrolled Act 297, which required Medicaid coverage for inpatient detoxification services for the treatment of opioid or alcohol dependence in accordance with the most current edition of ASAM or other comparable clinical criteria. Signed by Governor Holcomb on May 1, 2019, House Enrolled Act 1543 updated the requirement of providers to provide inpatient detoxification exclusively in accordance with the most current edition of ASAM criteria.

Section 4: Eligibility, Benefits and Cost Sharing

4.1: Demonstration Eligibility

The State requests no modifications to demonstration eligibility. Under this extension request, all enrollees eligible for a mandatory or optional eligibility group approved for full Medicaid coverage, and between the ages of 21 – 64, will be eligible for the SUD and SMI/SED benefits authorized through the waiver, as further described in Section 4.2. Only the eligibility groups outlined in Table 1 below will not be eligible for services under the waiver as they receive limited Medicaid benefits only.

Table 1: Eligibility Groups Excluded from the Demonstration

Eligibility Group Naue	Social Security Act & CFR Citations
Limited Services Available to Certain Aliens	42 CFR §435.139
Qualified Medicare Beneficiaries (QMB)	1902(a)(10)(E)(i) 1905(p)
Specified Low Income Medicare Beneficiaries (SLMB)	1902(a)(10)(E)(iii)
Qualified Individual (QI) Program	1902(a)(10)(E)(iv)
Qualified Disabled Working Individual (QDWI) Program	1902(a)(10)(E)(ii) 1905(s)
Family Planning	1902(a)(10)(A)(ii)(XXI)

4.2: Benefits

Indiana Medicaid provides comprehensive SUD and SMI/SED treatment services to enrollees. Throughout the development of the 2017 SUD waiver application process, the State conducted an assessment of available services compared with the standards outlined through the American Society of Addiction Medicine (ASAM). Many services that align with an ASAM level of care were previously covered. However, through the waiver, in conjunction with State Plan authority, Indiana has been able to provide coverage for a more complete continuum of services. This includes services provided in residential and inpatient treatment settings that qualify as an IMD, which are not otherwise matchable expenditures under Section 1903 of the Social Security Act.

Additionally, in development of the waiver amendment to provide coverage for acute inpatient stays in an IMD for SMI/SED, the State undertook a comprehensive review of its community-based mental health service array. As a result of this process and in accordance with the State's

SMI/SED Demonstration Implementation Plan, FSSA is in the process of piloting programs to increase access to crisis stabilization services.

The State requests no modification to covered benefits through this extension application. Services authorized through the waiver will continue to be available for all Medicaid enrollees, unless otherwise excluded as described in Section 4.1.

Table 2: SUD and SMI Benefits Coverage with Expenditure Authority

Benefit	Medicaid Authority	Expenditure Authority
SUD Residential Treatment	§1115 Waiver	Services provided to individuals in IMDs
Withdrawal Management	State Plan	Services provided to individuals in IMDs
Opioid Treatment Program Services	State Plan	Services provided to individuals in IMDs
Addiction Recovery Management Services	State Plan	Services provided to individuals in IMDs
Acute inpatient stays for SMI	State Plan	Services provided to individuals in IMDs

4.3 Cost Sharing

All cost-sharing for SMI/SED and SUD services provided through this waiver will be consistent with the Medicaid State Plan applicable to an enrollee's specific eligibility category. No modifications are proposed through this renewal request.

4.4 Delivery System and Payment Rates for Services

No modifications to the current Indiana Medicaid fee-for-service or managed care arrangements are proposed through this renewal. All enrollees will continue to receive services through their current delivery system. Additionally, payment methodologies will be consistent with those approved in the Medicaid State Plan.

Section 5: Waivers & Expenditure Authority

The State requests continuation of the current expenditure authority under Section 1115 for otherwise covered services furnished to otherwise eligible individuals for: (1) short term stays for acute care in a psychiatric hospital that qualifies as an IMD; and (2) treatment and withdrawal management services for SUD in facilities that meet the definition of an IMD. No additional waivers of Title XIX or Title XXI are requested in relation to the SUD/SMI initiatives through this extension application.

Section 6: Reporting

FSSA has a robust quality oversight plan for continually monitoring the services and outcomes delivered under the waiver. Oversight is conducted through a variety of strategies, including but not limited to:

- MCE monthly and quarterly reporting on compliance with contractual requirements related to behavioral health
- Annual external quality reviews (EQR) of MCEs
- Quality strategy plan which includes an overall framework for continuous quality improvement
- MCE-led quality improvement projects
- Quarterly and annual reporting in accordance with the CMS required "Medicaid Section 1115 SUD Demonstration Monitoring Protocol" and associated quantitative monitoring metrics

A summary of key findings gleaned from these oversight strategies is provided in the subsections below.

6.1: External Quality Review Organization Reports

FSSA contracts with Burns and Associates to conduct an annual EQR in accordance with the requirements at 42 CFR §438.350. The most recent EQR revealed positive findings on MCE performance related to the provision of behavioral health services. Specifically, all MCEs received the maximum score on the following contract provisions and federal regulations:

- The MCE shall employ or contract with case managers with training, expertise and experience in providing case management services for members receiving behavioral health services.
- At minimum, the MCE shall provide case management services for members discharged from an inpatient psychiatric or substance abuse hospitalization for no fewer than 90 days following hospitalization.
- With the appropriate consents, MCE case managers shall notify both primary medical providers (PMP) and behavioral health providers when a member is hospitalized or receives emergency treatment for behavioral health issues, including substance abuse. This notice must be provided within five calendar days of the inpatient admission or emergency treatment.
- The MCE shall, on at least a quarterly basis, send a behavioral health profile to the respective PMP. The profile lists the physical and behavioral health treatment received by the member during the previous reporting period.
- The MCE will contractually mandate that its behavioral health care network providers notify a member's MCE within five calendar days of the member's visit, and submit information about the treatment plan, the member's diagnosis, medications, and other pertinent information.
- The MCE shall, at a minimum, establish referral agreements and liaisons with both contracted and non-contracted community mental health centers (CMHCs), and shall provide physical health and other medical information to the appropriate CMHC for every member.
- MCE case managers shall regularly and routinely consult with both the member's physical and behavioral health providers to facilitate the sharing of clinical information,

and the development and maintenance of a coordinated physical health and behavioral health treatment plan for the member.

- In urban areas, the MCE must provide at least one behavioral health provider within 30 miles or 30 minutes; in rural areas, one within 45 minutes or 45 miles.
- For behavioral health providers, require that members receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. This treatment must be provided within seven calendar days from the date of the member's discharge.

6.2: Quality Assurance Monitoring

FSSA's 2019 Indiana Medicaid Managed Care Quality Strategy Plan, developed in accordance with 42 CFR §438.340, also includes a series of behavioral health initiatives, with goals aligned to those of the IMD waivers.

Table 3: 2019 Behavioral Health Quality Strategy Initiatives

OBJECTIVE	METHODOLOGY	GOAL
Hoosier Healthwise and Healthy Indiana Plan Initiatives		
Improvement in Behavioral Health (HEDIS) Percentage of members who received follow-up within seven days of discharge from hospitalization for mental health disorders	HEDIS measures for tracking the percentage of members receiving follow-up.	Achieve at or above the 90th percentile for members who receive follow-up within seven days of discharge from hospitalization for mental health disorders (HEDIS).
Traditional Medicaid Initiatives		
Improvement in Behavioral Health (HEDIS-like) Percentage of members who received follow-up within seven days of discharge from hospitalization for mental health disorders	Administrative reporting through the FSSA enterprise data warehouse (EDW) using HEDIS specifications.	Maintain with de minimis reduction in performance.
Hoosier Care Connect Initiatives		
Improvement in Behavioral Health (HEDIS) Percentage of members who received follow-up within seven days of discharge from hospitalization for mental health disorders – with Medicaid rehabilitation option (MRO)	HEDIS-like measure based on specifications developed by OMPP, including MRO HCPCS codes.	Achieve at or above 75th percentile for members who receive follow-up within seven days of discharge from hospitalization for mental health disorders – with Medicaid MRO services.

In alignment with the Quality Strategy Plan, FSSA's managed care contracts have a financial incentive for improvements in performance on the follow up after hospitalization for mental

health disorders HEDIS measure. A portion of the capitation is withheld with the ability for the MCE to receive the funding based on performance.

In addition to the ongoing activities associated with the Quality Strategy Plan, FSSA conducts targeted studies and oversight of services rendered under the waiver. For example, Burns and Associates has been engaged to conduct two separate studies of service authorizations granted under the waiver. The first study was conducted in Spring 2019 pertaining to authorizations in CY 2018. Findings revealed MCEs are processing authorization requests for SUD services within contractually required timelines. One MCE was slightly above the target, which FSSA continues to monitor. Additionally, a sample of service denials and approvals were reviewed by an independent physician; the physician concurred with the majority of clinical decisions (96%) rendered by the MCE's. Ongoing monitoring in this area is planned with a second study to be conducted in Spring 2020 pertaining to 2019 authorizations.

6.3: Additional Documentation on Quality and Access

FSSA monitors access to behavioral health services through a variety of strategies. For example, through regular review of MCE data on compliance with contractual requirements for network adequacy, which were developed in accordance with 42 CFR §438.68. All MCEs are currently demonstrating compliance with the access requirements for behavioral health providers for Hoosier Healthwise, HIP and Hoosier Care Connect.

The State also conducts ongoing waiver monitoring in accordance with CMS requirements for the "Medicaid Section 1115 SUD Demonstration Monitoring Protocol" and through submission of quarterly and annual reports following CMS required quantitative monitoring metrics. As the SMI portion of the IMD waiver has recently been implemented, outcomes are not yet available regarding the State's progress in meeting the milestones of this portion of the waiver. FSSA has implemented ongoing monitoring in accordance with CMS requirements for the SMI waiver.

High level findings from the most recently completed annual report are provided below. FSSA will continue to submit quarterly and annual monitoring reports in accordance with CMS requirements through the extension period.

Table 4: Summary Findings from Annual SUD Monitoring Protocol

Metric Name	Metric Description	Outcomes
Average Length of Stay in an IMD	The average length of stay for beneficiaries discharged from IMD residential treatment for SUD	7 days
SUD Provider Availability – MAT	The number of providers enrolled in Medicaid and qualified to deliver SUD services during the measurement period and who meet the standards to provide buprenorphine or methadone as part of MAT	725
Initiation and Engagement of Alcohol and Other Drug (AOD)	Initiation of AOD Treatment—percentage of beneficiaries who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial	55.34%

Metric Name	Metric Description	Outcomes
Dependence Treatment (IET) [NCQA; NQF #0004; Medicaid Adult Core Set]	hospitalization, telehealth, or MAT within 14 days of the diagnosis	
	Engagement of AOD Treatment—percentage of beneficiaries who initiated treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit	29.74%
Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer [PQA; NQF #2951]	Rate per 1,000 beneficiaries age 18 and older included in the denominator without cancer who received prescriptions for opioids with a daily dosage greater than 120 morphine milligram equivalents for 90 consecutive days or longer. Patients in hospice are also excluded.	40.9
Use of Opioids from Multiple Providers in Persons Without Cancer [PQA; NQF #2950]	Rate per 1,000 beneficiaries included in the denominator without cancer who received prescriptions for opioids from four or more prescribers and four or more pharmacies.	27.34
Use of Opioids at High Dosage from Multiple Providers in Persons Without Cancer [PQA, NQF #2951]	Rate per 1,000 beneficiaries included in the denominator without cancer who received prescriptions for opioids greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer, and from four or more prescribers and four or more pharmacies.	1.12
Concurrent Use of Opioids and Benzodiazepines [PQA]	Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines. Patients with a cancer diagnosis or in hospice are excluded.	17.08%
Continuity of Pharmacotherapy for Opioid Use Disorder [RAND; NQF #3175]	Percentage of adults in the denominator with pharmacotherapy for OUD who have at least 180 days of continuous treatment	17.44%
Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependences [NCQA; NQF #2605; Medicaid Adult Core Set]	Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).	40.33%
	Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 total days).	54.37%

Section 7: Financing

Please refer to the attached documentation prepared by the State's actuary for a detailed analysis of the budget neutrality impact.

Section 8: Interim Evaluation Report

An Interim Evaluation of the SUD portion of the waiver was completed by Burns and Associates. As the IMD waiver for acute psychiatric stays was implemented on January 1, 2020, evaluation findings are not yet available. The evaluation plan, and subsequent Summative Evaluation Report, will be updated to incorporate the SMI IMD components of the waiver and submitted for CMS review and approval in accordance with the State's special terms and conditions (STCs).

The SUD Interim Evaluation explored the hypotheses and research questions outlined in Table 5, in accordance with the CMS-approved evaluation plan.

Table 5: SUD Waiver Hypotheses and Research Questions

Hypothesis	Research Questions
Aims and Primary Drivers	
Key health outcomes improve in the SUD population in the post-waiver period.	Does the level and trend of initiation and engagement in treatment increase in the SUD population in the post waiver period?
	Does the level and trend of follow-up after discharge from the Emergency Department (ED) for SUD increase among the SUD population in the post waiver period?
	Does the level and trend in continuity of pharmacotherapy for opioid use disorder increase among the OUD population in the post waiver period?
	Does the level and trend in concurrent use of opioids and benzodiazepines decrease in the OUD population in the post waiver period?
	Does the level and trend in the rate of use of opioids at high dosage in persons without cancer decrease in the post waiver period?
Costs of care decreases in the SUD population in the post waiver period.	Does the level and trend in overall spending for the SUD population decrease in the post waiver period?
	Does the level and trend in SUD service spending for the SUD population increase in the post waiver period?
	Does the level and trend in acute utilization for SUD, potentially preventable emergency department or potentially preventable hospital readmissions decrease in the SUD population in the post waiver period?
Secondary Drivers	
Access to care improved in the SUD population in	Does the level and trend in the number of SUD and primary care providers and the number of providers per capita in the SUD population increase in the post waiver period for each ASAM level of care?

Hypothesis	Research Questions
the post-waiver period	Does the utilization per 1,000 of SUD services and primary care in the SUD population increase in the post waiver period for each ASAM level of care?
Prior authorization (PA) requirements do not negatively impact access to residential or inpatient services (ASAM 3.1, 3.5 and 4.0).	Are the rates of prior authorizations (PAs) submitted and PA requests that are denied in the SUD population, controlling for volume, relatively consistent by MCE and over time?
	Are prior authorization (PA) denials predominately for reasons directly related to not meeting clinical criteria as opposed to administrative reasons such as lack of information submitted?

The full report is provided as a separate attachment to this extension application.

8.1 Evaluation Plan for Extension Period

The State requests no modifications to the evaluation plan during the extension period. Given no waiver modifications are proposed through this extension request, and the IMD waivers have been in effect for a relatively short time, FSSA will continue to study the previously approved hypotheses and research questions. All evaluation activities will be conducted in accordance with the STCs, including continued use of an independent evaluator.

Section 9: Public and Tribal Comment

In accordance with 42 CFR §431.408, the public had an opportunity to comment on this waiver extension application through a public notice and comment period that ran from November 6, 2019 through December 6, 2019. The public notice and all waiver documents were posted on the FSSA website and made available for review at the FSSA offices. An abbreviated notice was also published on November 6, 2019 in the State's administrative record, the Indiana Register. Additionally, FSSA sent email notification to approximately 1,600 stakeholders. Finally, the State held two public hearings on November 19, 2019 (Medical Care Advisory Committee that operates in accordance with 42 CFR §431.12) and November 20, 2019 (open forum for interested parties to learn about the contents of the application and to comment on its content). Statewide accessibility was assured through web conference capabilities.

9.1 Summary of Public Comments

Of the 32 total comments received on the HIP waiver extension, six addressed the SUD/SMI components of the waiver. All were in support of continuation of the waiver and included feedback from the State's MCEs, as well as Covering Kids and Families, the Indiana State Medical Association and Indiana Hospital Association. Commenters noted the IMD waiver provides a more robust provider network, expands access to inpatient mental health services and reduces barriers to accessing behavioral health treatment. Further, commenters noted the importance of the waiver in assisting the State in addressing the opioid crisis and providing expanded access to evidence-based treatment.

The State appreciates the commenters support. As no requested changes to the SUD/SMI components of the waiver were noted by the commenters, no updates were made to the extension application in response.

9.2 Post Award Forum

In accordance with 42 CFR §431.420(c) and STC 10, the 1115 demonstration waiver post award forum was held on July 30, 2019 during a special meeting of the Medicaid Advisory Committee and was open to the public. Verbal comments provided during the forum were specific to the HIP components of the waiver. Additionally, a written comment was submitted from the National Alliance on Mental Illness Indiana expressing support for the SMI waiver amendment which was submitted to CMS on August 30, 2019.

9.3 Tribal Notice

In accordance with 42 CFR §431.408, notice of the waiver amendment was provided to Indiana's federally recognized tribe, the Pokagon Band of Potawatomi Indians, on November 1, 2019. The State received no comment in response.

Appendix 1: Public Notice

OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES ADMINISTRATION
NOTICE OF PUBLIC COMMENT PERIOD TO EXTEND THE HEALTHY INDIANA PLAN 1115 DEMONSTRATION

Pursuant to 42 CFR § 431.408(a), notice is hereby given that the Indiana Family and Social Services Administration (FSSA) will provide the public the opportunity to review and provide input on a proposed extension of the Healthy Indiana Plan Section 1115 demonstration waiver (HIP Waiver). This notice provides details about the waiver amendment submission and serves to open the 30-day public comment period, which closes on December 6, 2019.

In addition to the 30 day public comment period in which the public will be able to provide written comments to the FSSA via US postal service or electronic mail, the FSSA will host two public hearings in which the public may provide verbal comments. Hearings will be held at the following dates, times, and locations:

1) Tuesday, November 19th at 2:00 pm at the Indiana State Library, History Reference Room 211, 315 W. Ohio St., Indianapolis, IN 46202. This hearing will be a special session of the Medical Advisory Commission.
2) Wednesday, November 20th at 10:00 am at the Indiana Government Center South, Conference Room 18, 302 W. Washington St., Indianapolis, IN 46204. This hearing will be also be accessible via web conference at https://Indiana.AdobeConnect.com/indiana.

Prior to finalizing the proposed HIP Waiver extension, the FSSA will consider all the written and verbal public comments received. The comments will be summarized and addressed in the final version to be submitted to the Centers for Medicare and Medicaid Services (CMS).

EXTENSION PROPOSAL SUMMARY AND OBJECTIVES

The Healthy Indiana Plan (HIP) has been a feature of Indiana's Medicaid program since 2008. The current approval to operate HIP expires December 31, 2020. Based on the long-tenure and demonstrated success of HIP, FSSA is seeking a ten year extension of the HIP Waiver with no substantive changes. The extension request includes incorporation of the HIP Bridge Account amendment, which was submitted to CMS on July 25, 2019. FSSA will be requesting the following non-substantive, technical changes through the extension request:

- Flexibility to modify the POWER Account contribution tiers below average limit of three percent of member income, with appropriate notice to members, stakeholders and CMS, but without requiring the submission of a waiver amendment. Modifications are not currently proposed but could, for example, include increasing or decreasing the amounts of the POWER Account base contribution or the tobacco surcharge.
- Flexibility to modify the HIP Basic copayment amounts within the Medicaid allowable limits, with appropriate notice to members, stakeholders and CMS, but without requiring the submission of a waiver amendment. Modifications are not currently proposed but these modifications may include increases in copayment amounts within limits allowed for cost of

living increases, decreases in copayment amounts, or implementation of copayment waivers on target services.

Additionally, through this waiver extension application, FSSA is seeking federal approval for a five-year extension of the approved substance use disorder (SUD) and requested serious mental illness (SMI) components of the HIP Waiver. This includes authority to reimburse institutions for mental disease (IMDs) for short term stays for individuals diagnosed with SMI or SUD.

BENEFICIARIES & ELIGIBILITY

All current HIP eligibility limits and requirements will remain unchanged. HIP continues to target non-disabled adults between the ages of 19 and 64 with a household income less than less than 133 percent of the federal poverty level (FPL) with a 5 percent of income disregard, including individuals eligible for the adult group, including individuals eligible for the adult group, low- income parents and caretakers eligible under Section 1931 of the Social Security Act (Section 1931), pregnant women with income within the HIP limit, and individuals eligible for transitional medical assistance.

HIP includes Gateway to Work a community engagement initiative that connects HIP members with ways to look for work, train for jobs, finish school and volunteer. While eligibility suspensions for not completing Gateway to Work are on hold, this HIP Waiver extension requests the ability to continue the Gateway to Work program.

Additionally, all Medicaid enrollees ages 21-64, eligible for full Medicaid benefits, and with a SMI or SUD diagnosis would be eligible for short term stays in an IMD under the SUD and requested SMI component of the waiver extension.

The HIP Waiver extension includes incorporation of the HIP Bridge Account amendment, currently under review by CMS, under which Indiana proposes to adopt limited coverage for target individuals eligible in the group of adults who have income over the income eligibility level for the new adult group identified in § 1902(a)(10)(A)(ii)(XX) of the Social Security Act and in 42 CFR § 435.218. Individuals with MAGI-based income above 133% of the federal poverty level (FPL) who have lost HIP coverage solely due to an increase in income will be eligible for the defined benefit HIP Bridge Account for 12-months following HIP disenrollment. There will be no income limits on eligibility for the account.

ENROLLMENT & FISCAL PROJECTIONS

The HIP Waiver extension will have no impact on expected annual Medicaid enrollment as HIP is requested to be continued with no substantial changes. Further, it is expected to be budget neutral as outlined in the table below.

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	2021	2022	2023	2024	2025	
IMD Services MEG 1 (Fee-for-Service Inpatient)	$16,033,187	$16,987,010	$17,997,573	$19,068,244	$20,202,611	$90,288,625
IMD Services MEG 2 (Fee-for-Service Residential)	$5,130,495	$5,435,710	$5,759,076	$6,101,687	$6,464,681	$28,891,648
IMD Services MEG 3 (Managed Care)	$8,752,467	$9,273,174	$9,824,822	$10,409,288	$11,028,510	$49,288,261
TOTAL	$29,916,150	$31,695,893	$33,581,470	$35,579,219	$37,695,802	$168,468,534

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	2021	2022	2023	2024	2025	
IMD Services MEG 1 (Fee-for-Service Inpatient)	$16,033,187	$16,987,010	$17,997,573	$19,068,244	$20,202,611	$90,288,625
IMD Services MEG 2 (Fee-for-Service Residential)	$5,130,495	$5,435,710	$5,759,076	$6,101,687	$6,464,681	$28,891,648
IMD Services MEG 3 (Managed Care)	$8,752,467	$9,273,174	$9,824,822	$10,409,288	$11,028,510	$49,288,261
TOTAL	$29,916,150	$31,695,893	$33,581,470	$35,579,219	$37,695,802	$168,468,534

BENEFITS, COST SHARING, AND DELIVERY SYSTEM

The HIP Waiver extension does not propose any changes to benefits, cost sharing, or delivery system. However, it does incorporate the changes requested specific to the HIP Bridge Account amendment, currently under review by CMS, under which HIP members who qualify for the HIP Bridge Account will receive the benefits and cost sharing applicable to the HIP Bridge Account.

All HIP members will continue to receive a comprehensive benefit package, consistent with private market plans and compliant with all mandated essential health benefits as required by the Patient Protection and Affordable Care Act (ACA). The HIP benefit package does not include non-emergency transportation. Notwithstanding the foregoing, low-income parents and caretakers eligible under Section 1931, pregnant women, low-income 19 and 20-year-old dependents, individuals eligible for transitional medical assistance, and individuals identified as medically frail receive the same benefits as the Medicaid State Plan, including non-emergency transportation and other services not otherwise available to HIP members. Except for members receiving these HIP State Plan benefits, vision and dental services are only available through the HIP Plus plan. Participation in HIP Plus requires members to regularly contribute to their POWER account. The HIP Basic plan is only available to members below the federal poverty level who fail to make their monthly POWER account contributions. The HIP Basic plan does not cover vision and dental services and includes Medicaid allowable copayment amounts.

For all plans, preventive services, such as annual examinations, smoking cessation programs, and mammograms, are covered without charge to the members and are not included in the deductible amount. After the plan deductible is met by way of the $2,500 POWER account, the HIP program includes a comprehensive health plan benefits package.

All HIP medical benefits are currently provided through four (4) MCEs: Anthem, MDwise, Managed Health Services (MHS), and CareSource. Once an MCE has been selected, the member must remain in the MCE for 12 months, with limited exceptions. Members who do not select an MCE will be auto-assigned to an MCE have the opportunity to change the assigned MCE before the first POWER account contribution is made.

Enrollees receiving services under the SUD and requested SMI component of the waiver extension will continue to receive services through their current delivery system.

HYPOTHESES & EVALUATION

The HIP Waiver extension will not propose any changes to the evaluation design or hypotheses. Enhanced program goals, which include the below and will be incorporated into the existing evaluation design posted with the extension documentation, are proposed in the extension request. The enhanced program goals for the HIP extension include period the following:

- Provide timely and geographically appropriate access to healthcare services.
- Promote appropriate utilization of healthcare by maintaining low inappropriate use of the emergency department and supporting utilization of needed services from qualified non-emergency providers.
- Promote control of chronic conditions, delivery of needed care, and increase in member health and wellbeing.
- Increase community engagement leading to increased educational attainment, sustainable employment and member self-sufficiency.
- Reduce the number of uninsured Hoosiers, decrease gaps in coverage, and promote uptake of commercial insurance when leaving HIP.
- Meaningfully increase use of tobacco cessation services and meaningfully decrease tobacco use status for HIP members.

- Encourage healthy behaviors and appropriate care, including early intervention, prevention, and wellness.
- Leverage HIP policies to support the goals of HIP by promoting continuous coverage and improved health outcomes.
- Generate actionable information on social determinants of health.

WAIVER & EXPENDITURE AUTHORITY

FSSA requests an extension of all currently approved waivers and the waiver authority currently under review with CMS for the HIP Workforce Bridge amendment. As specified in the HIP Waiver extension, the requested waivers include:

1. **Premiums Section 1902(a)(14) insofar as it incorporates Section 1916 and 1916A**
   To enable the State to charge monthly contributions for HIP Plus at a minimum amount of one-dollar per month and not to exceed a maximum amount of three-percent of member income.

2. **Reasonable Promptness Section 1902(a)(8)**
   To the extent necessary to enable 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 individuals with incomes at or below 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 are found eligible through presumptive eligibility.

3. **Provision of Medical Assistance Sections 1902(a)(8) and 1902(a)(10)**
   To the extent necessary to enable Indiana to suspend eligibility for, and not make medical assistance available to, beneficiaries who fail to comply with community engagement requirements, unless the beneficiary is exempted.

4. **Eligibility Sections 1902(a)(10) and 1902(a)(52)**
   To the extent necessary to enable Indiana to make a determination of ineligibility, and terminate eligibility for, beneficiaries who are in a suspension of coverage for failure to meet the approved community engagement requirements, unless the beneficiary meets the requirement or is exempted as described in the STCs.

   To the extent necessary to enable Indiana to prohibit reenrollment, and deny eligibility, for up to six months, for individuals with income over 100 percent of the FPL who are disenrolled for failure to make POWER Account premium contributions within 60 days of the date of invoice, subject to the exceptions and qualifying events.

   To the extent necessary to enable Indiana to prohibit reenrollment, and deny eligibility, for up to three months following the end of the 90-day reconsideration period for individuals who are disenrolled for failure to provide the necessary information for the state to complete an annual redetermination, subject to the exceptions and qualifying events.

5. **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 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.

6. **Comparability and Amount, Duration and Scope of Services Sections 1902(a)(17) and 1902(a)(10)(B)**
To the extent necessary to enable the State to vary cost sharing requirements for beneficiaries for 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 copayment (for non-emergency use of the emergency department) and individuals who are in HIP Basic will be subject to copayments within Medicaid permissible levels.

To the extent necessary to enable Indiana to vary contribution requirements, for different HIP Plus program beneficiaries based on income and on tobacco use, and in a manner consistent with all otherwise applicable law. To allow for variations or waivers of POWER Account contribution requirements, within established limits, based on target initiatives such as encouraging uptake of employer insurance.

To allow the HIP Workforce Bridge Account to be available solely to defined eligible individuals that are disenrolled from HIP due to an increase in income.

To allow the State to provide only a limited defined benefit via the HIP Bridge Account, that is limited to cost sharing assistance up to an amount of $1,000, regardless of health care costs incurred by the member. To allow any balance payable in excess of $1,000, to be assigned to member responsibility without regard to cost-sharing limitations.

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

To enable the State not to provide three months of retroactive eligibility for beneficiaries receiving coverage through the HIP program as described in the STCs, except for pregnant women.

FSSA also requests extension of the following expenditure authorities that are currently approved or pending approval by CMS:

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 organizations (MCO) 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, except as described in the terms and conditions.
    b. 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(g) that automatic MCO reenrollment occur only if the beneficiary's disenrollment was due to a Medicaid eligibility lapse of two months or less, as described in the terms and conditions.

2. Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental disease (IMD) and expenditures for otherwise covered services furnished to otherwise eligible individuals for short term stays for acute care in a psychiatric hospital that qualifies as an IMD.

REVIEW OF DOCUMENTS & SUBMISSION OF COMMENTS

All information regarding the submission, including the public notice, the HIP Waiver extension, and other documentation regarding the proposal are available for public review at the FSSA, Office of General Counsel, 402 W. Washington Street, Room W451, Indianapolis, Indiana 46204. The full Public Notice and HIP Waiver documents are also available to be viewed online at https://www.in.gov/fssa/hip/.

Written comments may be sent to the FSSA via mail at 402 West Washington Street, Room W374, Indianapolis, Indiana 46204, Attention: Natalie Angel or via electronic mail at hip@fssa.in.gov through **December 6, 2019**.

Appendix 2: Abbreviated Public Notice

OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES
ADMINISTRATION
NOTICE OF PUBLIC HEARING

In accordance with 42 CFR §431.408(a)(2)(ii), the Indiana Family and Social Services Administration (FSSA) will be holding public hearings on a proposed extension of the Healthy Indiana Plan Section 1115 demonstration waiver (HIP Waiver) that will be submitted to the Centers for Medicare and Medicaid Services (CMS). The Healthy Indiana Plan (HIP) has been a feature of Indiana's Medicaid program since 2008. The current approval to operate HIP expires December 31, 2020. Through this submission, FSSA is seeking a ten year extension of the HIP Waiver with no substantive changes. The extension request includes incorporation of the HIP Bridge Account amendment, which was submitted to CMS on July 25, 2019. FSSA will be requesting the following non-substantive, technical changes through the extension request:

- Flexibility to modify the POWER Account contribution tiers below average limit of three percent of member income, with appropriate notice to members, stakeholders and CMS, but without requiring the submission of a waiver amendment. Modifications are not currently proposed but could, for example, include increasing or decreasing the amounts of the POWER Account base contribution or the tobacco surcharge.
- Flexibility to modify the HIP Basic copayment amounts within the Medicaid allowable limits, with appropriate notice to members, stakeholders and CMS, but without requiring the submission of a waiver amendment. Modifications are not currently proposed but these modifications may include increases in copayment amounts within limits allowed for cost of living increases, decreases in copayment amounts, or implementation of copayment waivers on target services.

Additionally, through this waiver extension application, FSSA is seeking federal approval for a five-year extension of the substance use disorder (SUD) and requested serious mental illness (SMI) components of the HIP Waiver. This includes authority to reimburse institutions for mental disease (IMDs) for short term stays for individuals diagnosed with SMI or SUD.

Hearings will be held as follows:

3) Tuesday November 19th at 2:00 pm at the Indiana State Library, History Reference Room 211, 315 W. Ohio St., Indianapolis, IN 46202. This hearing will be a special session of the Medical Advisory Commission.
4) Wednesday November 20th at 10:00 am at the Indiana Government Center South, Conference Room 18, 302 W. Washington St, Indianapolis, IN 46204. This hearing will be also be accessible via web conference at https://Indiana.AdobeConnect.com/indiana.

All information regarding the submission, including the public notice, the HIP Waiver extension, and other documentation regarding the proposal are available for public review at the FSSA, Office of General Counsel, 402 W. Washington Street, Room W451, Indianapolis, Indiana 46204. The full Public Notice and HIP Waiver documents are also available to be viewed online at https://www.in.gov/fssa/hip/.

Written comments may be sent to the FSSA via mail at 402 West Washington Street, Room W374, Indianapolis, Indiana 46204, Attention: Natalie Angel or via electronic mail at hip@fssa.in.gov through **December 6th, 2019 at 5:00 pm**.

Appendix 3: Tribal Notice

INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION
NOTICE OF TRIBAL COMMENT PERIOD FOR §1115 WAIVER EXTENSION

In accordance with 42 CFR § 431.408(b), notice is hereby given to the Pokagon Band of the Potawatomi that the Indiana Family and Social Services Administration (FSSA) will be seeking renewal of its Healthy Indiana Plan Section 1115 demonstration waiver (HIP Waiver) to the Centers for Medicare and Medicaid Services (CMS).

This notice also serves to open the **30-day tribal comment period, which closes December 1st at 5:00 pm.**

RENEWAL REQUEST SUMMARY

The Healthy Indiana Plan (HIP) has been a feature of Indiana's Medicaid program since 2008. The current approval to operate HIP expires December 31, 2020. Based on the long-tenure and demonstrated success of HIP, FSSA is seeking a ten year extension of the HIP Waiver with no substantive changes. The extension request includes incorporation of the HIP Workforce Bridge amendment, for which tribal notice was provided on May 15, 2019. FSSA will be requesting the following non-substantive, technical changes through the extension request:

- Flexibility to modify the POWER Account contribution tiers below average limit of three percent of member income, with appropriate notice to members, stakeholders and CMS, but without requiring the submission of a waiver amendment. Modifications are not currently proposed but could for example include increasing or decreasing the amounts of the POWER Account base contribution or the tobacco surcharge.
- Flexibility to modify the HIP Basic copayment amounts within the Medicaid allowable limits, with appropriate notice to members, stakeholders and CMS, but without requiring the submission of a waiver amendment. Modifications are not currently proposed but these modifications may include increases in copayment amounts within limits allowed for cost of living increases, decreases in copayment amounts, or implementation of copayment waivers on target services.

Additionally, through this waiver extension application, FSSA is seeking federal approval for a five-year extension of its substance use disorder (SUD) and requested serious mental illness (SMI) components of the HIP Waiver. This includes authority to reimburse institutions for mental disease (IMDs) for short term stays for individuals diagnosed with SMI or SUD.

TRIBAL IMPACT

As only technical changes related to POWER Account and cost sharing are proposed through this extension application, there will be no impact to tribal enrollees. Members of the Pokagon Band of the Potawatomi located in Indiana will continue to be eligible to obtain coverage under HIP when they meet the current criteria for eligibility. All eligible tribal members will also continue to receive HIP services in a manner consistent with federal regulations, including the American Recovery and Reinvestment Act of 2009, which in relevant part precludes states from imposing

Medicaid premiums or other cost-sharing on members of federally-recognized Indian tribes. As occurs today, all eligible tribal members who participate in the demonstration will be enrolled in the HIP Plus plan with no POWER Account contribution or cost-sharing requirements. Further, tribal members will continue to have the option to voluntarily participate in HIP. If an enrollment option is not specified, members will be enrolled in a managed care entity (MCE) by default, and will be given the option to disenroll and receive benefits through the Medicaid fee-for-service program. Pending CMS approval of the HIP Workforce Bridge Amendment, for which tribal notice was provided on May 15, 2019, those who opt to participate will receive an exemption to any active Gateway to Work requirements in place of the current activity credit received for participation in the Pathways program. Exempt members do not have a Gateway to Work requirement when it applies but may still access Gateway to Work resources and participate on a voluntary basis. In addition, tribal members will be eligible to receive the HIP Bridge Account, if applicable.

Additionally, through extension of FSSA's IMD waiver, members of the Pokagon Band of the Potawatomi located in Indiana and enrolled in full Medicaid benefits will continue to have access to: (1) short term stays for acute care in a psychiatric hospital that qualifies as an IMD; and (2) treatment and withdrawal management services for SUD in IMDs.

REVIEW OF DOCUMENTS AND SUBMISSION OF COMMENTS

Written comments may be sent to the FSSA via mail at 402 West Washington Street, Room W374, Indianapolis, Indiana 46204, Attention: Amy Owens or via electronic mail at amy.owens@fssa.in.gov **through December 1st, 2019**. Additionally, we would be happy to schedule a phone or in-person consultation to discuss the program in further detail.

MILLIMAN CLIENT REPORT

1115 Waiver – Healthy Indiana Plan

Second Renewal – Budget Neutrality

Expenditure authority for members with a substance use disorder or serious mental illness

Draft

State of Indiana

Family and Social Services Administration

October 30, 2019

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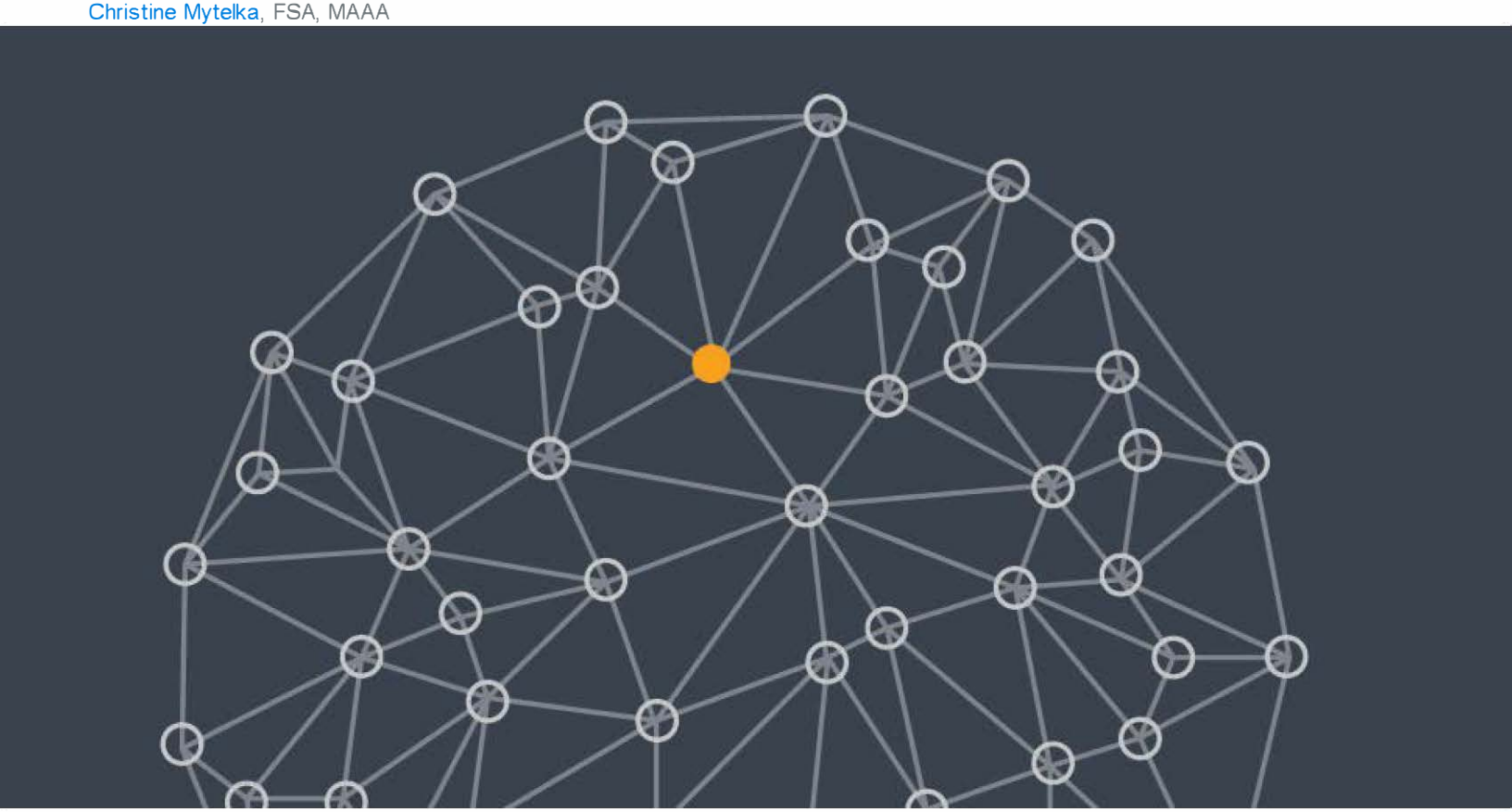

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BACKGROUND

The state of Indiana's current 1115 Healthy Indiana Plan (HIP) waiver, No. 11-W-00296/5, requests expenditure authority for adults who receive Substance Use Disorder (SUD) services delivered in an Institution for Mental Disease (IMD). Budget neutrality documentation for this Medicaid Eligibility Group (MEG) was provided in a report titled "*22-1115 Waiver Renewal – IMD only.pdf*" dated January 21, 2018. The current waiver has been approved for the period February 1, 2018 through December 31, 2020.

Based on the CMS letter[1] to State Medicaid Directors dated November 13, 2018, the state wished to revise the waiver to include Serious Mental Illness (SMI) services as well. The state submitted a waiver amendment reflecting the state's intention to transition from one MEG to three, effective January 1, 2020. Budget neutrality documentation for the waiver amendment was provided in a report titled *"02-1115 SUD SMI Budget Neutrality.docx"* dated July 23, 2019. This amendment is currently pending approval from CMS.

The state wishes to request a five-year waiver renewal for the period January 1, 2021 through December 31, 2025. The remainder of this report details the budget neutrality projections for this proposed waiver renewal.

EXECUTIVE SUMMARY

This report has been developed for the state of Indiana, Family and Social Services Association (FSSA) to document budget neutrality projections for the HIP 1115 waiver renewal. These projections reflect the MEGs proposed in the state's recently submitted waiver amendment, described in the "Background" section above.

For reference, the proposed MEGs are:

1. **Fee-for-service (FFS) intensive inpatient** – FFS member months for an adult aged 21-64 with a SUD or SMI intensive inpatient stay (ASAM level 4.0)
2. **FFS residential treatment** – FFS member months for an individual of any age with a SUD or SMI residential treatment (ASAM level 3.1 to 3.5)
3. **Managed care** – managed care member months for an adult aged 21-64 with a SUD or SMI intensive inpatient stay or an individual with a SUD or SMI residential treatment (ASAM level 3.1 to 4.0)

We estimated calendar year (CY) 2019 expenditures for each proposed population described above, including all Medicaid-funded expenses. For the managed care group, this includes capitation payments plus any carved out services administered under the FFS delivery system. We used CY 2019 estimated experience based on guidance communicated by CMS in a technical assistance call on October 7, 2019. Effective January 1, 2019, the hospital presumptive eligibility (PE) population, previously covered under managed care, transitioned to FFS. Due to this transition, it was decided that emerging 2019 experience would be more representative of the waiver renewal period than the most recently completed calendar year. Further details of the transition and the methodology used to estimate representative experience for the entire CY 2019 period are provided later in the "Hospital presumptive eligibility" section of this report.

For purposes of completing the budget neutrality template provided by CMS, we populated a placeholder assumption of 4.9% for the president's budget trend and a 1.0% enrollment trend rate for each MEG. However, it is our understanding that since the "IMD Without Waiver" and "IMD With Waiver" calculations are the same in the template, the CY 2019 PMPM values for each MEG are the primary information desired. This is also consistent with guidance communicated by CMS in various phone calls during the waiver amendment process.

Please refer to the Excel file named "*05-SMI IMD Budget Neutrality Template.xlsx*", included with the delivery of this report, to see the completed budget neutrality template. The remainder of this report details the data and methodology used to populate the template.

[1] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf

DATA, ASSUMPTIONS, AND METHODOLOGY

DATA

CY 2019 member months and expenditures were estimated based on enrollment, capitation payment, and claims data reported through the state of Indiana's Enterprise Data Warehouse (EDW), and originally provided by the fiscal agent. FFS enrollment and expenditure data reflect services reported as of September 30, 2019. Managed care enrollment and capitation data reflect information incurred through June 30, 2019 and reported as of July 31, 2019.

METHODOLOGY AND ASSUMPTIONS

The methodology used to determine the CY 2019 member months and expenditures is described below:

Fee-for-service methodology

FFS member months represent those individuals receiving residential treatment or intensive inpatient services in an IMD. Residential treatment was determined by procedure code, either H0010 or H2034. Intensive inpatient recipients were identified according to the IMD provider IDs included in Figure 1 below, and limited to adults ages 21-64. Individuals were accordingly assigned to either the residential treatment or intensive inpatient MEG. In the case where a recipient had both types of services in the same month, they were assigned to the intensive inpatient MEG.

FIGURE 1: INSTITUTIONS FOR MENTAL DISEASE (IMD) – INDIANA HEALTH COVERAGE PROGRAM

Billing Provider ID*	Provider Name
100273400	Valle Vista Health System
100273450	Fairbanks Hospital
100273680	Bloomington Meadows Hospital
200029610	Northern Indiana Hospital, Plymouth
200240620	Deaconess Cross Pointe, Evansville
200484350	Michiana Behavioral Health
200813230	Wellstone Regional Hospital
200903750	Harsha Behavioral Center Inc
200968000	Brentwood Meadows LLC
201050770	Options Behavioral Health System
201110540	Sycamore Springs LLC
201292260	Assurance Health Psychiatric Hospital

*AIM billing provider ID. In CORE, a location code may be appended.

Once the eligible recipient-months were identified as described above, we summarized all FFS expenditures for those months in which they received residential treatment or intensive inpatient services. We included all expenditures, not just the applicable SUD/SMI expenditures, because without the waiver these members would not be eligible for Medicaid during months in which they received treatment in an IMD.

Managed care methodology

Managed care member months were identified in the same manner as FFS. The only distinction is that there is only one managed care MEG for residential treatment and intensive inpatient services combined.

Once the eligible recipient-months were identified as described above, we summarized all expenditures for those months in which they received residential treatment or intensive inpatient services. Again, we included all expenditures, not just the applicable SUD/SMI expenditures, because without the waiver these members would not be eligible.

The expenditures for the managed care recipients consist of two components: capitation payments and services administered under the FFS delivery system.

Capitation payments

Capitation payments were calculated for each member based on their managed care rate cell. The capitation rates currently included in the EDW do not correspond to the latest CY 2019 capitation rates that will ultimately be paid. As such, we adjusted the capitation payments to include the impact of CY 2019 rates that are not yet reflected in the EDW.

Services administered under FFS

While capitation payments represent the bulk of expenditures for the managed care population, there are some services carved out of managed care that are administered via the FFS delivery system that also must be included. Examples of these carve-outs include some high-cost drugs, such as Hepatitis C therapies, and Medicaid Rehabilitation Option (MRO). The carved out claims expenditures for the applicable member months were added to the capitation payments to reflect the comprehensive total cost for this MEG.

Hospital presumptive eligibility

As of January 1, 2019, PE members began enrolling in FFS, rather than managed care. Due to this program change, there was a significant shift in enrollment and expenditures from the managed care MEG to FFS in CY 2019. Based on CMS guidance, we have reviewed and extrapolated emerging 2019 experience to develop the CY 2019 starting point for the budget neutrality projections.

CY 2019 projection

The FFS and managed care data described above was summarized by MEG, month, and Medicaid/Medicare dual eligibility status. Dual eligibility status was considered because the PE population is primarily non-dual, in contrast to most other members receiving IMD services through the state's FFS delivery system, who are predominantly dual eligible. The influx of non-dual IMD members into FFS is expected to increase average PMPM expenses since their costs are not shared with Medicare.

The monthly data was reviewed to identify the impact of the PE transition and select appropriate stable time periods to project the partial year emerging experience to a full calendar year. The different population stratifications were extrapolated as follows:

1. **FFS duals** – This population is not expected to change significantly as a result of the transition. Therefore, the average enrollment and PMPM expenditures from the first six months of 2019 were assumed to be representative of the entire CY 2019.
2. **FFS non-duals** – Effective May 1, 2019, the state changed the IMD reimbursement policy for PE individuals[2], producing a subsequent increase in enrollment and expenditures over the first four months of the year. The following four months, May through August, are more indicative of the expected ultimate levels of enrollment and expenditures. Therefore, we developed CY 2019 projections as if this policy were in force all year to more accurately represent renewal year experience.
3. **Managed care** – The managed care data is from an earlier time period than the FFS data and also appears to be incomplete in the later months. Consequently, the average member months and PMPM expenditures from the first three months of 2019 were assumed to be representative of the entire CY 2019.

Figure 2 below shows the calculation of the CY 2019 estimated values. The significant differences compared to CY 2018 experience underscore the need to use this alternative basis for budget neutrality projections. The decision to use FFS non-dual eligible experience after the May 2019 policy change is also supported by the table.

[2] http://provider.indianamedicaid.com/ihcp/Bulletins/BT201926.pdf

FIGURE 2: CALCULATION OF CY 2019 ESTIMATED EXPERIENCE

		TOTAL			FFS INTENSIVE INPATIENT DUAL ELIGIBLE			NON-DUAL ELIGIBLE		
	TIME PERIOD	EXPENDITURES	MEMBER MONTHS	PMPM	EXPENDITURES	MEMBER MONTHS	PMPM	EXPENDITURES	MEMBER MONTHS	PMPM
	CY 2018	$ 2,461,870	1,085	$ 2,269.00	$ 2,115,531	1,043	$ 2,028.31	$ 346,339	42	$ 8,246.17
(a)	201901-201904	2,200,801	380	5,791.58				2,200,801	380	5,791.58
(b)	201905-201908	4,119,097	621	6,633.01				4,119,097	621	6,633.01
(c)	201901-201906	962,969	463	2,079.85	962,969	463	2,079.85			
	Estimated CY 2019	**$ 14,283,229**	**2,789**	**$ 5,121.27**	**$ 1,925,938**	**926**	**$ 2,079.85**	**$ 12,357,290**	**1,863**	**$ 6,633.01**
	Extrapolation Formula				*(c) * 2*	*(c) * 2*		*(b) * 3*	*(b) * 3*	

		TOTAL			FFS RESIDENTIAL TREATMENT DUAL ELIGIBLE			NON-DUAL ELIGIBLE		
	TIME PERIOD	EXPENDITURES	MEMBER MONTHS	PMPM	EXPENDITURES	MEMBER MONTHS	PMPM	EXPENDITURES	MEMBER MONTHS	PMPM
	CY 2018	$ 288,642	72	$ 4,008.92	$ 160,220	50	$ 3,204.40	$ 128,422	22	$ 5,837.37
(a)	201901-201904	1,612,605	352	4,581.26				1,612,605	352	4,581.26
(b)	201905-201908	1,371,923	293	4,682.33				1,371,923	293	4,682.33
(c)	201901-201906	227,378	56	4,060.32	227,378	56	4,060.32			
	Estimated CY 2019	**$ 4,570,523**	**991**	**$ 4,612.03**	**$ 454,755**	**112**	**$ 4,060.32**	**$ 4,115,768**	**879**	**$ 4,682.33**
	Extrapolation Formula				*(c) * 2*	*(c) * 2*		*(b) * 3*	*(b) * 3*	

		TOTAL			MANAGED CARE DUAL ELIGIBLE			NON-DUAL ELIGIBLE		
	TIME PERIOD	EXPENDITURES	MEMBER MONTHS	PMPM	EXPENDITURES	MEMBER MONTHS	PMPM	EXPENDITURES	MEMBER MONTHS	PMPM
	CY 2018	$ 10,025,712	9,480	$ 1,057.56	$ 54,418	47	$ 1,157.83	$ 9,971,294	9,433	$ 1,057.07
(a)	201901-201903	1,949,299	1,863	1,046.32	6,936	6	1,155.96	1,942,363	1,857	1,045.97
	Estimated CY 2019	**$ 7,797,196**	**7,452**	**$ 1,046.32**	**$ 27,743**	**24**	**$ 1,155.96**	**$ 7,769,453**	**7,428**	**$ 1,045.97**
	Extrapolation Formula				*(a) * 4*	*(a) * 4*		*(a) * 4*	*(a) * 4*	

Note that the managed care member months and expenditures for CY 2018 are higher than what was shown in the recently submitted waiver amendment due to a change in the HIP monitoring logic; however, the PMPMs remain similar.

Limitations

The information contained in this report has been prepared for the state of Indiana, Family and Social Services Administration (FSSA) to assist with the development of budget neutrality for the HIP 1115 waiver renewal to be submitted to the Centers for Medicaid and Medicare Services (CMS). The data and information presented may not be appropriate for any other purpose.

It is our understanding that the information contained in this report may be utilized in a public document. To the extent that the information contained in this correspondence is provided to any third parties, the correspondence should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

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Milliman has relied upon certain data and information provided by the state of Indiana, Family and Social Services Administration and their vendors. The values presented in this letter are dependent upon this reliance. To the extent that the data was not complete or was inaccurate, the values presented in our report will need to be reviewed for consistency and revised to meet any revised data.

The services provided for this project were performed under the signed Consulting Services Agreement between Milliman and FSSA approved December 5, 2018.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries, and meet the qualification standards for performing the analyses in this report.

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