Indiana Family and Social Services Administration

Healthy Indiana Plan (HIP)
Section 1115 Waiver Extension Application

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Contents

Section 1: Executive Summary

The Healthy Indiana Plan (HIP) is the nation's first consumer-driven health plan for Medicaid beneficiaries. Since 2008, the HIP model has demonstrated remarkable success in transforming beneficiaries into engaged participants and improving health outcomes. The expanded "HIP 2.0" program has seen consistent results since 2015, proving that HIP's consumer driven model is scalable and remains successful in empowering enrollees to become active consumers of healthcare services.

HIP offers low-income Hoosiers a high deductible consumer-driven health plan paired with a Personal Wellness and Responsibility (POWER) account, similar to a health savings account. The POWER Account, valued at $2,500, pays for the full cost of the plan deductible. The POWER account contains contributions made by the State as well as the required monthly contributions from the member, equal to two percent (2%) of income. The POWER account gives participants "skin-in-the-game" and provides a financial incentive for members to become more invested and engaged in their healthcare by adopting healthy behaviors and to seek price transparency to make value conscious decisions, leading to better outcomes, including higher rates of primary and preventive care and lower emergency room usage.

Members are encouraged to actively manage their POWER account through the opportunity to rollover member funds remaining in the account at the end of the benefit period. The rollover amount may be doubled if the member obtains recommended preventive services during the benefit period. Any funds rolled over to the subsequent benefit period are used to offset the member's future required contributions to the plan. After their first year of enrollment, over 62% of all HIP members successfully managed to maintain a balance in their POWER account, and nearly half of all members (48%) earned the rollover incentive, with an average amount of $113.00 to offset future contribution requirements.[1]

In addition, HIP has introduced several market principles that align with standard commercial market policies to educate members and prepare them to eventually participate in the private market. First, unlike traditional Medicaid, HIP does not provide retroactive coverage, rather, HIP benefits become effective after the member makes a POWER account contribution (similar to premium payments required in commercial plans). In addition, similar to the commercial market, HIP offers members several benefit package options. The HIP Plus plan is the standard plan option, providing comprehensive benefits and requiring regular monthly POWER account contributions. HIP members with income at or below the federal poverty level who choose not to contribute to their POWER account are transferred to the reduced HIP Basic plan, which offers a more limited benefit package (for example not covering vision or dental services) and applies copayments to all healthcare services. While members at or below the poverty level transfer to the HIP Basic plan following non-payment and a 60-day grace period, members with income greater than the poverty level are terminated from HIP for six months. In addition to the HIP Plus and HIP Basic plan options, HIP includes the HIP Employer Link option which supports HIP eligible individuals enroll in their employer sponsored coverage in lieu of the standard HIP program.

[1] Indiana Family and Social Services Administration, Administrative Data, 2017.

The design of HIP provides a combination of complementary incentives and disincentives, intended to create a significant value proposition to incentivize members to proactively invest in their healthcare. This program design has been successful in encouraging active engagement as nearly two-thirds of all members are choosing to proactively make monthly contributions into their POWER account.[2] Despite the option for members below the poverty level to participate in the HIP Basic plan which does not require monthly contributions, almost 85% of these individuals are choosing to regularly contribute to their healthcare.[3] Further, members have found the monthly contributions are affordable, as the majority of surveyed members (90% of HIP Basic, and 80% of HIP Plus) indicated that they would be willing to pay more for HIP.[4] Further, only 5% of members who left the program did so for affordability reasons, while most (52%) left due to increased income and/or access to private market insurance.[5]

In addition, the POWER account has helped engage members and educate them about the cost of healthcare in a way that traditional Medicaid is unable to do. Among members who reported having a POWER Account, 40% of HIP Plus and 30% of HIP Basic members reported checking their POWER Account balance monthly, and nearly one in four HIP Plus members surveyed (27%) reporting asking their provider about the cost of care.[6] While an early member survey conducted within months of the program implementation found that only 48% and 35% of HIP Plus and HIP Basic members, respectively, understood they had a POWER account, the same evaluation found that nearly 97% and 78% of HIP members above and below the poverty level, respectively, understood that POWER account contributions were required to maintain HIP Plus coverage.[7] This fundamental understanding of the program structure is demonstrated by the fact that over two-thirds of HIP members choose to make regular contributions to their POWER account, even though the majority of members are not required to do so as a condition of eligibility. Finally, members making monthly contributions to their POWER account were more satisfied with the program than individuals who did not contribute to the account (86% to 71%).[8]

HIP has achieved extraordinary improvements in healthcare utilization patterns as compared to a traditional Medicaid model that provides little incentive for participants to consider the cost of their publicly funded care or to take personal responsibility for their health. The recent independent evaluation of the HIP found that members who contributed to their POWER Accounts (versus members who did not contribute) were twice as likely to obtain primary care (31% to 16%); had better drug adherence (84% to 67%); and relied less on the emergency room for treatment (775 to 1,034 visits per 1,000 member years).[9] Further, 87% of HIP Plus members used preventive health services during their first year of enrollment.[10]

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[2] THE LEWIN GROUP, INDIANA HEALTHY INDIANA PLAN 2.0 INTERIM EVALUATION REPORT (2016), *available at* http://www.in.gov/fssa/hip/files/Lewin_IN%20HIP%202%200%20Interim%20Evaluation%20Report_FINAL.pdf.

[3] *Id*.

[4] *Id*.

[5] *Id*.

[6] *Id*.

[7] *Id*.

[8] *Id*.

[9] *Id*.

[10] *Id*.

Through this waiver request, the State aims to continue its highly successful HIP demonstration waiver program for the maximum waiver extension period of three years in its current form with minor technical revisions, updates and enhancements aimed at improving member health outcomes through coordinated efforts targeting tobacco cessation, substance use disorder, chronic disease management, and increased employment among HIP members. In addition to the proposed enhancements in HIP, this waiver request also seeks to target one of the more pressing health challenges facing the State—substance use disorder. The State seeks to expand access to critical mental health and substance use disorder services to all Medicaid recipients.

Section 2: Historical Narrative and Program Description

2.1 Historical Narrative

2.1.1 Program History

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 Center for Medicare & Medicaid Services (CMS) approval, HIP began enrolling working-age, uninsured adults in coverage on January 1, 2008.

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 Ind. 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 the Healthy Indiana Plan, operated in a manner consistent with the statutory provisions.

2.1.2 HIP 2.0 Implementation & Current Operations

Immediately upon receiving CMS approval for HIP 2.0 on January 27, 2015, the State began accepting applications for the HIP program. Services began just days later, as the enhanced HIP 2.0 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 2.0 by the end of the first quarter of operations, and to date HIP has continued to meet its enrollment goals with over 394,000 individuals fully enrolled in HIP as of December 1, 2016.
The State also implemented new features of the program during the first year, including 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. Other innovative features enhanced during the first year included the rollout of debit cards that allow members to make payments directly from their POWER account at the point of service and the ability for members to pay POWER account contributions to all MCEs at no additional charge at Wal-Mart locations. The State also rolled out enhancements including presumptive eligibility for the HIP population, including the addition of new providers that can make presumptive eligibility determinations including county health departments, federally qualified health centers, rural health centers, and community mental health centers. HIP presumptive eligibility integrates directly with HIP coverage by leveraging the same MCEs that provide HIP coverage and providing the fast track prepayment option to allow individuals found eligible to expedite their enrollment into HIP. 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. In addition, 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.

Beyond the HIP enhancements, the State implemented the HIP Employer Link program which provides HIP eligible individuals support to enroll in their employer sponsored insurance instead of HIP coverage. HIP Employer Link provides individuals with the benefits available on their employer-sponsored health insurance (ESI) plan through the provision of a $4,000 HIP Link POWER account. This account reimburses enrollees for the costs associated with the ESI plan, including premium costs that are in excess of the required monthly POWER account contribution and other out of pocket cost sharing (such as copayments) up to the $4,000 account limit. The HIP Employer Link program was operationalized following the approval of HIP 2.0. The development of HIP Employer Link included full design and testing of an online employer portal to allow for employer submission of health plan benefits and premium information as well as employer verification of participating employees. In November 2016, with the program fully operational, the State launched a new outreach campaign, which included rebranding the program to HIP Employer Link. The new campaign transitioned the existing outreach materials, such as the employer manual, employee handbook, member eligibility cards and other public facing materials to include the new logo and program name. In addition to the rebranding efforts, the State simultaneously launched a marketing campaign, which included a redesigned website, radio ads, program videos, and other similar marketing activities and materials. At the time of waiver submission, the HIP Employer Link outreach and marketing campaign is ongoing.

The State also coordinated with CMS on the approvals of three separate alternative benefit plans (ABPs) for HIP and HIP Employer Link, which detail the provision of benefits for members in the expansion population and index benefits to commercial market benefit packages. The HIP

Link ABP broke new ground by being the first approved ABP for employer sponsored insurance and the first to set three separate commercial market based benefit options.

Indiana has implemented a strong operational foundation through consistent communication with vendors and other stakeholders. In fact, to maximize public-relations initiatives, both member and other stakeholder research was used to inform the strategic plan to promote HIP 2.0. In addition, a team of experts from the State provided standard language on various HIP 2.0 written materials including, but not limited to: (i) member information, (ii) provider credentialing information, (iii) public promotional material, and (iv) MCE policy and procedure documentation. Further, since implementation, the HIP operations team has worked to develop a strong internal monitoring process, including regular program reporting and daily review of program metrics. This foundation has been in place since the start of the HIP waiver, and it will continue to support the waiver in the extension period.

In addition, to the enhanced operational processes, Indiana developed a specialized unit, the Customer Service Team (CST), to handle and streamline unique member concerns and identify any possible underlying systemic issues as quickly as possible. Processes have been put in place to triage member concerns and elevate issues in a manner seamless to the members. Member complaints received by the State or MCE call centers are reviewed, and any issues that require manual attention to resolve are elevated to CST. The CST coordinates responses across the various vendors and their respective systems to ensure accurate and timely resolution of member concerns. The prompt and coordinated member issue resolution process supported by the CST over the first two years of the HIP program has promoted ongoing operational success of the HIP program.

The HIP team has also met all of the submission deadlines for the protocols and reports that are required by the CMS Special Terms and Conditions (STCs). This includes the regular quarterly reporting and evaluation reporting, as well as completion of reports specific to the HIP program. While the State's submissions have been timely, due to approval delays some studies have been delayed. For example the study of the emergency room copayment could not be started on time due to delays of CMS approval of the study methodology. Ultimately, the HIP program has been documented through the numerous mandated protocols, reports, and evaluation documents required to be submitted throughout the demonstration period, including:

1. Retroactive Coverage Reporting;
2. Prior Claims Payment Program Reporting;
3. Presumptive Eligibility Report on Qualified Entities and Training;
4. Presumptive Eligibility Standards;
5. HIP Employer Link Protocol;
6. POWER Account Contributions and Copayments Infrastructure Operational Protocol;
7. POWER Account Contributions and Copayments Monitoring Protocol;
8. Emergency Room Copayment Protocol;
9. Annual Report on Provider Payment Rates;
10. Demonstration Annual Report;
11. Comprehensive State Quality Strategy;
12. Submission of Draft Evaluation Design;

13. NEMT Evaluation;
14. HIP Plus POWER Account Contribution Evaluation;
15. Emergency Department Copayment Evaluation;
16. Retroactive Coverage Evaluation;
17. Interim Evaluation Report; and
18. Final Evaluation Design and Implementation.

The STCs specifically set forth that the results of several of the reports would determine continuation of the applicable policy. For example, the non-emergency medical transportation (NEMT) waiver was limited to one-year pending the results of the NEMT evaluation. Due to delays in approving the NEMT evaluation design, CMS temporarily extended the NEMT waiver through November 30, 2016 to allow more time for adequate data collection. Following the completion of two distinct member surveys and program evaluations by a third-party independent evaluator, on August 1, 2016, Indiana requested an amendment of the HIP demonstration project to extend the NEMT waiver. Based on the favorable findings of the two evaluations, on November 25, 2016, CMS approved the amendment to extend the NEMT waiver for the duration of the demonstration period.

2.2 Program Description

HIP's consumer-driven health plan paired with the unique health savings account-like account, the POWER account, gives participants a financial incentive to adopt healthy behaviors and to proactively seek price and quality transparency to make value conscious health care decisions. HIP offers members three benefit packages—HIP Plus, HIP Basic, and HIP Employer Link. The enhanced benefits of the HIP Plus plan, which are only available to members making regular monthly contributions to their POWER account, create a significant value proposition to incentivize members to proactively invest and engage in their healthcare. Members with income at or below the federal poverty level are transferred to the HIP Basic plan if they do not make their contributions. The HIP Basic plan offers a more limited benefit package (for example not covering vision or dental services) and applies copayments to all healthcare services. By contrast, members with family income above the poverty level will be terminated from HIP for non-payment of required monthly contributions, consistent with commercial market policies. These members do not have access to the HIP Basic plan and cannot re-enroll for six months. Notwithstanding the foregoing, individuals determined medically frail, regardless of income, are exempt from non-payment penalties and do not lose benefits due to non-payment of POWER account contributions.

Unlike traditional premiums or copayments, HIP members own their POWER account contributions and are entitled to their portion of unused contributions when they leave the program. Due to the direct financial investment in the POWER account, HIP members are incentivized to manage their accounts judiciously and to take advantage of free preventive care services offered by the plan outside of the member's POWER account. For this reason, POWER accounts remain a critical feature of HIP and are provided to every HIP member, regardless of their benefit plan. To further incentivize healthy behaviors, members who obtain preventive services are eligible to reduce their future POWER account contributions amounts. Through the combination of incentives and disincentives, HIP has been able to actively engage HIP members in their healthcare and achieve improved outcomes as compared to traditional Medicaid.

2.1.1 Eligibility

HIP targets non-disabled adults between the ages of 19 and 64 with a household income less than 138% FPL, including individuals eligible for the adult group, low-income parents and caretakers eligible under Section 1931, and individuals eligible for transitional medical assistance. Individuals who become pregnant while on HIP may continue to be covered by the HIP program for the remainder of their current benefit period before transitioning to the Hoosier Healthwise program- Indiana's Medicaid program for children and pregnant women.

2.1.2 Benefits

All HIP members receive a comprehensive benefit package, consistent with private market plans and compliant with all mandated essential health benefits as required by the ACA. However, the HIP benefit package is more consistent with commercial plan benefits and does not include chiropractic services or non-emergency transportation. Notwithstanding the foregoing, low-income parents and caretakers eligible under Section 1931, low-income 19 and 20 year old dependents, individuals eligible for transitional medical assistance, and individuals identified as medically frail, will receive the same benefits as on the Medicaid State Plan, including non-emergency transportation and chiropractic services not otherwise available to HIP members. Except for members receiving State Plan benefits, vision and dental services are only available through the HIP Plus plan. Participation in HIP Plus requires members to regularly pay monthly contributions 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 is a more limited benefit plan, and does not cover vision and dental services.

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 of $2,500. After the plan deductible is met by way of the $2,500 POWER account, the HIP program includes a comprehensive health plan benefits package.

Individuals enrolled in HIP Employer Link receive the benefits provided by their employer sponsored health plan and not the HIP Basic or Plus benefits. All approved employer sponsored health plans are reviewed by the HIP Employer Link team to ensure compliance with the benefit requirements.

2.1.3 Cost-Sharing

Each HIP member is provided a POWER account valued at $2,500 to pay for the cost of the plan deductible. The POWER account contains contributions made by the State as well as the required monthly contributions from the member. Member contributions are equal to two percent (2%) of income, but in no event will a member contribute less than $1.00 per month or more than $100.00 per month. By contrast, members not paying monthly POWER account contributions participating in HIP Basic are required to make copayments for all services. The copayments are established at maximum Medicaid allowable rates, ranging from $4 per office visit up to $75 per hospital stay, making it potentially more expensive than HIP Plus. Consistent with CMS rules, the program ensures that no member pays more than five percent (5%) of their income, except that HIP Plus requires a minimum $1.00 contribution, even among individuals with no reported income.

Consistent with commercial market practices, applicants are required to make their first month's POWER account contribution prior to the start of benefits. Once an individual pays the POWER account contributions, benefits begin the first day of the month in which the contribution was received. However, in order to expedite coverage, applicants are provided the opportunity to pay a ten dollar ($10.00) fast track POWER account prepayment, while their eligibility application is being processed to accelerate enrollment into the HIP Plus. Individuals with income below the federal poverty level who have not made their initial fast track prepayment or first monthly POWER account contribution within 60 days of invoice will be enrolled in the HIP Basic plan beginning the first day of the month of the expiration of the payment period. Individuals above the poverty level who do not make their first monthly POWER account contribution are not enrolled in HIP and must reapply for coverage and make a contribution to access benefits.

Other than the monthly contributions to the POWER account, the only other cost-sharing for HIP Plus members are copayments for non-emergency use of hospital emergency departments. HIP non-emergency use of hospital emergency copayments equal $8.00 for the first inappropriate visit, and $25.00 for each subsequent visit.

Individuals enrolled in HIP Employer Link have the payment for their employer sponsored insurance deducted from their pay check and receive a check in advance from their HIP Employer Link POWER account to cover the difference between their 2% of income contribution, and the amount their employer deducts for insurance. HIP Employer Link enrollees do not have any cost sharing applied to covered services, provided there are funds remaining in the individuals POWER account.

Section 3: Program Evaluation

Data from an independent evaluation of the HIP program indicates that HIP 2.0 is successfully meeting its goals in delivering affordable consumer-driven healthcare across Indiana. In its first year, HIP 2.0 provided coverage to 345,656[11] individuals, which exceeds the projected enrollment of 319,886.[12] In addition to surpassing enrollment estimates, HIP 2.0 is expanding access to healthcare among those who may not otherwise be able to obtain or afford it, as 60%[13] of members who enrolled into HIP 2.0 were previously uninsured.

A fundamental goal of HIP 2.0 is to promote personal accountability in consumer healthcare behavior, and the evidence demonstrates that HIP 2.0 is achieving this goal. An average of 70% of HIP 2.0 members choose to contribute to their Personal Wellness and Responsibility (POWER) account to enroll into HIP Plus, and over 92% of members continue to contribute

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[11] THE LEWIN GROUP, INDIANA HEALTHY INDIANA PLAN 2.0 INTERIM EVALUATION REPORT (2016), *available at* http://www.in.gov/fssa/hip/files/Lewin_IN%20HIP%202%200%20Interim%20Evaluation%20Report_FINAL. Total number members enrolled in HIP for at least one month.

[12] MILLIMAN, 1115 WAIVER – HEALTHY INDIANA PLAN EXPANSION PROPOSAL (2014), *available at* https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-Expansion-Proposal-06232014.pdf.

[13] THE LEWIN GROUP, INDIANA HEALTHY INDIANA PLAN 2.0 INTERIM EVALUATION REPORT (2016), *available at* http://www.in.gov/fssa/hip/files/Lewin_IN%20HIP%202%200%20Interim%20Evaluation%20Report_FINAL.

throughout their enrollment.[14] Moreover, nearly 60% of these members check the balance of their POWER account, and 40% check their balance at least once a month.[15] Importantly, HIP 2.0 is achieving its goals even amongst the very poor, as 86% of members who choose to contribute to participate in HIP Plus have incomes below the federal poverty level (FPL).[16] This demonstrates that HIP's promotion of value-based decisions among members is working, as members with income below the FPL have the option to not contribute, and accept a lower-value healthcare benefit package known as HIP Basic.

HIP's goal of promoting personal responsibility is driven by the research which indicates that individuals who are vested in their healthcare have better health outcomes.[17] The independent Interim Evaluation of HIP 2.0 confirms the principle of personal responsibility in healthcare, and finds that HIP members who contribute are twice as likely to obtain primary care (31% to 16%), have better prescription drug adherence (84% to 67%), and rely less on the emergency room for routine treatment (775 to 1,034 visits per 1,000 member years), compared to members who choose not to contribute.[18] Further, among members enrolled for the first full twelve months of the program, HIP Plus members obtained more preventive care services than HIP Basic members (87% to 62%).[19] Just as important, HIP members themselves have embraced the value of personal responsibility, as evidenced by the fact HIP Plus members who contribute to their POWER account are more likely to report being satisfied with the program (86%) as compared to HIP Basic members (71%) who are not required to financially contribute to their account. Moreover, 95% of HIP Plus members would re-enroll if they left the program and became eligible again, and 80% would *pay more* to be in the program.[20]

In addition to successfully engaging members, HIP 2.0 is also attracting more healthcare providers. HIP maintains the reimbursement rates established by the original HIP program, which compensates HIP providers at higher Medicare reimbursement rates (or 130% of Medicaid reimbursement rates where a comparable Medicare rate does not exist). This policy initiative has enabled Indiana to add over 6,700[21] new providers to serve both Medicaid and HIP members since the implementation of HIP 2.0. Importantly, almost 30% of providers surveyed indicated they have seen a decline in bad debt, and nearly 40% of providers have seen a reduction in charity care since the introduction of HIP 2.0.[22]

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[14] *Id*.

[15] *Id*.

[16] *Id*.

[17] ROBERT WOOD JOHNSON FOUNDATION, INFOGRAPHIC: STABLE JOBS = HEALTHIER LIVES (2013), *available at* http://www.rwjf.org/content/dam/files/rwjf-web-files/Infographics/Better%20Jobs%20Healthier%20Lives%20Infographic.pdf.

[18] THE LEWIN GROUP, INDIANA HEALTHY INDIANA PLAN 2.0 INTERIM EVALUATION REPORT (2016), *available at* http://www.in.gov/fssa/hip/files/Lewin_IN%20HIP%202%200%20Interim%20Evaluation%20Report_FINAL.

[19] *Id*.

[20] *Id*.

[21] Indiana Family and Social Services Administration, Office of Medicaid Management and Policy (2016).

[22] THE LEWIN GROUP, INDIANA HEALTHY INDIANA PLAN 2.0 INTERIM EVALUATION REPORT (2016), *available at* http://www.in.gov/fssa/hip/files/Lewin_IN%20HIP%202%200%20Interim%20Evaluation%20Report_FINAL.

The following sections provide a detailed analysis on the accomplishments of HIP 2.0.

3.1 Progress on Program Goals

3.1.1 Reduce the number of uninsured, low income Hoosiers and increase access to healthcare services.

Independent analysis of the available data demonstrates that HIP 2.0 has reduced the number of uninsured, low income Hoosiers. In its first year, HIP 2.0 provided coverage to 345,656 unique individuals, which exceeded the projected enrollment count of 319,886 cited to meet budget neutrality.[23] Specific data regarding the reduction in the number of uninsured, low-income Hoosiers is seen in the fact 60% of HIP members were previously uninsured.[24]

Analyses also indicate that HIP is increasing access to healthcare services in two important ways. First, HIP has added over 6,700 new healthcare providers to serve both Medicaid and HIP members. [25] Moreover, HIP requires that each of its three managed care entities (MCEs) ensure that their assigned members have access to a primary medical provider within 30 miles of their residence, and all three MCEs have met this requirement.[26] HIP also requires that each MCE ensure that their assigned members have access to a vision provider and dental provider within 60 miles of their residence, and all three MCEs have met this requirement.[27]

In addition, HIP has been successful in helping low-income individuals maintain access to health insurance through affordable contributions. Approximately 70% of HIP members have elected to enroll in HIP Plus, and more than 92% of members have consistently contributed on a monthly basis to their POWER account.[28] In addition, nearly 90% of HIP members have income below the federal poverty level, demonstrating that participating in HIP is affordable even among very low-income members.[29] In addition, the HIP evaluation member survey found that over half (52%) of members who left the program did so because their income increased or because they acquired private insurance, while only 5% of members surveyed reported leaving the program due to affordability.[30] Further, 80% of HIP Plus members reported being willing to pay more to stay in the program, and 95% reported that they would try to re-enroll in the program if they left and became eligible again.[31]

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[23] MILLIMAN, 1115 WAIVER – HEALTHY INDIANA PLAN EXPANSION PROPOSAL (2014), *available at* https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-Expansion-Proposal-06232014.pdf.

[24] THE LEWIN GROUP, INDIANA HEALTHY INDIANA PLAN 2.0 INTERIM EVALUATION REPORT (2016), *available at* http://www.in.gov/fssa/hip/files/Lewin_IN%20HIP%202%200%20Interim%20Evaluation%20Report_FINAL.

[25] Indiana Family and Social Services Administration, Office of Medicaid Management and Policy (2016).

[26] THE LEWIN GROUP, INDIANA HEALTHY INDIANA PLAN 2.0 INTERIM EVALUATION REPORT (2016), *available at* http://www.in.gov/fssa/hip/files/Lewin_IN%20HIP%202%200%20Interim%20Evaluation%20Report_FINAL.

[27] *Id*.

[28] *Id.*

[29] *Id.*

[30] *Id*.

[31] *Id*.

3.1.2 Promote value-based decision-making and personal health responsibility.

Evidence indicates that HIP is promoting value-based decision-making and personal health responsibility. This fact is demonstrated by five key points.

1. Nearly 70% of all HIP members choose to enroll into HIP Plus, which provides comprehensive healthcare coverage (including dental and vision benefits) with zero copayments in exchange for income-based member contributions to their POWER account.[32] Importantly, HIP 2.0 is promoting value-based decision making even among the very poor, as the vast majority (86%) of individuals who contribute have incomes below the federal poverty level (FPL).[33] The fact that most HIP Plus members have income below the FPL demonstrates that these members are making an active value-based decision to participate in HIP Plus, as members with incomes below the FPL have the option to not contribute and enroll in a reduced-value healthcare benefit package called HIP Basic. Like HIP Plus, HIP Basic provides preventive healthcare coverage free of charge, but requires copayments for non-preventive services, and does not provide coverage for dental or vision services. To summarize, the overwhelming majority (86%) of HIP Plus members have the option to not contribute, and maintain healthcare coverage through a reduced benefit package (HIP Basic), but instead make an active value-based decision to secure healthcare coverage through HIP Plus.[34]

2. In addition to making a value-based decision to contribute to their POWER account, early evidence suggests that HIP Plus members are also taking personal responsibility for their health by checking their POWER account balances. A survey of HIP members conducted less than one year after the start of HIP found that, even with only a few months of program experience, nearly 60% of HIP Plus members check the balance of their POWER account, and 40% check their balance at least once a month.[35]

3. Nearly half of all HIP members (48%) qualified for rollover of their unused POWER account funds during the first year of the program. On average, HIP members with rollover earned $113.00 in remaining funds to reduce their future POWER account contribution amounts, with nearly one in five (18%) of members with rollover earning at least $200 in rollover. Of the members who earned rollover, 47% also earned State-matching funds, which members earn by receiving recommended preventive care services. In the first year, HIP members received over $1.6 million in State-matching rollover funds. In addition, HIP Basic members also successfully managed their POWER accounts. For the first year of HIP rollover, 80% of HIP Basic members who qualified for rollover by managing their account well and receiving preventive care were able to earn the maximum discount amount of 50% off their future HIP Plus contributions.[36]

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[32] *Id*.
[33] *Id*.
[34] *Id*.
[35] *Id*.
[36] Indiana Family and Social Services Administration, Administrative Data, 2017.

4. HIP Plus members also demonstrate personal responsibility by attending primary and specialty appointments, and adhering to the medications prescribed during these appointments at rates considerably higher than HIP Basic members. Specifically, HIP Plus members are nearly twice as likely to obtain primary care (31% to 16%), 40% more likely to obtain specialty care (46% to 28%), and are 20% more likely to adhere to adhere to their prescription drug regimens (84% to 67%) compared to HIP Basic members.[37]

5. In addition to prescription drug adherence and primary care, HIP 2.0 is also promoting value-based decision-making and personal health responsibility in preventive care. Specifically, among members who were enrolled for the full twelve months of the first demonstration year of HIP 2.0 (February 1, 2015 – January 31, 2016), 87% of HIP Plus members have obtained preventive healthcare services.[38] This high rate of preventive care utilization demonstrates HIP's success in encouraging members to take personal responsibility for their healthcare decisions. This high preventive healthcare utilization rate also reflects HIP's success in encouraging members to make value-based decisions. In particular, HIP Plus members who obtain preventive care are able to double the amount of their remaining POWER account contributions rolled over at the end of their benefit period, which can greatly reduce or even eliminate their cost-sharing for the next benefit period. Evidence that HIP's enhanced rollover for preventive care policy is promoting value-based decision-making is shown by the fact over half (52%) of all HIP members surveyed in December 2015 (after less than a year of program experience) reported being aware of this policy.[39]

6. HIP members are relying less on the emergency room for non-emergency healthcare treatment. First, members who contribute (HIP Plus members) are 25% less likely to use the emergency room for non-emergency issues compared to members who choose not to contribute (HIP Basic members).[40] Second, data indicate that HIP's emergency room copayment policy—which requires an $8 copayment for the first non-emergency visit, followed by a $25 copayment for additional non-emergency visits—is reducing non-emergency utilization of the emergency room. As the State did not receive approval from CMS to implement the emergency room copayment policy until February 2016, the State has had a limited opportunity to obtain data regarding the policy's impact on emergency room utilization. However, data from Anthem, the largest of the three MCEs servicing HIP members, found that members who transitioned from the State's traditional Medicaid program (Hoosier Healthwise) had 30% lower emergency room utilization.[41] This finding

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[37] THE LEWIN GROUP, INDIANA HEALTHY INDIANA PLAN 2.0 INTERIM EVALUATION REPORT (2016), *available at* http://www.in.gov/fssa/hip/files/Lewin_IN%20HIP%202%200%20Interim%20Evaluation%20Report_FINAL.

[38] *Id*.

[39] *Id*.

[40] *Id*.

[41] ANTHEM PUBLIC POLICY INSTITUTE, HEALTHY INDIANA PLAN 2.0: ENHANCED CONSUMER ENGAGEMENT AND DECISION-MAKING ARE DRIVING BETTER HEALTH (2016), *available at* https://www.antheminc.com/cs/groups/wellpoint/documents/wlp_assets/d19n/mjuy/~edisp/pw_g252936.pdf.

is significant, because Anthem services over 40% of all HIP members.[42] A comprehensive evaluation of the impact of HIP's emergency room copayment policy will be available approximately two years from CMS approval to implement the policy (December 2017), commensurate with the timelines established within the HIP 2.0 Special Terms and Conditions.

3.1.3 Promote disease prevention and health promotion to achieve better health outcomes.

The available data demonstrate that HIP 2.0 is promoting disease prevention and health promotion to achieve better health outcomes. As stated within the previous section, the vast majority of HIP Plus members (who were enrolled in the full first year) are obtaining preventive healthcare (87%).[43] Further exploration of the data on preventive service utilization among HIP members reveals the cumulative time-sensitive enrollment effect of HIP 2.0, in that the longer members are enrolled in HIP, the more likely they are to obtain preventive healthcare services. In fact, after one month of HIP enrollment, less than 10% of HIP Plus members and less than 5% of HIP Basic members receive preventive healthcare.[44] By twelve months of enrollment, however, those numbers increase to 87% and 62% respectively.[45] This linear relationship between length of enrollment and increasing likelihood of obtaining preventive healthcare is a strong indication that HIP policy is promoting disease prevention and health promotion. As the length of time of member enrollment in HIP increases, so does member awareness and understanding of HIP policies and therefore become increasingly more likely to engage in the health promotion behaviors incentivized by the policies.

3.1.4 Promote private market coverage and family coverage options to reduce network and provider fragmentation within families.

Evidence indicates that HIP 2.0 is promoting private market coverage and family coverage options to reduce network and provider fragmentation within families. HIP 2.0 builds upon the existing private healthcare insurance market by providing premium assistance to low-income families who are offered health insurance coverage through their employer. Leveraging the established private healthcare market conserves Medicaid resources, and keeps families together under a single healthcare insurance plan. HIP Employer Link is an optional program for HIP members whose employers are willing to participate.

In June 2015, the HIP Employer Link program implemented an employer portal to receive employer applications for participation, which allowed the State to approve employers and employer health plans that offer HIP Employer Link to their employees. As of October 2016, HIP Employer Link has enrolled 62 employers, which demonstrates the States aggressive approach in promoting private market coverage.[46] In addition, 31% of HIP Employer Link enrollees have their families enrolled (spouse; child; or spouse and child), which exhibits the program's success in reducing network and provider fragmentation within families.[47]

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[42] Indiana Family and Social Services Administration, *Medicaid Monthly Enrollment Reports*, INDIANA FAMILY & SOCIAL SERVICES ADMINISTRATION, http://www.in.gov/fssa/ompp/4881.htm (last visited Dec. 19, 2016).

[43] *Id*.

[44] *Id*.

[45] *Id*.

[46] Indiana Family and Social Services Administration, Office of Medicaid Management and Policy (2016).

[47] *Id*.

3.1.5 Facilitate HIP member access to job training and stable employment to reduce dependence on public assistance.

The available data demonstrate that HIP 2.0 is facilitating member access to job training and stable employment to reduce dependence on public assistance. The State developed the Gateway to Work program in order to assist unemployed individuals and those working fewer than 20 hours a week in securing new or better employment. Research demonstrates that employed individuals experience better health compared to unemployed individuals, therefore, helping HIP members secure employment is an effective health improvement strategy.[48] The Gateway to Work program launched in May 2015. As of August 2016, a total of 358,342 letters were mailed to inform HIP members of the Gateway to Work program. A total of 1,248 Gateway to Work orientations have been scheduled, with a total of 580 orientations attended.

3.1.6 Assure State fiscal responsibility and efficient management of the program.

HIP was designed to be a fiscally sustainable program to cover uninsured Hoosiers below 138% FPL, as the financing plan does not increase state taxes for Indiana taxpayers but is rather jointly financed through an existing cigarette tax and the Indiana hospitals. Further, HIP is cost-effective and continues to meet its federal budget neutrality requirements to date. In fact, the estimated total cumulative cost from February 1, 2015 through September 30, 2016 was $3.5 billion, including administrative costs.[49] The State has successfully managed the program, as total HIP expenditures to date are below the projected costs contained in the original program projections.

3.2 Health Plan Performance

Indiana has a robust quality oversight plan for continually monitoring the performance of the three managed care entities (MCEs) serving the HIP population: Anthem, MDwise, and MHS. Beginning in calendar year 2017, CareSource, the state's newest MCE, will also be included in the State's ongoing monitoring and quality oversight activities.

The Office of Medicaid Policy and Planning's (OMPP) Quality and Outcome section conducts oversight of the MCEs by regularly monitoring program wide data, required MCE quarterly and annual reporting documents, as well as contract compliance supervision. The State conducts multiple monitoring activities to assure quality and consistent delivery of healthcare services to members consistent with the State's quality strategy plan. Specifically, the various monitoring activities include the following:

- Quality Management and Improvement Program Work Plans (QMIPs);
- Data analysis;
- Enrollee hotlines operated by the State's enrollment broker;
- Geographic mapping for provider network;
- External quality review (EQR);
- Network adequacy assurance submissions;
- On-site monitoring reviews;
- Recognized performance measure reports; and
- Surveys.

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[48] ROBERT WOOD JOHNSON FOUNDATION, INFOGRAPHIC: STABLE JOBS = HEALTHIER LIVES (2013), *available at* http://www.rwjf.org/content/dam/files/rwjf-web-files/Infographics/Better%20Jobs%20Healthier%20Lives%20Infographic.pdf.

[49] Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning (2016).

Each of the contracted health plans are required to develop and maintain a quality management and improvement program (QMIP). The program must incorporate and address data from the plans' Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, quality metrics obtained from the Healthcare Effectiveness Data and Information Set (HEDIS) collected by the National Committee for Quality Assurance (NCQA), as well as address any opportunities for improvement identified in the annual external quality review.

The State utilizes Burns & Associates, Inc. to annually conduct an external quality review (EQR) of each of the MCEs. The current EQR report in production is based on 2015 program data, reflective of the first year of implementation of the expanded HIP 2.0 program. In addition to validating general performance measures and the performance improvement projects, the 2016 EQR for the 2015 calendar year will focus on initiation and engagement of alcohol and other drug treatment, an audit of provider directories, timeliness of prenatal care, and access to dental services. As of the date of publication of this HIP demonstration waiver extension application, the results of the EQR report have not yet been published.

One of the areas of particular focus for the HIP program oversight was related to the medically frail process. Individuals with certain physical, mental and behavioral health conditions are eligible for enhanced benefits aligned with the standard Medicaid state plan benefits. Therefore, appropriate identification of medically frail individuals is a critical MCE function. Throughout 2015, OMPP gathered extensive data regarding members identified as medically frail to ensure that individuals were properly identified and receiving necessary healthcare services. Of the 38,655 individuals in 2015 that were identified as medically frail, a random audit of 10% of the medically frail members revealed a 0.96% error rate, as only 37 HIP medically frail members could not be determined medically frail by the compliance audit team. Based on the results of this first medically frail audit, the MCEs are compliant with the contract terms.

In addition to the formal quality oversight processes, the State maintains consistent and open lines of communications with the health plans. Since 2014, the State has held weekly "office hours" with all three of the MCEs to discuss the operations of the HIP program. In addition, State and MCE executive level staff for all of the MCEs meet once every three weeks. During these regular meetings, the State and MCEs are able to collaborate and address member concerns identified by the customer service team (CST) and to discuss results of the various regular operational reports that support continued program operations. For example, the MCEs are required by contract to submit regular HIP specific operational reports to the State in accordance with the HIP MCE Reporting Manual, which include, but is not limited to a POWER account report, preventive care report, and roll-over report.

Section 4: Requested HIP Program Enhancements

The HIP program has been successful in achieving the underlying program goals of expanding access to care and promoting personal responsibility in a fiscally responsible manner. Therefore, the State desires to maintain the HIP program in its current form and will add the following enhancements.

1. Expand incentives program;

2. Require tobacco-user contribution surcharge;
3. Add new HIP Plus incentive;
4. Reestablish an open enrollment period;
5. Facilitate enrollment in HIP Maternity coverage for pregnant women; and
6. Technical updates to the 2015 Special Terms and Conditions.

4.1 Healthy Incentive Initiative

Private sector research demonstrates that corporations implementing member healthy incentive programs have seen reductions in individual healthcare claims and overall healthcare spending, resulting in lower-than-industry yearly growth in healthcare costs. In addition, industry research shows that lower dollar value incentives are insufficient to change member health behavior or even entice members to engage in a new program.[50]

Medicaid managed care programs have also utilized member incentive programs to influence appropriate healthcare utilization and encourage healthy behaviors, although the dollar value of incentives tends to be significantly lower than those offered in the private sector. Each of the HIP MCEs currently operate member incentive programs that primarily target preventive care and chronic disease management. While the programs vary, each one offers low monetary or gift card incentives (approximately $10-$25 value) to members after the completion of various activities, including participation in a health needs assessment, preventive exams, and prenatal care. Participation rates for these member incentive programs to date has only been between 5% and 15% of total HIP membership.

To increase HIP member participation in these programs and significantly reduce the growth of healthcare costs for Indiana, health incentives must be aligned with the target population and with the State's strategic health goals. One of the primary goals of HIP has always been to improve health outcomes for all members. To better accomplish this goal, the State will align member incentives with specific health challenges facing HIP members. Therefore, the HIP healthy incentive initiative will be targeted to address each of the following focus areas:

- Tobacco cessation;
- Substance use disorder treatment;
- Chronic disease management; and
- Employment related incentives.

The program will be designed to offer outcomes-based incentives to members who meet individually achievable relative goals, as well as some process and participation measures. For example, a member could earn incentives for participation in a disease management program and for decreasing their body weight by a certain percentage over a one year period. Outcomes-based incentives tend to lead to increased member engagement as opposed to the "sign up" types of incentives, as some people will sign up for a program to receive an incentive and thereafter do

[50] Jen Weiczner, *Your Company Wants to Make You Healthy*, THE WALL STREET JOURNAL, April 8, 2013, *available at* http://www.wsj.com/articles/SB10001424127887323393304578360252284151378. *See also GE Brings Wellness to Life,* CORPORATE WELLNESS MAGAZINE, http://www.corporatewellnessmagazine.com/cwminterviews/ge-brings-wellness-to-life/ (last visited Dec. 19, 2016).

not participate in the program.[51] For this reason, the healthy incentive program will offer both types of incentives to encourage initial member sign-up as well as long-term member engagement.

Further, to attain comparable cost reductions experience by the private sector, the State seeks to significantly enhance its existing member incentive program by removing the current low-dollar incentive limitation, and increase available member healthy incentives to a maximum of $200 per initiative, with a total of no more than $300 per member per year in total incentives. To accompany this initiative, the State will launch an outreach campaign to promote member utilization of the program and ensure that incentives are equally available to all members.

The overall healthy incentive initiative will not be limited to members, but will also include components to align MCE and provider quality incentives with the program's strategic health improvement goals. First, the State's managed care contracts will be revised to align MCE withholds and bonuses with the member health focus areas outlined above. Further, as positive health outcomes are more likely to occur when patients work in partnership with their care teams, provider incentives will also be aligned with these focus areas.

4.1.1 Tobacco Cessation Initiative

Tobacco use remains the leading cause of preventable disease and death in the United States, with a disproportionate impact on Medicaid beneficiaries, the uninsured, American Indian/Alaska Natives and multiracial adults, and those living in poverty.[52] It contributes to increased risk for cancers, cardiovascular disease, strokes, and lung diseases. Tobacco use also contributes to health risks for pregnant women and their babies; impacts bone, teeth, and gum health; increases the risk for cataracts, diabetes, and inflammation; and decreases immune function. Family members and friends of smokers can also be adversely impacted, as secondhand smoke exposure has been shown to cause serious disease and death.[53]

Over the past ten years, the United States has seen a decrease in national adult smoking rates from 20.9% in 2005 to 16.8% in 2014.[54] In Indiana, the adult cigarette smoking rate in 2014 was 22.9% - over 6% higher than the national average.[55] A disparity also exists according to income. Nationally, smoking rates among individuals below the federal poverty level are 26.3%, compared to 15.2% for individuals at or above the poverty level. Low income Indiana residents have particularly high smoking rates, with 42.0% of adults with a household income under

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[51] *GE Brings Wellness to Life,* CORPORATE WELLNESS MAGAZINE, http://www.corporatewellnessmagazine.com/cwminterviews/ge-brings-wellness-to-life/ (last visited Dec. 19, 2016).

[52] ROBERT WOOD JOHNSON FOUNDATION, INFOGRAPHIC: STABLE JOBS = HEALTHIER LIVES (2013), *available at* http://www.rwjf.org/content/dam/files/rwjf-web-files/Infographics/Better%20Jobs%20Healthier%20Lives%20Infographic.pdf.

[53] U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, THE HEALTH CONSEQUENCES OF SMOKING—50 YEARS OF PROGRESS (2014), *available at* http://www.surgeongeneral.gov/library/reports/50-years-of-progress/full-report.pdf.

[54] A. Jamal et al., *Current Cigarette Smoking Among Adults — United States, 2005–2014*, 64 MORBIDITY AND MORTALITY WEEKLY REPORT, 44 (2015).

[55] *Behavioral Risk Factor Data: Tobacco Use (2011 to Present)*, U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION (2016), https://chronicdata.cdc.gov/Survey-Data/Behavioral-Risk-Factor-Data-Tobacco-Use-2011-to-pr/wsas-xwh5 (last visited Dec. 19, 2016).

$15,000 a year describing themselves as current smokers.[56] By comparison, 14.2% of adults with a household income over $50,000 per year reported current tobacco use.[57] Another study in Indiana suggests a smoking rate of 37.7% among individuals with a household income of less than $25,000 per year, which equates to approximately 414,400 low income Indiana residents who smoke—many of which are eligible for HIP. A recent report from the Centers for Disease Control and Prevention also indicated that smoking prevalence among Indiana Medicaid beneficiaries was 48.3% as of December 2015—one of the highest rates in the nation.[58] In addition, Indiana has the 4th highest secondhand smoke exposure rate in the country. In 2012, 53.4% of Hoosiers reported exposure to secondhand smoke within the past seven days.[59]

The costs associated with smoking are substantial. In all, costs attributable to direct healthcare expenditures and lost productivity related to tobacco use and secondhand smoke in the United States now approach $300 billion annually.[60] In Indiana, tobacco contributes to over 11,000 deaths, and an estimated $6.1 billion in tobacco-associated medical costs and productivity losses, annually.[61] Finally, an estimated $589.8 million in tobacco-associated medical costs for services such as cancer treatment, respiratory disease management, diabetes management, etc. are covered by Indiana Medicaid annually.[62]

As of December 1, 2016, over 394,000 people were enrolled in the current Healthy Indiana Plan.[63] Of the members who completed the Health Needs Screening (approximately 93,239 individuals), over 35,400 members, or approximately 38%, were identified as current tobacco users. Further, out of the 89,464 members with a formal "tobacco use disorder" diagnosis, only 7,008 individuals had a claim for tobacco cessation medication in calendar year 2015.[64]

This low utilization rate is consistent with national utilization rates. One of the most likely reasons for low utilization of Medicaid tobacco dependency treatment benefits is the lack of

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[56] BRFSS Prevalence and Trends Data, U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/brfss/brfssprevalence/ (last updated Aug. 18, 2016).

[57] *Id*.

[58] A. DiGiulio et al., *State Medicaid Expansion Tobacco Cessation Coverage and Number of Adult Smokers Enrolled in Expansion Coverage—United States, 2016*, 65 MORBIDITY AND MORTALITY WEEKLY REPORT 1364 (2016).

[59] *Tobacco Control State Highlights: Indiana*, U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION, http://www.cdc.gov/tobacco/data_statistics/state_data/state_highlights/2012/states/indiana/index.htm (last reviewed Dec. 9, 2014).

[60] L. Bach, *Toll of Tobacco in the United States of America*, CAMPAIGN FOR TOBACCO FREE KIDS, http://www.tobaccofreekids.org/facts_issues/toll_us (last updated Nov. 29, 2016).

[61] U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, THE HEALTH CONSEQUENCES OF SMOKING—50 YEARS OF PROGRESS (2014), *Toll of Tobacco in the United States: The Toll of Tobacco in Indiana,* CAMPAIGN FOR TOBACCO FREE KIDS, https://www.tobaccofreekids.org/facts_issues/toll_us/indiana (last updated Nov. 1, 2016).

[62] *Id*.

[63] Indiana Advanced Information Management (Indiana*AIM*) (2016). Total of all members fully open and enrolled.

[64] Indiana Family and Social Services Administration (2016).

awareness among beneficiaries and providers.[65,66] This lack of awareness is demonstrated throughout the literature. For example, a study by Vt. Tong et al., found that among surveyed obstetricians-gynecologists, 83% were unaware of the ACA requirements to provide tobacco cessation services without cost-sharing for pregnant Medicaid beneficiaries. Another study of two states with comprehensive tobacco cessation benefits for Medicaid beneficiaries found that only 36% of Medicaid-enrolled smokers and 60% of Medicaid physicians knew that their state program offered any coverage for tobacco dependence.[67] Finally, in those states where utilization of Medicaid tobacco dependency treatment benefits is particularly high (e.g., Massachusetts and Wisconsin), public health and Medicaid programs report collaborating to develop beneficiary and provider-specific education campaigns to promote awareness of smoking cessation benefits.[68]

To improve tobacco cessation service utilization, Indiana's Medicaid program has recently enhanced its benefit package to be one of the most robust in the country. Currently, all of the HIP health plans provide the Food and Drug Administration (FDA) approved tobacco cessation products, as well as a variety of counseling services (individual counseling, group counseling, and phone counseling) to ensure member access to smoking cessation tools and resources. Until recently, one key limitation on tobacco cessation coverage was the restriction allowing a single 12-week course of treatment every 12 months. In 2016, the State removed this restriction, as well as added several provider types eligible to provide treatment, including optometrists, clinical social workers, marriage and family counselors, mental health counselors, and others.[69]

To build upon these efforts, the State seeks to increase member utilization of these tobacco cessation services by: (1) improving member and provider awareness of the benefits; (2) offering an incentive program for participants to complete smoking cessation courses and to quit smoking and (3) discouraging tobacco use through a premium surcharge for HIP Plus members.

Research shows that other state Medicaid programs have been able to decrease adult smoking rates by 10% over two years and increase successful quit attempts by approximately 12%.[70] Specifically, one state saw substantial reductions in hospital inpatient admissions for acute heart attacks, reductions for other health disease-related services, and reductions in inpatient admissions for chest pain, implying health outcome improvements for members. In addition, it also saw financial benefits from the efforts—for every $1 invested in the effort, the Medicaid program saved a net $2.12.[71]

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[65] J. Green et al., *The Impact of Tobacco Dependence Treatment Coverage and Copayments in Medicaid,* 46(4) AMERICAN JOURNAL OF PREVENTIVE MEDICINE 331 (2014).

[66] V. Tong, *Clinicians' Awareness of the Affordable Care Act Mandate to Provide Comprehensive Tobacco Cessation Treatment for Pregnant Women Covered by Medicaid*. 2 PREVENTIVE MEDICINE REPORTS 686 (2015).

[67] S. McMenamin et al., *Physician and enrollee knowledge of Medicaid coverage for tobacco dependence treatments*, 26(2) AMERICAN JOURNAL OF PREVENTIVE MEDICINE 99 (2004).

[68] L. Ku et al., *Medicaid Tobacco Cessation: Big Gaps Remain In Efforts To Get Smokers To Quit*, 35(1) HEALTH AFFAIRS 62 (2016).

[69] 405 Ind. Admin. Code 5-37 (2016).

[70] MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH, MASSHEALTH SMOKING CESSATION BENEFIT: BRIEFING NOTES (2012), *available at* http://www.mass.gov/eohhs/docs/dph/tobacco-control/masshealth-smoke-cessation-benefit.doc.

[71] *Id*.

The Indiana Family and Social Services Administration (FSSA) would leverage a multitude of outreach strategies, as well as existing MCE knowledge of its provider and member communities and public health partners, to identify communication strategies that are most likely to be successful in Indiana. FSSA will collaborate with the HIP MCEs to develop a robust and consistent communication plan to inform both participating providers and beneficiaries of the available tobacco cessation benefits.

To enhance the tobacco cessation initiative, FSSA will encourage service utilization through the implementation of an incentive program. Both private companies and state Medicaid agencies have piloted incentive programs as a means of encouraging beneficiaries to discontinue their tobacco use. Studies on the impact of incentive programs find that the incentive does consistently increase program engagement and member satisfaction.[72,73]

Two studies of private company tobacco cessation incentive programs indicate that periodic and increasing incentive amounts will encourage members to participate in the program; and that these types of incentives make participants more likely to abstain from tobacco for longer periods of time than the control groups that do not receive incentives.[74] To leverage this private industry success, HIP aims to further encourage increased participation in tobacco cessation efforts by requiring its MCEs to offer incentives to members who participate in tobacco cessation treatments. All program participants will have access to all FDA-approved tobacco cessation medications and a variety of counseling formats including individual, group, and phone counseling.

To encourage MCE participation in the tobacco cessation incentives initiative, the State will also utilize financial incentives with the managed care contracts related to achieving specified smoking cessation outcomes.

Lastly, HIP will seek to encourage member level participation in these available tobacco cessation benefits and programs by leveraging an existing private market insurance policy—charging higher premiums on tobacco users. POWER account contributions will increase for tobacco users in accordance with the allowable ACA rating rules, as detailed in Section 4.2 of this demonstration extension application.

Ultimately, the HIP tobacco cessation initiative is a multi-faceted approach that builds off of the recent expansion of the tobacco cessation benefit to align with industry best-practice recommendations. For the demonstration period, HIP will seek to actively encourage member participation in tobacco cessation activities through a robust communication campaign to educate

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[72] K. Volpp et al., *A Randomized, Controlled Trial of Financial Incentives for Smoking Cessation*, 360 NEW ENGLAND JOURNAL OF MEDICINE 699 (2009), S. Halpern, *Randomized Trial of Four Financial-Incentive Programs for Smoking Cessation*, 372 NEW ENGLAND JOURNAL OF MEDICINE 2108 (2015).

[73] S. Halpern, *Randomized Trial of Four Financial-Incentive Programs for Smoking Cessation*, 372 NEW ENGLAND JOURNAL OF MEDICINE 2108 (2015).

[74] K. Volpp et al., *A Randomized, Controlled Trial of Financial Incentives for Smoking Cessation*, 360 NEW ENGLAND JOURNAL OF MEDICINE 699 (2009), S. Halpern, *Randomized Trial of Four Financial-Incentive Programs for Smoking Cessation*, 372 NEW ENGLAND JOURNAL OF MEDICINE 2108 (2015).

members about the available benefits and incentives, complementary incentive and disincentive structure, and the addition of MCE contractual requirements and financial incentives for positive outcomes.

4.1.2 Substance Use Disorder (SUD) Incentives

A recent report from the Substance Abuse and Mental Health Services Agency (SAMHSA) estimated that the prevalence of SUD among persons eligible for Medicaid is 21%.[75] An analysis of the HIP population estimates that there are approximately 81,000 HIP members living with SUD.[76] However, despite the growing drug crisis in the State and estimates of high prevalence of SUD among HIP members, utilization of available mental health and SUD treatment benefits remains relatively low among HIP participants. Specifically, an analysis of program claims data indicates that only 28% of HIP members with a formal substance use disorder diagnosis are receiving treatment for their addiction. Due to the nature of substance use disorder, many people do not seek treatment for their SUD.

As detailed in Section 6 of this waiver extension application, the State is seeking to add coverage for new SUD treatment in order to enhance current benefits to provide the full continuum of care for all Medicaid recipients. Additional services will include expansion of inpatient detoxification, additional residential services (as well as an expansion in the number of providers eligible to provide residential treatment services), and the addition of addiction specific outpatient treatment services, including, peer recovery supports and relapse prevention. By allowing reimbursement for residential services, persons recovering from SUD following detoxification treatment will have the opportunity to establish a meaningful period of sobriety prior to returning to unsupervised daily living. While this waiver will expand access to SUD treatment services, the State also seeks to encourage members to utilize these available benefits in a meaningful way by requiring MCEs to develop targeted member incentive programs aimed at addressing SUD and engaging individuals in treatment. Various studies have concluded that incentives for achieving drug abstinence are effective, with one study in particular finding that a linear increase in efficacy as incentives increased, with best outcomes obtained with incentives averaging nearly $16 per day.[77] The study further concluded that while the SUD incentive program costs may seem great, nearly every cost-effectiveness analysis conducted on such programs have found them to be cost-effective.[78]

The member incentive program will provide financial incentives for members who voluntarily complete specified activities related to SUD treatment and recovery, which may include compliance with the SUD treatment plan established by a licensed medical professional or achieving clean follow-up appointments. All MCE SUD member incentive programs must be approved by the State.

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[75] SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, BEHAVIORAL HEALTH TREATMENT NEEDS ASSESSMENT TOOLKIT FOR STATES (2013), *available at* https://store.samhsa.gov/shin/content/SMA13-4757/SMA13-4757.pdf.

[76] MILLIMAN, GROUP-UP SUD COST DEVELOPMENT METHODOLOGY (2015), on file with author.

[77] D. Hand et al., *Improving Medicaid Health Incentives Programs: Lessons from Substance Abuse Treatment Research*, 63 PREVENTIVE MEDICINE 87 (2014).

[78] *Id.*

4.1.3 Chronic Disease Management Incentives

Since the program was first implemented in 2008, HIP has long focused on encouraging members to engage in healthy behaviors, including obtaining preventive health and, if needed, engaging in chronic disease management activities. The MCEs all have robust chronic disease management programs available to their members as well as several member incentive programs to encourage participation. While the MCEs have relatively high initial member enrollment in their chronic disease management programs (approximately 115,000 HIP members), the State seeks to encourage more active member participation to more effectively improve health outcomes. Therefore, as part of the broader healthy incentive initiative, the State seeks to give increased flexibility to the MCEs to direct additional resources towards encouraging *active* member participation in their chronic disease management programs and producing improved health outcomes. MCEs will be expected to offer members incentives not only for enrollment in chronic disease management programs, but also completion of specified milestones and healthy targets in each of the various chronic disease management programs established by the MCE, including diabetes management, weight management, and pharmacy compliance initiatives.

4.1.4 Employment Related Incentives

In 2015, HIP introduced the new Gateway to Work program designed to promote employment by integrating the State's various work training and job search programs with HIP. Through this initiative, all eligible HIP members who are unemployed or working less than 20 hours per week are referred to available employment, work search and job training programs to assist the member in securing gainful employment. After the referral is made via Gateway to Work, member participation in the available employment and training related programs is voluntary. Due to the voluntary nature of the program, as of August 27, 2016, only 580 Gateway to Work orientations had been attended by members interested in participating in the available employment and training services available to them.

It has been well documented that employed individuals are both physically and mentally healthier, as well as more financially stable, as compared to unemployed individuals.[79] Due to the strong connection between employment and overall health, people who are unemployed have a higher mortality and poorer health outcomes, and, further, longitudinal studies have found that these effects of unemployment exist regardless of any pre-existing health conditions.[80] CMS has long-recognized this important connection and has consistently supported Medicaid employment initiatives. In fact, the enabling act for Medicaid explicitly states that one of the goals of the program is to connect Medicaid recipients to services aimed at assisting "families and individuals attain or retain capability for independence."[81] This goal is reinforced on CMS' website which states:

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[79] F.M. McKee-Ryan et al., *Psychological and physical well-being during unemployment: a meta-analytic study,* 90(1) JOURNAL OF APPLIED PSYCHOLOGY 53 (2005), K.I. Paul et al., *Latent deprivation among people who are employed, unemployed, or out of the labor force*, 143(5) JOURNAL OF PSYCHOLOGY 477 (2009).

[80] ROBERT WOOD JOHNSON FOUNDATION, WORK MATTERS FOR HEALTH (2008), *available at* http://www.commissiononhealth.org/PDF/0e8ca13d-6fb8-451d-bac8-7d15343aacff/Issue%20Brief%204%20Dec%2008%20-%20Work%20and%20Health.pdf.

[81] 42 U.S.C. §1396-1 (2015).

> *"The Center for Medicare & Medicaid Services (CMS) recognizes that employment is a fundamental part of life for people with and without disabilities. Employment provides a sense of purpose, how we contribute to our community and are associated with positive physical and mental health benefits. Meaningful work is part of building a healthy lifestyle as a contributing member to society and essential to individual's economic self-sufficiency, self-esteem and well-being."*[82]

Through this HIP extension application, the State seeks to encourage participation in the Gateway to Work program in order to connect members to gainful employment, which not only improves physical and mental health, but the individual's overall financial stability and well-being. To this end, the managed care entities will be required to develop member incentive programs specific to promoting employment, including but not limited to rewarding members for successful participation in the HIP Gateway to Work program through the completion of available job training, work search, or educational activities that will assist members in securing gainful employment. The State will investigate whether providing member incentives will improve participation in the various employment and training programs available to HIP members, and thus increase overall employment rates among HIP participants. Ultimately, these efforts to improve employment rates are critical to improving member health (including addressing the drug abuse epidemic) and reducing overall poverty.

4.2 Cost-Sharing Modification: Tobacco Contribution Surcharge

To compliment the positive incentives related to the tobacco cessation initiative as described above in Section 4.1.1 of this waiver extension application, the State will seek to strengthen this initiative by adding a tobacco-user surcharge to HIP Plus members. Currently, all HIP members are required to contribute two percent (2%) of income per month to their POWER account to maintain access to the enhanced HIP Plus plan. However, to encourage participation in the voluntary tobacco cessation initiative, members who are known tobacco users will be required to pay monthly contributions equal to three percent (3%) of income in their second year of eligibility. For individuals identified as a tobacco user, the tobacco surcharge will be waived for the first year of enrollment in order to provide the individual the opportunity to take advantage of the robust tobacco cessation benefits offered through HIP. During this 12-month period, the MCEs will be required to conduct active outreach and member education related to the tobacco cessation benefits available through HIP as well as the tobacco cessation member incentive program. If after a year, the member continues to be a tobacco user, their monthly premiums will increase beginning in the first month of their renewed benefit period.

The proposed tobacco surcharge is consistent with the Affordable Care Act (ACA) rating rules which allow qualified health plans on the Marketplace to charge up to 1.5 times the rate charged to a non-smoker. Tobacco use is defined in federal regulation as the "use of tobacco on average four or more times per week within no longer than the past six months." HIP will align with this definition by ensuring the MCE member Health Needs Screening captures tobacco use frequency

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[82] *Medicaid Employment Initiatives*, CENTERS FOR MEDICARE AND MEDICAID SERVICES, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Grant-Programs/Employment-Initiatives.html (last visited Dec. 19, 2016).

within the past six months, with an option to impose a higher usage threshold and/or shorter look-back period.

4.3 HIP Plus Incentive

The State will add chiropractic benefits to the HIP Plus plan to promote participation in HIP Plus through regular contributions to the member's POWER account. Specifically, the HIP Plus alternative benefit plan will be amended to add chiropractic services, limited to one (1) visit per day and six visits per covered person per benefit year. This benefit modification will further enhance the value proposition underlying the HIP plan structure, which will include vision, dental and chiropractic services.

4.4 Reestablish HIP Open Enrollment

Since 2008 when the program was first implemented, HIP has instituted various policies aimed at encouraging members to take personal responsibility. One such long standing HIP policy targeted compliance with annual redetermination processes in order to prepare members for the annual open enrollment processes typical in the commercial market. The original HIP program required a 12-month open enrollment period, whereby members who failed to comply with redetermination process had to wait 12 months prior to re-enrolling in HIP. In 2016, the Indiana General Assembly reconfirmed this policy and lowered the open enrollment period to six months, rather than 12 months, consistent with other 2015 HIP program modifications. Therefore, in accordance with Ind. Code 12-15-44.5-4.9(b), the State seeks to implement a member specific open enrollment period, whereby members who lose eligibility due to failure to comply with redetermination process will be required to wait six months until their next open enrollment period to re-enroll in HIP coverage.

All HIP members will be required to complete the annual redetermination process within the required timeframes. Approximately 3 months prior to the expiration of their 12 month benefit period, each HIP member will be notified of the upcoming redetermination period and may be asked to submit documentation necessary for the State to determine continued program eligibility. If the required documentation is not provided prior to the expiration of the current benefit period, the member will be disenrolled from HIP. The member can reenroll within 90 days from the end of the expired benefit period without a new application, if the former member submits the requested redetermination information. However, after the 90 day period, the member is required to wait another three months, or six months from the initial date of disenrollment, until their next open enrollment before being permitted to reenroll in HIP. Ultimately, all HIP members are given a total of six months (three months before the end of their benefit period and three months after their benefit period ends) to comply with the redetermination requirements, and receive numerous communications from the State and MCEs during this time.

In addition, the open enrollment policy does not apply to members who are medically frail, pregnant, low-income parents and caretakers, or low-income 19 and 20 year old dependents. In addition, individuals who experience a change in circumstances which prevented completion of

the redetermination process as detailed in 405 IAC 10-10-13(e) are also exempt from the open enrollment period and may reapply at any time.[83]

This long-standing redetermination and open enrollment policy in the original HIP program was successful in educating members about the importance of complying with commercial market open enrollment policies. When this policy was implemented in the original HIP program, eighty-five percent (85%) of members returned the redetermination packet in a timely manner in the first two years of the program. However, by the end of 2012 after the initial 5 year demonstration period, that proportion increased to ninety-two percent (92%). Improved compliance with redetermination requirements not only helps to prepare members for participation in the commercial insurance marketplace, but it also results in better continuity of care and improved health outcomes for members. Ultimately, as demonstrated in the original HIP waiver, the open enrollment policy will help to encourage completion of the required redetermination processes which will result in an overall increase in continuity of care for HIP members.

4.5 HIP Maternity Coverage

HIP members who become pregnant may choose to remain enrolled in HIP, or may transfer to the Hoosier Healthwise program- Indiana's traditional Medicaid managed care program for children and pregnant women. However, women who choose to remain in HIP are *required* to transfer from HIP to Hoosier Healthwise if they remain pregnant during their annual redetermination period. In addition, individuals who apply for Medicaid coverage while pregnant are automatically enrolled in Hoosier Healthwise, and then transition to HIP following the post-partum coverage period if their income is equal to or less than 138% FPL.

HIP provides maternity coverage that is equal to the coverage provided under the Hoosier Healthwise program, and, consistent with federal law, there is no cost sharing for pregnant women under either program. Further, the managed care entities managing the programs are the same. However, despite the fact that there is no functional difference between the programs, the required program transfers are burdensome for the member, providers, and the State. Therefore, the State requests to modify eligibility criteria to require enrollment in HIP for pregnant women with income under 138% FPL. The State would continue to track these individuals separately for purposes of federal medical assistance percentages (FMAPs) used to determine the federal matching funds. In addition, the Hoosier Healthwise program will be maintained for pregnant women with income greater than 138% FPL who would not be eligible for HIP following the end of pregnancy. The program consistency resulting from this policy modification would improve continuity of care for the member and reduce the administration for the State and providers, without negatively impacting member care.

[83] 405 Ind. Admin. Code 10-10-13(e) (2015). Indiana Administrative Code states that a member who is disenrolled may be reinstated prior to the expiration of the six (6) month period in the event the member experience one of the following qualifying events: (1) obtained and subsequently lost private insurance coverage; (2) had a loss of income after disqualification due to increased income; (3) took up residence in another state and later returned; (4) was a victim of domestic violence; (5) was residing in a county subject to a disaster declaration made in accordance with IC 10-14-3-12 at any time during the sixty (60) calendar days prior to or including the date such member was terminated from the plan.

4.6 Technical Revisions & Updates to Current HIP Special Terms and Conditions

In addition to the above, the State will seek the following minor technical updates to special terms and conditions, each of which, are discussed in more detail below:

1. Remove prior claims payment program;
2. Continue waiver allowing HIP emergency room copayment policy;
3. Continue waiver of non-emergency medical transportation for HIP Basic and HIP Plus;
4. Carve out hepatitis C drugs from managed care; and
5. Plan changes and member transitions.

4.6.1 Prior Claims Payment Program.

The 2015 HIP Special Terms and Conditions (STCs) included a waiver of retroactive coverage for all HIP members, but maintained a one year phase out program for a small subsection of newly enrolled HIP members. This "prior claims payment" program provides retroactive coverage for medical services received during the 90-day period prior to the new member's HIP enrollment. However, this limited program is only available to a small subsection of HIP members eligible pursuant to Section 1931 parents and caretakers who have not received Medicaid coverage within two (2) years of enrollment and who did not gain HIP coverage through presumptive eligibility. Due to the very small target population as well as the general lack of need for the transition program, the prior claims payment program initiative had very low utilization, as the State anticipated. Between February 1, 2015 and October 1, 2016, only 15,699 individuals (8% of the total Section 1931 group) were eligible for the program, and only 2,409 individuals (15% of the total individuals qualifying) actually utilized the benefit.[84]

This program was designed to help very low-income parents and caretakers transition to coverage without the financial burden of medical claims incurred immediately prior to enrollment. However, as demonstrated by the low utilization, this transitional assistance program is no longer needed for several reasons. First, due to the expanded HIP program and availability of tax credits, more individuals are moving to HIP from other coverage, meaning less individuals are enrolling in HIP with unpaid medical bills. Second, a survey of three of the largest hospital systems in the state (comprising nearly 45% of all hospitals) indicated that HIP members are not being billed for claims incurred prior to enrollment. Third, the expanded presumptive eligibility process has been very successful in enrolling uninsured individuals into coverage quickly at the site of care prior to the individual incurring non-covered claims. For these reasons, the State requests that CMS remove the transitional prior claims payment program for the waiver extension period.

4.6.2 Copayments for Non-Emergent Use of Hospital Emergency Department.

The State received a two-year Section 1916(f) waiver to test the application of graduated copayments, whereby HIP members are charged an $8.00 copayment for the first inappropriate emergency department visit, and $25 for each subsequent inappropriate emergency department visit. The STCs required CMS to approve an emergency room copayment protocol prior to implementation of the graduated copayment, including the detailed design and processes to support the initiative, as well as the establishment of a control group which would be subject to the standard $8.00 copayment for each visit. This final protocol was not finalized and approved

[84] Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning (2016).

for nearly a year, delaying implementation of the graduated copayment policy until February 2016. Due to the timing of the waiver extension application submission requirements, the initial independent evaluation of this policy has not yet been completed at the time of publication.

However, one of the HIP managed care entities (MCEs), Anthem, published a report in July 2016, citing internal data indicating that emergency room utilization was approximately 30% lower among HIP Plus members compared to emergency room utilization among the same group while enrolled in traditional Medicaid.[85] This is consistent with the data from the original HIP program, which experienced a 34% decrease in emergency department visits from 2009 to 2013 among the group subject to $25 copayments for inappropriate emergency department visits. Based on early program data, the State anticipates that the final report will demonstrate that the graduated copayment structure resulted in cost savings and better quality of care through avoidance of inappropriate emergency department visits.

Based on initial HIP 2.0 program data, results of MCE led focus groups, and the State's prior program experience demonstrating the effectiveness of $25 copayments for inappropriate emergency room utilization, the State requests that CMS renew the cost sharing waiver beyond the initial two-year Section 1916(f) waiver period, which is currently set to expire on January 31, 2018. Specifically, the State requests that CMS make the HIP emergency department copayment policy permanent, and not subject to the additional restrictions imposed during the previous waiver period.

4.6.3 Non-Emergency Medical Transportation (NEMT).

While Indiana previously operated HIP with an NEMT waiver for seven years, the HIP 2.0 STCs only granted the State a one-year waiver of this policy. On December 22, 2015, CMS temporarily extended the NEMT waiver through November 30, 2016, to allow more time for adequate data collection. On August 1, 2016, Indiana submitted a request to amend the current STCs to extend the NEMT waiver for the duration of the current demonstration.

To support this request, the State included extensive data from an independent evaluation of the impact of the NEMT waiver on member access to care. The State submitted an initial evaluation of the Indiana HIP NEMT waiver to CMS on March 1, 2016 based on a survey of 600 HIP members conducted in December 2015 and January 2016.[86] The State later funded a second survey – administered in June 2016 – with a much larger sample size: 5,173 HIP members as of May 2016. Of these, there were 4,357 completed surveys from Regular Plan members and 816 completed surveys from State Plan members. The larger sample size allowed for in-depth analysis of differences in member access to health care between those receiving and not receiving NEMT services. However, both of these separate member surveys found that HIP members *without* access to NEMT actually reported lower incidents of missed medical

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[85] ANTHEM PUBLIC POLICY INSTITUTE, HEALTHY INDIANA PLAN 2.0: ENHANCED CONSUMER ENGAGEMENT AND DECISION-MAKING ARE DRIVING BETTER HEALTH (2016), *available at* https://www.antheminc.com/cs/groups/wellpoint/documents/wlp_assets/d19n/mjuy/~edisp/pw_g252936.pdf.

[86] THE LEWIN GROUP, INDIANA HEALTHY INDIANA PLAN 2.0: EVALUATION OF NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) WAIVER (2016), *available at* https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-nemt-eval-03112016.pdf

appointments due to transportation-related issues as compared to HIP members *with* access to NEMT benefits.[87] Based on the clear data, state-provided NEMT benefits do not lead to improved member access to healthcare services for HIP members. Further, approximately two-thirds of members reported driving themselves to appointments in their own car, while over 90% reported using their own car or someone else's.[88]

Therefore, the State renews its request for a waiver of NEMT for the duration of the HIP extension waiver period. The HIP program is designed to provide commercial healthcare coverage to able-bodied adults. However, the more vulnerable and high risk members of the HIP population who are exempt from alternative benefit plans and receive Medicaid State Plan benefits will continue to be provided NEMT services, including pregnant women, individuals determined to be medically frail, Section 1931 parents and caretaker relatives, and individuals eligible for transitional medical assistance.

4.6.4 Hepatitis C Drug Coverage.

Effective September 1, 2016, all covered hepatitis C drugs were carved out of managed care, including HIP. HIP members are still able to access all such covered hepatitis C drugs through the Medicaid fee-for-service pharmacy benefit manager, rather than through their assigned MCE. The State requests that this program revision be documented in the revised STCs.

4.6.5 Plan Changes and Member Transitions.

Currently, HIP members select a managed care entity on the application, and can change their selection at any time prior to making their initial POWER account contribution. Thereafter, HIP members may change their health plan annually during their redetermination period, or anytime during the 12-month benefit period for one of the specified "for cause" reasons described in 405 IAC 10-8-2(b), such as receiving poor quality of care.[89] While the reasons for transitioning between plans is limited, members often leave and return to the program within a 12 month period, often resulting in changed health plans and new POWER accounts. The State seeks to maintain plan choice for members for the complete 12 month period. Therefore, if a member selects an MCE and begins eligibility, they will remain with that MCE for the full 12 months, even if the individual disenrolls and re-enrolls in HIP coverage within the same 12 month period. Members will continue to have the ability to change plans for "just cause" reasons specified in 405 IAC 10-8-2(b). In addition, rather than providing new POWER accounts, individuals who re-enroll in coverage in the same 12 month period will have their POWER account reinstated

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[87] *Id.* The member survey, conducted in 2015, found that transportation was reported as the primary reason for missing a healthcare appointment for 11% of HIP members with access to NEMT coverage, and only 6% among individuals without access to NEMT benefits. The 2016 member survey found that HIP members without state-provided NEMT benefits missed fewer appointments than members with state-provided NEMT (10.9% to 13.6%).

[88] *Id*.

[89] 405 Ind. Admin. Code 10-8-2(b) (2016). Indiana Administrative Code provides the following as "for cause" reasons for MCE disenrollment: (1) the causes for disenrollment set forth in 42 CFR 438.56(d)(2)(i) – (iii); (2) receiving poor quality care; (3) failure of the insurer to provide covered services; (4) failure of the insurer to comply with established standards of medical care administration; (5) lack of access to providers experienced in dealing with the member's health care needs; (6) significant language or cultural barriers; (7) corrective action levied against the insurer by the office; (8) limited access to a primary care clinic or other health services within reasonable proximity to a member's residence; (9) a determination that another insurer's formulary is more consistent with a new member's existing health care needs; and (10) other circumstances determined by the office to constitute poor quality of health care coverage.

rather than receiving a new POWER account. Minimizing changes associated with member transitions will result in improved continuity of care for the member as well as administrative savings for the State.

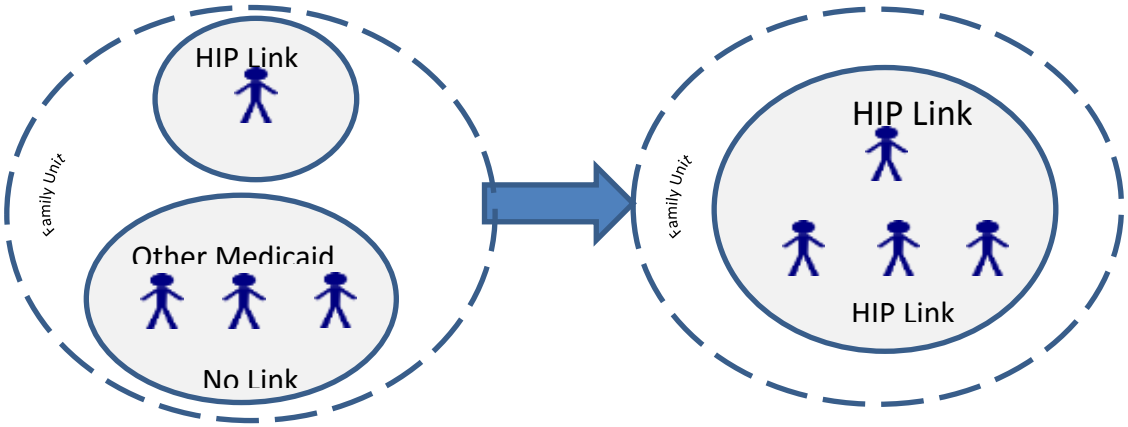
In addition, to ease transitions for members transitioning to HIP from other Medicaid categories or between types of HIP coverage, HIP eligible individuals making such a transition will be immediately enrolled in the HIP Basic plan with a 60-day opportunity to make an initial POWER account contribution to move to HIP Plus. This process avoids potential gaps in coverage during the critical transition periods for post-partum women transitioning from Hoosier Healthwise, incarcerated individuals transitioning back to the community, and other similar member transitions.

Section 5: Enhancements to HIP Employer Link

HIP Employer Link allows HIP eligible individuals who have access to qualifying employer sponsored insurance to enroll in the employer's health insurance instead of enrolling in HIP. Individuals enrolled in HIP Employer Link receive a $4,000 POWER account to cover the costs of the premiums and medical care on their employer sponsored plan. HIP Employer Link began enrolling employers in July of 2015 and coverage began for the first employee in November 2015. Today, HIP Employer Link is only available to HIP eligible individuals, while the other family members of HIP Employer Link eligible members in different Medicaid categories are not eligible to participate in this program. For example, children of HIP Employer Link members under age 19 are not currently eligible for HIP Employer Link premium assistance. This results in the HIP Employer Link eligible parent enrolling in their employer sponsored insurance with HIP Link premium support, and the child not having the option of premium support and remaining enrolled only in Medicaid.

HIP Employer Link builds upon one of the fundamental goals of the HIP program—to promote private market coverage and family coverage options to reduce network and provider fragmentation within families. To more fully achieve this goal, the State plans to extend the HIP Employer Link coverage option to all Medicaid eligible family members of HIP Employer Link enrollees. This would mean that in place of a parent receiving HIP Employer Link premium assistance and the children being enrolled in Medicaid, that the entire Medicaid eligible family of the HIP Employer Link enrollee would be eligible for premium assistance.

HIP Employer Link: Enhancement to offer Family Coverage



Non-HIP but Medicaid eligible family members of HIP Employer Link enrollees would have the option to enroll in the HIP Employer Link coverage, provided that the family coverage is affordable based on the HIP Employer Link affordability assessment. Specifically, any Medicaid eligible family member of HIP Employer Link enrollee, regardless of aid category, would be eligible to voluntarily enrollee in the HIP Employer Link Coverage, except for the eligibility groups that receive limited benefit coverage or are Medicare eligible duals listed in *Table 5.1* below.

Table 5.1: Eligibility Groups Excluded from Participation in HIP Employer Link Plans

Eligibility Group Name	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)

Non-HIP eligible family members participating in HIP Employer Link coverage will not receive a HIP Link POWER account since they are not HIP eligible. In addition, these individuals will receive a benefit wrap to the full Medicaid State Plan benefit package, and standard State Plan cost sharing policies will apply. The primary HIP Employer Link employee will receive the full reimbursement for the family premium on their regular monthly check.

Employers that offer high deductible health plans are not excluded from HIP Link provided, that the overall premium contribution and cost sharing structure passes the HIP Link affordability assessment. In alignment with the HIP Link premium assistance process, premium assistance for family members of HIP Link employees will not exclude high deductible plans if the plan is otherwise affordable. As part of the HIP Link enhancement, the State requests authority to consider high deductible plans cost effective for family members of HIP Link enrollees, including children, provided that these plans meet the HIP Link affordability requirements.

Section 6: Substance Use Disorder

Through this waiver extension application, the State seeks to address the substantial drug abuse epidemic facing the State by adding critical new evidence-based substance use disorder (SUD) treatment services, as well as expanding access to qualified providers through a waiver of the long-standing CMS exclusion of IMD providers (IMD exclusion). The IMD exclusion currently prohibits federal financial participation for medically necessary, inpatient mental health services provided in freestanding psychiatric hospitals with greater than sixteen (16) beds for Medicaid eligible adults between 21 and 64 years of age. The IMD exclusion has created a significant access issue in the State. In fact, nearly 35% of all public comments received during the original HIP 2.0 waiver public comment period urged the State to include IMD providers in the HIP program. Since that time, in July 2015, CMS issued a letter indicating a willingness to waive the

IMD exclusion, provided the IMD waiver is only a component of broad based and comprehensive reforms to address SUD.

In September 2015, Governor Pence created the Taskforce on Drug Enforcement, Treatment and Prevention (Taskforce) to identify solutions to Indiana's drug abuse epidemic, recently exemplified by a March 2015 public health emergency in Scott County, Indiana, following a significant HIV outbreak.[90] As of September 15, 2016, the Indiana State Department of Health reported a total of 206 individuals testing positive for HIV in Scott County, with the vast majority of cases being linked to syringe-sharing partners injecting oxymorphone, a prescription opioid.[91] During its first meeting, the Taskforce recommended that the State explore the feasibility of pursuing the IMD waiver opportunity to address the significant SUD public health threat facing the state.

The historic HIV outbreak in Scott County is just one example of the devastating impact to families and communities caused by the heroin and opioid epidemic sweeping across the country. Drug addiction is a widespread problem in Indiana that affects the lives of far too many Hoosiers. The following statistics begin to outline the scope of the problem:

- Nearly six times as many Hoosiers died from drug overdose in 2014, as did in 2000 (twice the national rate).[92]
- The number of heroin overdose deaths increased by nearly 25 times between 2000 and 2014.[93]
- In 2014, Indiana had the 16th highest drug overdose death rate in the nation, which represented a statistically significant increase in the rate from 2013.[94]
- Since 2009, more Hoosiers have lost their lives due to a drug overdose than in automobile accidents on state highways.[95]

For over a year, the Taskforce has studied the issues and identified a number of recommendations. With respect to enforcement, the Taskforce recommendations included support of legislation to enhance penalties for serious drug dealing offenses; implementation of a Regional Therapeutic Communities pilot program in northwest Indiana; and implementation of a therapeutic substance use disorder treatment program for offenders awaiting adjudication and for

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[90] Governor Mike Pence, *Executive Order 15-05: Declaration of Public Health Emergency in Scott County, Indiana*, STATE OF INDIANA (March 26, 2016), http://www.in.gov/gov/files/Executive_Order_15-05.pdf.

[91] Press Release, Indiana State Department of Health, Scott County Public Health Emergency Declaration Extended (Aug. 3, 2016), *available at* http://www.in.gov/isdh/files/May_2_2016_SCOTT_COUNTY_PUBLIC_HEALTH_EMERGENCY_DECLARATION_EXTENDED.pdf.

[92] INDIANA STATE DEPARTMENT OF HEALTH, INDIANA: SPECIAL EMPHASIS REPORT, DRUG OVERDOSE DEATHS, 1999-2013 (2015), *available at* http://www.in.gov/isdh/files/2015_SER_Drug_Deaths_Indiana_Updated.pdf.

[93] *Id*.

[94] R. Rudd et al., *Increases in drug and opioid overdose deaths — United States, 2000–2014*, 64(50) MORBIDITY AND MORTALITY WEEKLY REPORT 1378 (2016).

[95] INDIANA STATE DEPARTMENT OF HEALTH, INDIANA: SPECIAL EMPHASIS REPORT, DRUG OVERDOSE DEATHS, 1999-2013 (2015), *available at* http://www.in.gov/isdh/files/2015_SER_Drug_Deaths_Indiana_Updated.pdf.

those serving sentences while in jail. Regarding treatment, in addition to seeking this 1115 SUD waiver, the Taskforce recommendations included implementation of a Gold Card program and promulgation of chronic pain, acute pain, and emergency department controlled substance prescribing guidelines. Finally, concerning prevention, the Taskforce recommendations included identification of best practices related to INSPECT, measures to increase provider access to the system, and expanded integration of prescription data with hospital patient records; efforts to increase awareness of Aaron's Law and access to naloxone, as well as supporting youth assistance and SUD education programs.[96]

As the State's broader drug enforcement, treatment, and prevention efforts take root, FSSA aims to support the Taskforce through the SUD initiative set forth in this waiver. This waiver extension application seeks to enhance the Indiana Medicaid and HIP benefit packages to provide a more comprehensive SUD continuum of care, as well as to improve access and quality of care across the entire mental health and SUD delivery system. Specifically, the State seeks to add new SUD benefits, such as residential treatment services and expanded intensive outpatient treatment services, so that all Medicaid recipients can access benefits across the full continuum of care in alignment with best practice standards set forth by the Association of Addiction Medicine (ASAM). As part of this request, the State seeks a waiver of the IMD exclusion for Medicaid beneficiaries ages 21-64 with short-term stays up to thirty (30) days, in order to expand access to treatment options. Ultimately, through this waiver, the State seeks to support the overall initiative by developing a robust SUD benefit that not only adds critical short-term inpatient and residential services, but also builds out sufficient recovery support services to maintain individuals in treatment at all stages of SUD recovery consistent with evidence-based practices. Taken together with the work of the Taskforce and the State's comprehensive multi-agency SUD initiative, the State meets the additional expectations and the requirements of a Section 1115 SUD program as detailed in the CMS Medicaid Director's letter dated July 27, 2015.

6.1 SUD Initiative Eligibility

The SUD initiative will include all mandatory and optional eligibility groups approved for full benefit Medicaid or CHIP coverage under the Indiana Medicaid and CHIP State Plans. Only the eligibility groups outlined in *Table 6.1* below will not be eligible for the enhanced SUD benefits described in this waiver, as they receive limited Medicaid benefits only.

Table 6.1: Eligibility Groups Excluded from the Demonstration

Eligibility Group Name	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)

[96] 119th Ind. Gen. Assemb., 1st Reg. Sess. (2015). S.E.A. 406. In 2015, the Indiana General Assembly passed, and Governor Pence signed into law House Enrolled Act 406, known as "Aaron's Law," which authorizes prescribers to use standing orders to dispense naloxone and provides civil immunity to individuals administering the medication in good faith.

Qualified Disabled Working Individual (QDWI) Program	1902(a)(10)(E)(ii) 1905(s)
Family Planning	1902(a)(10)(A)(ii)(XXI)

6.2 Enhanced Benefits

The current SUD benefit available to Medicaid enrollees (whether through the State Plan or waiver programs) will be expanded to provide the full continuum of evidence-based best practice care, allowing individuals to step down treatment in the best manner possible to prevent relapse and increase the long-term success.

6.2.1 Detoxification Services

In spring 2016, the Indiana General Assembly passed Senate Enrolled Act 297, which requires 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. This change significantly increases access to these previously covered services, as former State coverage policy required a showing of immediate danger or death to themselves or others as a prerequisite for admission for inpatient detoxification services. Following this change, medical necessity for this level of care will be aligned with ASAM medical necessity criteria.

6.2.2 Residential Treatment

Following detoxification, residential treatment facilities provide persons recovering from SUD the opportunity to establish a pattern of healthy behaviors and a meaningful period of sobriety before returning to unsupervised daily living. Currently, Indiana Medicaid does not reimburse for residential treatment. Rather, the State provides grants to specific facilities for the provision of limited residential treatment services for specific vulnerable populations, such as pregnant women. Although residential treatment itself is not covered, Medicaid enrolled providers may receive Medicaid reimbursement for covered professional services delivered to beneficiaries in a residential setting, but this limited reimbursement opportunity does not fully address the needs of this population.

Through this waiver, the State seeks to add residential detoxification and SUD treatment services (ASAM levels 3.1, 3.5, and 3.7) as a Medicaid covered benefit. The State will comply with the requirements set forth CMS Medicaid Director's letter dated July 27, 2015.

6.2.3 IMD Exclusion

In addition, the State seeks to expand access to residential treatment providers in order to provide meaningful access to the new residential treatment benefit. Federal law currently prohibits all federal financial participation for medically necessary services provided by qualified healthcare providers in certain institutions that meet the definition of an IMD. The IMD exclusion has resulted not only in a lack of access to appropriate mental health services for certain Medicaid beneficiaries, but also an increase in the amount of uncompensated care IMDs provide to adult Medicaid beneficiaries and the indigent.

On June 30, 2016, Indiana Medicaid announced that effective for dates of services on or after July 5, 2016, contracted MCEs may authorize coverage for stays of up to 15 days in an IMD for inpatient services related to mental health, behavioral health, and SUD in lieu of other settings under the Medicaid State Plan. However, this limited IMD allowance only applies to Indiana

Health Coverage Program members enrolled in a managed care program (i.e. HIP, Hoosier Care Connect, and Hoosier Healthwise). Through this waiver extension application, the State seeks a waiver of the IMD exclusion for all Medicaid beneficiaries ages 21-64, regardless of delivery system, with short-term stays up to thirty (30) days, as a mechanism to increase access to residential treatment services across the State. Medicaid members with an SUD diagnosis, including members with dual SUD and mental health diagnoses, will be able to access services in an IMD through this waiver.

The waiver of the IMD exclusion would allow several psychiatric facilities the opportunity to provide reimbursable services to Medicaid recipients, and it would allow several additional psychiatric facilities, currently operating with less than 16 beds, the opportunity to increase capacity. Overall, the IMD exclusion waiver would allow Medicaid patients to access at least 15 new facilities across the state, and potentially increase capacity at 12 other facilities.

6.2.4 Intensive Outpatient Treatment- Addiction Recovery Supports

After receiving detoxification and/or residential treatment services, it is essential that persons recovering from SUD receive the ongoing treatment and support required to sustain their established period of sobriety. Currently, many of these critical recovery support services are only available through a Community Mental Health Center (CMHC). CMHCs serve as the State's mental health delivery safety net system, providing a source of mental health and SUD treatment for individuals with no other source of care. The State contracts with all 25 of the CMHCs operating in Indiana to provide a range of mental health and addiction services, to Medicaid enrolled individuals. Further, CMHCs play a critical role in the delivery of intensive outpatient mental health and addiction services, as they are the exclusive provider of all Medicaid Rehabilitation Option (MRO) services, which provides wrap-around support services to individuals living in the community undergoing intensive outpatient treatment.

To address the growing SUD epidemic, increased access to services is a critical need. Therefore, the State will add "Addiction Recovery Management Services" as a Medicaid covered benefit, available to members outside of MRO. This will allow all qualified providers (not just CMHCs) to provide critical intensive outpatient support services to individuals recovering from substance use disorder, which will significantly increase access to care throughout the state. Specifically, the new service will provide reimbursement for the essential recovery support services including:

- Recovery education;
- Peer recovery support services;
- Housing support services;
- Recovery focused case management; and
- Relapse prevention services.

6.3 Cost Sharing

All cost-sharing for SUD services provided through this waiver will be consistent with the Medicaid State Plan applicable to the individual's specific eligibility category.

Section 7: Evaluation Plan

As outlined in Section 3 of this waiver extension application, HIP has a comprehensive evaluation plan—approved by CMS—that has been successful in tracking HIP's progress toward achieving its stated goals. Throughout the HIP demonstration period, the evaluation tools have revealed the positive impact of incentives and consumer-driven design in improving health care utilization behaviors. During the new demonstration period, Indiana will maintain the original evaluation design, but will add new components in order to assess the impact of the new programs and policies presented within this waiver extension application. Specifically, Indiana will include an analysis of the following new components within its updated HIP evaluation plan:

1. Tobacco Cessation
2. Substance Use Disorder (SUD)
3. Chronic Disease Management
4. Employment Related Incentives

The following table outlines the evaluation methodology for the new program components within the HIP waiver extension:

Hypothesis	Methodology	Data Source
1. Tobacco Cessation		
HIP will increase utilization of tobacco cessation benefits among individuals who use tobacco	Track and compare rates of tobacco cessation utilization among individuals who use tobacco.	Claims Data • Number and percentage of members with tobacco cessation utilization codes MCE Data • Number and percentage of members with tobacco use indicated by MCE health risk assessment Pharmacy Benefit Data • Number and percentage of members with tobacco cessation prescriptions Member Survey Data • Member knowledge of tobacco-cessation benefits; member self-report of tobacco use; member self-report of tobacco cessation utilization
HIP's increased contribution requirement for tobacco users will discourage tobacco	Track and compare rates of tobacco use and tobacco cessation utilization among individuals who use tobacco.	Claims Data • Number and percentage of members with tobacco cessation utilization codes MCE Data

Hypothesis	Methodology	Data Source
use among current smokers		• Number and percentage of members with tobacco use indicated by MCE health risk assessment Pharmacy Benefit Data • Number and percentage of members with tobacco cessation prescriptions Member Survey Data • Member knowledge and perceptions of increased contribution for tobacco users; member self-report of tobacco use; member self-report of tobacco cessation utilization
2. Substance Use Disorder (SUD)		
HIP will increase access to SUD treatment among individuals with SUD	Track and compare rates of SUD treatment engagement among members with SUD	Claims Data • Number and percentage of members with SUD diagnosis codes • Number and percentage of members with SUD treatment codes MCE Data • Number and percentage of members with SUD indicated by MCE health risk assessment Pharmacy Benefit Data • Number and percentage of members with SUD treatment prescriptions Quality measures from the Medicaid Adult and Children's Core Sets for individuals with SUD • Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NQF #0004)
HIP will improve the continuum of care among individuals engaged in SUD treatment	Track and compare SUD treatment engagement following discharge from SUD treatment facilities and hospitals	Quality measures from the Medicaid Adult and Children's Core Sets for individuals with SUD • SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided

Hypothesis	Methodology	Data Source
		or Offered at Discharge (NQF #1664) • SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge (NQF #1664) measures • Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence (NQF #2605) • Timely Transmission of Transition Record (NQF #0648) • Transition Record with Specified Elements Received by Discharged Patients (NQF #0647)
HIP will reduce SUD readmission rates to the same level of care or higher	Track and compare rates of SUD treatment readmission	Claims Data • Number and percentage of members with SUD diagnosis codes • Number and percentage of members with SUD treatment codes Quality measures from the Medicaid Adult and Children's Core Sets for individuals with SUD • Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NQF #0004).
HIP will reduce emergency department utilization due to drug overdose	Track and compare rates of emergency department utilization due to drug overdose	Claims Data • Number and percentage of members with ER visits and admissions with drug overdose codes
HIP will reduce the rate of preventable hospitalization among members with SUD	Track and compare rates of preventable hospitalization among HIP members with SUD	Claims Data • Number and percentage of members with SUD and ambulatory case sensitive conditions who are hospitalized
3. Chronic Disease Management		
HIP's chronic disease management incentive structure will promote active engagement in MCE	Track and compare rates of chronic disease management program participation	MCE Data • Number and percentage of members engaged in chronic disease management programs Member Survey Data

Hypothesis	Methodology	Data Source
chronic disease management programs and activities		• Member knowledge and perceptions of chronic disease management program incentives
HIP's chronic disease management incentive structure will reduce the rate of preventable hospitalization among members enrolled in chronic disease management programs	Track and compare rates of preventable hospitalization among members enrolled in chronic disease management programs	MCE Data • Number and percentage of members engaged in chronic disease management programs Claims Data • Number and percentage of members engaged in chronic disease management with ambulatory case sensitive conditions who are hospitalized
4. Employment Related Incentives		
HIP's employment related incentive structure for MCEs will promote active member engagement the Gateway to Work Program	Track and compare rates of participation in the Gateway to Work Program	Administrative Data • Number and percentage of members enrolled in the Gateway to Work Program MCE Data • Number and percentage of members who earn incentives for engagement in the Gateway to Work program
HIP's employment related incentive structure for MCEs will promote employment among HIP members	Track and compare rates of employment among HIP members	Eligibility and Enrollment Data • Number and percentage of members who earn employment • Number and percentage of members who are disenrolled from HIP due to increased earnings from employment MCE Data • Number and percentage of members who earn incentives for obtaining employment

Section 8: Demonstration Financing and Budget Neutrality

A detailed financing and budget neutrality report is attached hereto as Attachment I.

Section 9: Requested Waivers

The State requests a renewal of all currently approved waivers, and only requests the following revisions and additions to the existing HIP waivers:

1. Premiums Section 1902(a)(14) and Section 1916
To enable the State to charge premiums in HIP Plus at levels not more than two percent of household income and not more than three percent of household income for tobacco-users after their first year of HIP enrollment. Total cost-sharing for a household is subject to a quarterly aggregate cap of five percent of household income, except that all HIP Plus households will be required to contribute, at a minimum, monthly one dollar ($1.00) POWER account contributions. Individuals at or below 100 percent of poverty will not have premiums as a condition of eligibility.

2. Amount, Duration, Scope, and Comparability Section 1902(a)(10)(B)
To the extent necessary to enable Indiana to permit Medicaid eligible individuals to choose to participate in an employer-sponsored health insurance plan through a HIP Employer Link participating family member, with wrap-around to their existing Medicaid benefits.

3. Reasonable Promptness Section 1902(a)(8)
To the extent necessary to enable Indiana to establish an open enrollment period for HIP, such that members who are disenrolled for failure to comply with the redetermination process will be required to wait until their next open enrollment period to re-enroll (up to six months).

4. Cost Not Otherwise Matchable
The State requests that expenditures related to providing services in an IMD be regarded as expenditures under the State's Medicaid Title XIX State Plan.

Section 10: Public Comment

The State held public hearings for this three-year HIP waiver extension application pursuant to the requirements set forth at 42 CFR 431.408. A copy of the full public notice that announced the two public hearings and formally opened the 30-day public comment period is included in Attachment II of this application. The notice was posted on the agency's website at the web address of the HIP program homepage: HIP.in.gov, as well as formally published in the Indiana Register on December 21, 2016. In addition, the Indiana Family and Social Services Administration sent electronic notification of the extension application to the agency's stakeholder distribution list. The public notice provided the option for any individual, regardless of whether he or she attended the public hearing, to submit written feedback to the State by email or by USPS mail. Electronic copies of all documents related to the HIP waiver extension application were also available on the HIP website.

In addition, the State initiated consultation and provided notice of the HIP waiver extension application and its contents to Indiana's federally recognized Indian tribe, the Pokagon Band of Potawatomi Indians, on December 2, 2016. The notice and opportunity for consultation was provided in accordance with 42 CFR 431.408(b). Following the 30-day comment period, the State received no comments or requests for additional consultation from members of the tribe.

Public hearings regarding the waiver were conducted on January 4, 2017 and January 5, 2017, as scheduled and publicized, at the Indiana Government Center Conference facilities and at the Indiana State Library. Three individuals testified regarding the HIP extension proposal on January 4, 2017, and eleven (11) individuals testified on January 5, 2017. Many of the individuals who testified later provided a written copy of their testimony. A court reporter

transcribed both hearings. The January 4, 2017 hearing was also made available to the public statewide via a live, free webcast.

On January 5, 2017, in addition to holding a public hearing, FSSA presented this waiver extension application to the Medicaid Advisory Committee, the State's Medical Care Advisory Committee that operates in accordance with 42 CFR 431.12. Also, pursuant to state law, the waiver extension application will also be presented to the Indiana Budget Committee in 2017 prior to implementing any revisions to the HIP waiver.

The State received a total of 32 public comments, both written and verbal, during the 30-day public comment period. The below summary combines the testimony offered at the public hearings as well as the comments received via mail and email.

10.1 Summary of Public Comments

The vast majority of the comments were supportive of the HIP waiver extension application, and there were no comments opposing the State's submission of the extension application. Many commenters shared support for several of the proposed program enhancements contained in the application, including the tobacco cessation initiative and other initiatives aimed at improving health outcomes. For example, the Indiana State Medical Association (ISMA) praised the State's efforts to address chronic disease management, SUD and tobacco cessation, noting that these areas are also a focus of ISMA and other interested groups throughout the State through the Alliance for a Healthier Indiana.

The majority of commenters were particularly enthusiastic to write in support of the SUD initiative, particularly the addition of SUD services for Medicaid members and expansion of access to qualified providers through seeking a waiver of the IMD exclusion. Over 50% of the comments received included positive comments regarding the steps the State is taking to address the opioid epidemic in Indiana through this waiver extension application. Several commenters, comprised of impacted providers, requested clarification regarding the scope of the IMD exclusion waiver, such as detailing covered services, defining the application of the 30-day limit, and clarifying eligible providers.

Several commenters also expressed appreciation of the aspects of the program that will remain intact, specifically the key design features of the program that continue to promote personal responsibility and consumerism. As Indiana University Health, one of the nation's busiest hospital systems, wrote, POWER accounts "empower [members] to demand price and quality transparency as they make cost-conscious health care decisions." Members of the healthcare community, including the Indiana Hospital Association, the Indiana State Medical Association, some of the state's largest hospital systems, and some of the state's managed care entities (MCEs) expressed support for the HIP program as an innovative, consumer-driven approach to expanding coverage. Some of these organizations praised HIP's ability to decrease use of the emergency department, increase use of preventive care, and improve consumer behavior. Members of the healthcare community also continue to support HIP's higher provider reimbursement rates and the associated decrease in cost-shifting to the private market.

A couple of commenters noted a general preference for HIP compared to no Medicaid expansion, but also expressed a desire for greater administrative simplification, particularly around the POWER account process. The State also received a few comments from individuals

noting concern with reestablishment of a HIP open enrollment period. While several commenters praised the tobacco cessation initiative, two of those commenters expressed concern with inclusion of the surcharge for known tobacco users. Additionally, the State received suggestions (two comments) to expand coverage for non-emergency medical transportation.

The MCEs currently serving HIP members commented that members seem to take pride in paying their monthly contributions. These entities continue to support HIP's consumer oriented program, and indicated that HIP's member responsibility provisions positively contribute to member health outcomes. The MCEs note HIP members have lower emergency room use and lower inpatient admissions and are more likely to complete recommended preventive services when compared to traditional Medicaid members. The plans all praised the State for its focus on improving the program with the program enhancements included in this application. One of the health plans recommended that the State consider permitting "ASAM aligned criteria," rather than specifically mandating the use of ASAM criteria, as it would allow greater flexibility for the State to quickly incorporate various innovations in SUD care ahead of formal adoption by the professional society.

10.2 State Response & Summary of Revisions

The State appreciates all comments received either during a public hearing or shared with the State in writing. The majority of the comments received did not include suggested revisions to the waiver extension, so the State has not addressed individual comments. However, the State has reviewed all comments in depth and will consider many of the comments in its discussions with CMS and in context of the program evaluation and outcomes data related to HIP's design features and the impact on the goals of the program.

The State has made the following revisions and clarifications to the application as a result of the public comment period.

1. ASAM. Based on concerns raised by one of the managed care entities, the State clarified that new SUD services will be provided based on ASAM or other ASAM-aligned criteria approved by the State.

2. Emergency Department Copayments. Based on a request for clarification, the State revised Section 4.6.2 of the waiver application to clarify its request to extend the current HIP copayment policy for non-emergency use of hospital emergency departments. Specifically, based on the favorable data to date and pending the results of the formal study, the State seeks to make this policy permanent for the duration of the extension period.

3. Substance Use Disorder. Due to several requests for clarification, the State removed the tables in Section 6.2.3 of the waiver application, which specifically listed existing IMD facilities throughout the state. The new reimbursement opportunity for IMDs is not limited to the facilities previously included on the tables, but rather will be available to any properly licensed facility that meets the Medicaid provider requirements. In addition, language was added to clarify that the IMD exclusion will allow reimbursement for short term residential stays for Medicaid eligible adults with an SUD diagnosis, including those with a dual SUD and mental health diagnosis.

4. New Rollover Data. Following the initial posting of this waiver extension application, the State received preliminary data related to the utilization of the rollover program feature. The waiver application was amended to reflect this newly available program data.

Other than the addition of the content of Section 10 of this application summarizing the public comment period, as well as the substantive changes identified above, this application is identical to the copy of the application initially posted on the FSSA website on December 21, 2016.

Section 11: Demonstration Administration

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Attachment I: Demonstration Financing and Budget Neutrality

1115 Waiver – Healthy Indiana Plan

Healthy Indiana Plan – First Renewal

Budget Neutrality Projections

State of Indiana

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BACKGROUND

INITIAL FILING

The Healthy Indiana Plan (HIP) 1115 Waiver was approved for a three-year period from February 1, 2015 through January 31, 2018. (Project Number 11-W-00296/5). The waiver was approved January 27, 2015, and technical corrections to the special terms and conditions (STCs) were issued May 14, 2015.

Through the HIP waiver, Indiana provides coverage to non-disabled adults between the ages of 19 and 64 with a household income less than 138 percent of the Federal poverty level (FPL). A Personal Wellness and Responsibility (POWER) account is established to pay for the $2,500 plan deductible. Those who make monthly contributions to the account are enrolled in HIP Plus, while those with incomes at or below 100 percent of FPL who do not make contributions are enrolled in HIP Basic. The accounts are intended to promote efficient use of healthcare. Those enrolled in HIP Plus receive an enhanced benefit package and are not subject to cost sharing, with the exception of copayments for non-emergency use of the emergency department services.

APPROVED TITLE XIX WAIVERS

HIP includes the following Title XIX waivers:

1. **Premiums** - Section 1902(a)(14) and Section 1916: HIP Plus premiums may not exceed 2% of household income, and total cost sharing may not exceed 5% of quarterly income. Enrollees at or below 100 percent of poverty are not required to contribute as a condition of eligibility, but those who do not contribute may be enrolled in HIP Basic.
2. **Freedom of Choice** - Section 1902(a)(23)(A**)**: HIP Employer Link providers may be limited to those participating in the network of a HIP Employer Link plan. This waiver does not apply to family planning providers.
3. **Reasonable Promptness** - Section 1902(a)(8**)**: Enrollment may begin on the first day of the month following which an individual makes their initial POWER account contribution, and, for those at or under 100 percent FPL, no later than the first day of the month in which the 60 payment period expires. Reasonable promptness is also waived to allow Indiana to prohibit reenrollment for 6 months for individuals over 100% of FPL who are dis-enrolled for failure to make POWER account premium contributions, subject to exceptions in the STCs. This provision is not waived for AI/AN enrollees.
4. **Methods of Administration** – Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53: Non-emergency medical transportation waiver for one year. Does not apply to pregnant women, the medically frail, or Section 1931 parents and caretakers.
5. **Comparability** – Section 1902(a)(17): Allows cost sharing requirements to vary between HIP Plus and HIP Basic.
6. **Retroactivity** – Section 1902(a)(34): Waives the requirement for retroactive coverage.
7. **Cost sharing for non-emergency use of the emergency department** – Section 1916(f): Allow the graduated co-payment up to $25 for all HIP populations for two years.
8. **Payment to providers** – Section 1902(a)(13) and Section 1902(a)(30): To permit Indiana to pay providers serving the HIP Employer Link population no more than rates paid by the employer sponsored insurance (ESI) plan, and such that amounts paid by the ESI plan plus payment from the POWER account and member cost sharing serves as payment in full.

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 Healthy Indiana Plan (HIP) 1115 waiver renewal (Project Number 11-W-00296/5).

BUDGET NEUTRALITY – ACTUAL AND PROJECTED (DY01 – DY06)

The current waiver has been approved for the period February 1, 2015 through January 31, 2018. Indiana is currently requesting a three-year renewal.

Table 1 illustrates the actual and projected Waiver Margin for the Demonstration. Values were developed using CMS Schedule C reporting through September 30, 2016, with estimated adjustments for presumptive eligibility (PE) program reporting (described later in this report).

Table 1
State of Indiana, Family and Social Services Administration
1115 HIP Waiver Budget Neutrality Summary
HIP 2.0 Waiver Renewal (11-W-00296/5)
(Values in $Millions)

Calendar Year	Demonstration Year	Without Waiver Expenditures	With Waiver Expenditures	Total Savings	Waiver Margin	Cumulative Waiver Margin
2015	1	$ 2,058.9	$ 1,660.6	$ 398.3	$ 191.0	$ 191.0
2016	2	$ 3,295.2	$ 2,611.9	$ 683.3	$ 231.3	$ 422.3
2017	3	$ 3,848.0	$ 3,036.8	$ 811.3	$ 262.4	$ 684.7
2018	4	$ 4,116.9	$ 3,243.0	$ 873.9	$ 292.1	$ 976.8
2019	5	$ 4,284.0	$ 3,357.5	$ 926.5	$ 323.4	$ 1,300.2
2020	6	$ 4,481.7	$ 3,495.1	$ 986.6	$ 357.1	$ 1,657.2

Expenditures in Table 1 represent incurred expenditures for each demonstration year, and also reflect program adjustments proposed for the renewal period.

FIRST RENEWAL

Indiana seeks to renew the HIP waiver for an additional three years with the following enhancements:

1. **Member incentives**: The State will increase the upper limit on member health incentives to $300. The State will ask for focus on tobacco cessation, substance abuse management, and chronic disease management.
2. **Tobacco user surcharge**: The State would like to increase monthly contribution requirements for HIP Plus tobacco users from 2% of household income to 3%. This increase would take effect in the member's second year of eligibility.
3. **HIP Plus Enhancement**: The State would like to add chiropractic benefits for the HIP Plus population only (this benefit is already available to those receiving State plan services, including Section 1931 caretakers, pregnant women, and the medically frail). The service will have an annual limit of six spinal manipulation visits per covered person per benefit year.
4. **Open enrollment period**: Individuals who do not submit redetermination paperwork in a timely manner must wait six months following disenrollment until their next open enrollment period to re-enroll in HIP coverage.
5. **Substance use disorder benefits:** The State is requesting a waiver to reimburse for short-term stays of less than 30 days in an Institution of Mental Diseases (IMD). In addition, the State seeks to add other enhanced substance abuse services for all Medicaid populations.
6. **HIP Employer Link dependents**: To allow Medicaid-eligible family members of a HIP Employer Link participant, including children, to access coverage through the HIP Employer Link program.
7. **Enhanced health plan incentives**: To tighten focus on outcomes.

BASELINE PROJECTIONS

This section provides additional detail on the data, assumptions, and methodology associated with baseline projections for the 1115 waiver budget neutrality filing – before proposed changes to the waiver.

BUDGET NEUTRALITY MODEL

We continue to utilize the budget neutrality model provided for the first HIP waiver submission. It has been updated to reflect historical enrollment and expenditures through September 30, 2016, as reported by Indiana in Schedule C of the Form CMS 64.

We have also included an Excel file version of the development of the waiver budget neutrality exhibits: "HIP Budget Neutrality – 2018 HIP Renewal.xlsx".

BASELINE ENROLLMENT

1115 waiver populations for HIP

HIP enrollment, including the Section 1931 Caretaker population, was approximately 400,000 enrollees as of October 31, 2016, excluding conditional enrollees. Baseline enrollment is projected to expand to approximately 450,000 by the end of DY 06.

Eligibility data from the State of Indiana's Enterprise Data Warehouse, reported through October 31, 2016, was used to estimate enrollment for each 1115 Waiver population. The populations were identified as follows:

1. Section 1931 Parents: aid category SB or SP and not Medically Frail (as defined below)
2. New Adult Group: aid category RB or RP and not Medically Frail
3. Medically Frail: capitation code FB, FP, or PC
4. HIP Employer Link: aid category HL
5. HIP Presumptive Eligibility: aid category HA

Enrollment trends

Enrollment has been projected starting with actual October 31, 2016 enrollment. Enrollment growth rates are consistent with those used in the Medicaid budget forecast, and are illustrated in Table 2. Elevated growth rates continue to be projected for newly eligible populations through June 30, 2017, or halfway through DY 03. Presumptive eligibility was used heavily during DY 01, but has been declining, and is projected to continue to decline through the projection period, due to elevated enrollment penetration in the eligible population.

Table 2
State of Indiana
Family and Social Services Administration
Annual Enrollment Growth Assumptions

Population	Through June 2017	After June 2017
Section 1931 Parents	0.5%	0.5%
New Adult Group	5,000 per month	1.0%
Medically Frail	2.0%	1.0%
HIP Employer Link	Grow to 2,000	1.0%
HIP Presumptive Eligibility	reduced by 2% per month	

Enrollment projection - baseline

Actual and projected enrollment is illustrated in Table 3, *before* the impact of proposed renewal changes (baseline projection). The projection was developed with eligibility data through October 31, 2016.

Table 3 State of Indiana Family and Social Services Administration Actual and Projected Average Monthly Enrollment - Healthy Indiana Plan Baseline						
Population	**DY 01**	**DY 02**	**DY 03**	**DY 04**	**DY 05**	**DY 06**
Section 1931 Parents	93,881	114,834	117,189	117,567	117,976	118,408
New Adult Group	134,179	225,322	269,015	276,835	278,884	281,094
Medically Frail	21,585	40,268	46,226	46,392	46,587	46,843
HIP Employer Link	1	97	1,696	2,010	2,022	2,041
HIP Presumptive Eligibility	81	78	55	43	34	27
Total Healthy Indiana Plan enrollment	**249,728**	**380,598**	**434,181**	**442,847**	**445,503**	**448,413**

WITHOUT WAIVER PMPM COSTS AND TRENDS

The Without Waiver projection model requires a baseline trend rate to project PMPM expenditures for future demonstration years. Annual PMPM amounts and trend rates for the initial waiver, DY 01 to DY 03, were approved by CMS. For the renewal, we have retained the initial trend rates, and assumed a 3.0% trend for the New Adult Group and HIP Employer Link.

Table 4 State of Indiana Family and Social Services Administration Without Waiver PMPM Costs and Trend Rates				
Population	**Trend Rate**	**DY 01**	**DY 02**	**DY 03**
Section 1931 Parents	5.30%	$ 666.15	$ 701.46	$ 738.64
New Adult Group	1.10%	545.14	551.14	557.20
Medically Frail	4.30%	1,662.65	1,734.14	1,808.71
HIP Employer Link	1.10%	348.33	352.17	356.04
Population	**Trend Rate**	**DY 04**	**DY 05**	**DY 06**
Section 1931 Parents	5.30%	777.79	819.01	862.42
New Adult Group	3.00%	573.92	591.14	608.87
Medically Frail	4.30%	1,886.48	1,967.60	2,052.21
HIP Employer Link	3.00%	366.72	377.72	389.05

Please note that trend rates illustrated above for the renewal have not yet been reviewed by CMS.

WITH WAIVER EXPENDITURES

Historical HIP expenditures – DY 01 and partial DY 02

Expenditures for the HIP program were provided by FSSA, as reported on the Form CMS 64.9 Waiver and Schedule C, project number 11-W-00296, as reported through September 30, 2016. These were summarized by demonstration year (calendar year), according to dates of service.

Adjustments to historical expenditures

Several adjustments were made to historical expenditures, as described in Appendix 4 of this report. These include annualization of DY 02 expenditures, reallocation of presumptive eligibility expenditures based on each enrollee's ultimate eligibility population, adjustments for prior period payments reported after September 30, 2016, and adjustments for anticipated future payments.

WITH WAIVER PMPM COSTS AND TRENDS

PMPM costs

With Waiver PMPM costs for DY 01 and DY 02 were developed by dividing expenditures by member months. PMPM costs for future demonstration years were projected from DY 02 using trend assumptions.

With Waiver trend rate

With the exception of the Section 1931 Caretakers, the With Waiver projections assume annual trend rates consistent with those indicated in the Table 4 above as the Without Waiver trend rates. For the Section 1931 Caretakers, the with waiver trend rate is assumed to be 3.5%, which is lower than the Without Waiver trend rate, as the structure of the demonstration is expected to result in more thoughtful healthcare utilization by members.

The HIP Presumptive eligibility population (extension to day 60) is only included in With Waiver projections and uses a trend rate of 1.10% for the initial waiver period and 3.0% for the renewal period (same trend as the New Adult Population).

The enclosures illustrate additional detail, including enrollment and expenditures for each population.

PROPOSED RENEWAL MODIFICATIONS

Effective DY 04, estimated With Waiver PMPM costs have been adjusted to reflect Indiana's proposed enhancements.

PROPOSED MODIFICATIONS TO THE HIP PROGRAM

Enhanced member incentives

The State proposes to increase the upper limit on member health incentives from $50 to $300. The State will request the MCEs focus on tobacco cessation, substance abuse management, chronic disease management, and employment.

On average, HIP members are currently earning $0.51 PMPM as incentives for healthy behaviors. Assuming a minimum requirement of $1 PMPM, we have added $0.50 PMPM to the with waiver costs for HIP populations (Section 1931 Parents, New Adults, and the Medically Frail).

Tobacco user contribution surcharge

The State proposes to increase contribution requirements for HIP Plus tobacco users from 2% of household income to 3% of income. This will result in a 50% increase in contribution amounts for tobacco users.

Since POWER account contributions by members reduce the amount that must be contributed by the State, this should reduce net PMPM cost of the program. We have estimated the value of the tobacco user contribution increase in Table 5.

Table 5
State of Indiana
Family and Social Services Administration
Estimated savings from tobacco user premium

Population	Percent Plus	Average Monthly Contribution	Percent in Plus who smoke	Contribution PMPM	
				Currently Paid by Smokers	Proposed Increase
Section 1931 Parents	54%	$ 4.38	40%	$ 0.95	$ 0.47
New Adult Group	71%	$ 13.85	35%	$ 3.44	$ 1.72
Medically Frail	80%	$ 9.87	35%	$ 2.76	$ 1.38

Only members enrolled in HIP Plus make POWER account contributions. The percent of members who choose to enroll in HIP Plus and the average monthly contribution were developed based on current data. Multiplying these two amounts results in the PMPM cost reduction represented by member contributions.

The percentage of members enrolled in HIP Plus who use tobacco products was estimated based on Health Needs Screening responses. Multiplying values in the first three columns of Table 5 results in the PMPM value of the POWER account contributions from smoking members, illustrated in column 4.

The proposed increase in the contribution amount for tobacco users will increase tobacco user contributions by 50%. The increase is illustrated in the last column of Table 5, and subtracted from the With Waiver PMPMs as a cost reduction.

Chiropractic benefits

The State has proposed adding chiropractic benefits to the HIP Plus new adult alternative benefit plan (ABP). This service would not be made available to HIP Basic new adult members. However, in populations on the State plan ABP both plus and basic members already have access to chiropractic benefits, including Section 1931 caretakers, the medically frail, and pregnant women.

The State has proposed an annual limit of six spinal manipulation visits. Other services that may be provided by chiropractors, including diagnosis and physical therapy, are already covered under the existing ABP. We have estimated the spinal manipulation benefit will add approximately $0.85 PMPM to the benefit cost for HIP Plus new adult members, who constitute approximately 71% of the new adult population, resulting in an overall PMPM increase of $0.60 PMPM for the new adult population. This is projected to increase DY 04 expenditures for the HIP Plus population by approximately $2 million. This estimate was developed based on the PMPM cost for Section 1931 caretaker members, adjusted to reflect the annual limit of six spinal manipulations.

We have added $0.60 PMPM to the New Adult population as of DY 04, both With and Without Waiver, to reflect inclusion of chiropractic benefits.

Reestablish the open enrollment period

Under Indiana's redetermination policies, over 62% of enrollees are eligible for auto-renewal or passive renewal. However approximately 38% are required to provide information as part of the annual process. 15% of those required to take action, were closed for non-compliance and did not take corrective action within 90 days. This represents 6% (15% * 38%) of all renewals). Non-compliant individuals could be required to wait six months until their next open enrollment period to re-enroll in HIP coverage.

We have estimated approximately half of those who do not comply are no longer eligible, and would not have re-applied for HIP even in the absence of open enrollment policy. HIP annual lapse rates (turnover) are approximately 3%. Of the remainder who remain eligible, enforcement may encourage better compliance, reducing what might otherwise be a 3% impact to an estimated 2%. Since the open enrollment policy will affect eligibility for half the year, the projected final impact of the waiting period on enrollment is estimated as a 1% enrollment reduction, affecting mainly the new adult group.

The impact is phased in over redeterminations that will occur during DY 04. Resulting enrollment is projected in Table 6, which may be compared with Table 3 (baseline enrollment).

Table 6
State of Indiana
Family and Social Services Administration
Actual and Projected Enrollment - Healthy Indiana Plan with Open Enrollment Policy

Population	DY 01	DY 02	DY 03	DY 04	DY 05	DY 06
Section 1931 Parents	93,881	114,834	117,189	117,567	117,976	118,408
New Adult Group	134,179	225,322	269,015	274,863	274,915	277,099
Medically Frail	21,585	40,268	46,226	46,160	46,122	46,374
HIP Employer Link	1	97	1,696	2,010	2,022	2,041
HIP Presumptive Eligibility	81	78	55	43	34	27
Total Healthy Indiana Plan enrollment	**249,728**	**380,598**	**434,181**	**440,644**	**441,068**	**443,949**

HIP Employer Link dependents

The State proposes to allow all Medicaid-eligible family members of HIP Employer Link enrollees to enroll in HIP Employer Link. This will allow those participating in employer sponsored insurance a choice of whether to enroll as an individual or family, using any tier offered by the employer plan. Dependents may include adult and/or child dependents, as long as the employer's program for dependent coverage is determined to be cost effective. Dependents will receive full wrap-around to ensure children receive all benefits that they would be eligible for under Medicaid, including EPSDT services. The 57 individuals currently enrolled in HIP Employer Link have 74 family members, mostly children, who are enrolled in other Medicaid programs and could potentially transition to HIP Employer Link.

Milliman has estimated that allowing children to enroll as dependents will cost approximately $60 PMPM less than providing coverage under regular Medicaid. However, it is unclear how many children will enroll. In the renewal filing, we have not reflected a reduction in HIP Employer Link cost projections. This will ensure the Without Waiver HIP Employer Link PMPM is adequate to cover costs regardless of how many children enroll. This population is not permitted to generate waiver savings.

ENHANCED SUBSTANCE USE DISORDER BENEFITS FOR ALL POPULATIONS

Medicaid beneficiaries in the State of Indiana currently have access to a limited array of services to treat substance use disorders (SUDs). Under the expanded benefit that is proposed, beneficiaries may be eligible for the full spectrum of SUD services as defined by the American Society of Addiction Medicine (ASAM) guidelines. The State is requesting a waiver to provide Institution of Mental Diseases (IMD) services and other enhanced SUD services for all Medicaid populations.

Additional 1115 waiver populations for substance use disorder (SUD) benefits

The State would like to provide enhanced SUD benefits to all Medicaid populations, using 1115 waiver authority. This requires the State to add the following populations to the waiver:

1. Disabled children
2. Disabled adults under age 65
3. Aged population aged 65 and older
4. HHW children
5. HHW adults

The Hoosier Healthwise (HHW) child and adult populations are non-disabled but may include pregnant children and adults. These population have been added to the waiver, solely for the purpose of accessing these new SUD services, and will not be subject to other provisions of the HIP waiver.

Estimated substance abuse expenditures

The State proposes that expenditures for non-HIP populations will reflect only enhanced SUD service expenditures. HIP expenditures will reflect all costs for HIP enrollees, including but not limited to enhanced SUD services.

Table 7 illustrates estimated PMPM costs for enhanced SUD services.

Table 7 State of Indiana Family and Social Services Administration Estimated Substance Use Disorder treatment cost by population	Projected DY 04 Enrollment	Estimated DY 04 Expenditures	PMPM
Disabled Children Population	66,092	$ 1,562,415	$ 1.97
Disabled Under 65 Population	217,874	11,242,298	4.30
Aged Over 65 Population	126,813	1,263,057	0.83
HHW Child Population	648,676	15,334,701	1.97
HHW Adult Population	30,637	1,033,080	2.81
Section 1931 Caretakers	117,567	5,155,622	3.65
Other HIP enrollees	323,077	35,163,701	9.07
Composite	1,530,736	$ 70,754,873	$ 3.85

The assumptions and methodology used to develop these assumptions are described in Appendix 6:

LIMITATIONS

The information contained in this report has been prepared for the State of Indiana, Family and Social Services Administration (FSSA). This report has been developed to assist in the development of the 1115 waiver filing to be submitted to the Centers for Medicaid and Medicare Services (CMS) associated with the Healthy Indiana Plan. 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.

Milliman makes no representations or warranties regarding the contents of this correspondence to third parties. Likewise, third parties are instructed that they are to place no reliance upon this correspondence prepared for OMPP by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

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 16, 2015.

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.

APPENDIX 1: BUDGET NEUTRALITY EXHIBITS

Healthy Indiana Plan	*Summary Budget Neutrality Estimates - 1115 Waiver Application*			
	Updated December 20, 2016			
Without Waiver Summary	**DY 01**	**DY 02**	**DY 03**	**DY 01 - DY 03**
XIX - HIP Populations				
Section 1931 Caretakers	750,466,604	966,618,193	1,038,725,796	2,755,810,593
New Adult Group	877,758,261	1,490,205,952	1,798,738,553	4,166,702,766
Medically Frail	430,666,254	837,960,726	1,003,320,376	2,271,947,356
HIP Employer Link	5,225	407,813	7,247,906	7,660,944
Subtotal	*2,058,896,344*	*3,295,192,684*	*3,848,032,631*	*9,202,121,658*
XIX - Non-HIP Populations (SUD)				
Disabled Children Population				
Disabled Under 65 Population				
Aged Over 65 Population				
HHW Child Population				
HHW Adult Population				
Subtotal				
Total Without Waiver Costs	***2,058,896,344***	***3,295,192,684***	***3,848,032,631***	***9,202,121,658***
With Waiver Summary	**DY 01**	**DY 02**	**DY 03**	**DY 01 - DY 03**
XIX - HIP Populations				
Section 1931 Caretakers	*557,518,446*	*734,327,216*	*775,613,053*	*2,067,458,715*
New Adult Group	*617,541,597*	*1,283,468,739*	*1,549,200,703*	*3,450,211,039*
Medically Frail	*483,610,759*	*593,034,046*	*710,058,669*	*1,786,703,474*
HIP Employer Link	1,648	67,048	1,191,699	1,260,395
HIP Presumptive Eligibility	1,902,684	1,001,230	713,884	3,617,798
Subtotal	*1,660,575,134*	*2,611,898,280*	*3,036,778,007*	*7,309,251,421*
XIX - Non-HIP Populations (SUD)				
Disabled Children Population				
Disabled Under 65 Population				
Aged Over 65 Population				
HHW Child Population				
HHW Adult Population				
Subtotal				
Total With Waiver Costs	***1,660,575,134***	***2,611,898,280***	***3,036,778,007***	***7,309,251,421***
Total Waiver Margin	*398,321,210*	*683,294,404*	*811,254,624*	*1,892,870,238*
Waiver Margin excluding Newly Eligible	***191,045,474***	***231,289,747***	***262,398,859***	***684,734,079***
Coverage Estimates	**DY 01**	**DY 02**	**DY 03**	
Anticipated Enrollment				
Section 1931 Caretakers	93,881	114,834	117,189	
New Adult Group	134,179	225,322	269,015	
Medically Frail	21,585	40,268	46,226	
HIP Employer Link	1	97	1,696	
HIP Presumptive Eligibility	81	78	55	
Total HIP Enrollment	**249,728**	**380,598**	**434,181**	

Healthy Indiana Plan *Summary Budget Neutrality Estimates - 1115 Waiver Application*

Updated December 20, 2016

Without Waiver Summary	DY 04	DY 05	DY 06	DY 01 - DY 06
XIX - HIP Populations				
Section 1931 Caretakers	1,102,461,022	1,164,929,485	1,231,168,089	6,254,369,189
New Adult Group	1,924,889,329	1,983,016,878	2,058,725,504	10,133,334,476
Medically Frail	1,049,986,847	1,094,221,651	1,147,521,334	5,563,677,188
HIP Employer Link	8,847,120	9,164,620	9,529,002	35,201,686
Subtotal	*4,086,184,318*	*4,251,332,634*	*4,446,943,929*	*21,986,582,539*
XIX - Non-HIP Populations (SUD)				
Disabled Children Population	1,562,423	1,645,916	1,735,844	4,944,183
Disabled Under 65 Population	11,242,296	11,978,760	12,770,721	35,991,777
Aged Over 65 Population	1,263,060	1,353,980	1,448,436	4,065,476
HHW Child Population	15,334,694	16,274,236	17,310,441	48,919,370
HHW Adult Population	1,341,921	1,399,525	1,459,644	4,201,090
Subtotal	*30,744,394*	*32,652,417*	*34,725,085*	*98,121,896*
Total Without Waiver Costs	***4,116,928,712***	***4,283,985,050***	***4,481,669,014***	***22,084,704,435***
With Waiver Summary	**DY 04**	**DY 05**	**DY 06**	**DY 01 - DY 06**
XIX - HIP Populations				
Section 1931 Caretakers	*809,826,690*	*841,086,280*	*873,712,025*	*4,592,083,710*
New Adult Group	*1,656,597,280*	*1,706,628,334*	*1,771,794,772*	*8,585,231,425*
Medically Frail	*743,788,626*	*775,124,864*	*812,881,638*	*4,118,498,601*
HIP Employer Link	1,454,738	1,506,975	1,566,817	5,788,925
HIP Presumptive Eligibility	576,620	466,155	376,999	5,037,572
Subtotal	*3,212,243,953*	*3,324,812,608*	*3,460,332,251*	*17,306,640,232*
XIX - Non-HIP Populations (SUD)				
Disabled Children Population	1,562,423	1,645,916	1,735,844	4,944,183
Disabled Under 65 Population	11,242,296	11,978,760	12,770,721	35,991,777
Aged Over 65 Population	1,263,060	1,353,980	1,448,436	4,065,476
HHW Child Population	15,334,694	16,274,236	17,310,441	48,919,370
HHW Adult Population	1,341,921	1,399,525	1,459,644	4,201,090
Subtotal	*30,744,394*	*32,652,417*	*34,725,085*	*98,121,896*
Total With Waiver Costs	***3,242,988,347***	***3,357,465,024***	***3,495,057,336***	***17,404,762,128***
Total Waiver Margin	*873,940,365*	*926,520,026*	*986,611,678*	*4,679,942,307*
Waiver Margin excluding Newly Eligible	***292,057,712***	***323,377,050***	***357,079,066***	***1,657,247,908***
Coverage Estimates	**DY 04**	**DY 05**	**DY 06**	
Anticipated Enrollment				
Section 1931 Caretakers	117,567	117,976	118,408	
New Adult Group	274,863	274,915	277,099	
Medically Frail	46,160	46,122	46,374	
HIP Employer Link	2,010	2,022	2,041	
HIP Presumptive Eligibility	43	34	27	
Total HIP Enrollment	**440,644**	**441,068**	**443,949**	
Disabled Children Population	66,092	66,907	67,595	
Disabled Under 65 Population	217,874	222,819	227,886	
Aged Over 65 Population	126,813	129,692	132,641	
HHW Child Population	648,676	655,162	661,714	
HHW Adult Population	30,637	30,372	30,108	
Total Non-HIP Enrollment	**1,090,092**	**1,104,952**	**1,119,944**	
Grand Total Enrollment	**1,530,736**	**1,546,020**	**1,563,893**	

APPENDIX 2: WITHOUT WAIVER PROJECTIONS

Healthy Indiana Plan

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION

HIP POPULATIONS					
ELIGIBILITY GROUP	**Trend**	**DEMONSTRATION YEARS (DY) DY 01**	**DY 02**	**DY 03**	**TOTAL WOW**
Section 1931 Caretakers					
Eligible Member Months		1,126,573	1,378,009	1,406,268	
Total Cost Per Eligible	5.30%	$ 666.15	$ 701.46	$ 738.64	
Total Expenditure		$ 750,466,604	$ 966,618,193	$ 1,038,725,796	$ 2,755,810,593
New Adult Group					
Eligible Member Months		1,610,152	2,703,861	3,228,174	
Total Cost Per Eligible	1.10%	$ 545.14	$ 551.14	$ 557.20	
Total Expenditure		$ 877,758,261	$ 1,490,205,952	$ 1,798,738,553	$ 4,166,702,766
Medically Frail					
Eligible Member Months		259,024	483,214	554,716	
Total Cost Per Eligible	4.30%	$ 1,662.65	$ 1,734.14	$ 1,808.71	
Total Expenditure		$ 430,666,254	$ 837,960,726	$ 1,003,320,376	$ 2,271,947,356
HIP Employer Link					
Eligible Member Months		15	1,158	20,357	
Total Cost Per Eligible	1.10%	$ 348.33	$ 352.17	$ 356.04	
Total Expenditure		$ 5,225	$ 407,813	$ 7,247,906	$ 7,660,944

Healthy Indiana Plan

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION

HIP POPULATIONS					
ELIGIBILITY GROUP	**Trend**	**DY 04**	**DY 05**	**DY 06**	**TOTAL WOW**
Section 1931 Caretakers					
Eligible Member Months		1,410,807	1,415,708	1,420,901	
Total Cost Per Eligible	5.30%	$ 781.44	$ 822.86	$ 866.47	
Total Expenditure		$ 1,102,461,022	$ 1,164,929,485	$ 1,231,168,089	$ 6,254,369,189
New Adult Group					
Eligible Member Months		3,298,359	3,298,980	3,325,191	
Total Cost Per Eligible	3.00%	$ 583.59	$ 601.10	$ 619.13	
Total Expenditure		$ 1,924,889,329	$ 1,983,016,878	$ 2,058,725,504	$10,133,334,476
Medically Frail					
Eligible Member Months		553,922	553,459	556,490	
Total Cost Per Eligible	4.30%	$ 1,895.55	$ 1,977.06	$ 2,062.07	
Total Expenditure		$ 1,049,986,847	$ 1,094,221,651	$ 1,147,521,334	$ 5,563,677,188
HIP Employer Link					
Eligible Member Months		24,125	24,263	24,493	
Total Cost Per Eligible	3.00%	$ 366.72	$ 377.72	$ 389.05	
Total Expenditure		$ 8,847,120	$ 9,164,620	$ 9,529,002	$ 35,201,686

NON-HIP POPULATIONS					
ELIGIBILITY GROUP	**Trend**	**DY 04**	**DY 05**	**DY 06**	**TOTAL WW**
Disabled Children					
Eligible Member Months		793,108	802,886	811,142	
Total Cost Per Eligible	4.3%	$ 1.97	$ 2.05	$ 2.14	
Total Expenditure		$ 1,562,423	$ 1,645,916	$ 1,735,844	$ 4,944,183
Disabled Adults Under 65					
Eligible Member Months		2,614,487	2,673,830	2,734,630	
Total Cost Per Eligible	4.3%	$ 4.30	$ 4.48	$ 4.67	
Total Expenditure		$ 11,242,296	$ 11,978,760	$ 12,770,721	$ 35,991,777
Aged - Age 65 and Over					
Eligible Member Months		1,521,759	1,556,299	1,591,687	
Total Cost Per Eligible	4.3%	$ 0.83	$ 0.87	$ 0.91	
Total Expenditure		$ 1,263,060	$ 1,353,980	$ 1,448,436	$ 4,065,476
HHW Child					
Eligible Member Months		7,784,109	7,861,950	7,940,569	
Total Cost Per Eligible	5.30%	$ 1.97	$ 2.07	$ 2.18	
Total Expenditure		$ 15,334,694	$ 16,274,236	$ 17,310,441	$ 48,919,370
HHW Adult					
Eligible Member Months		367,650	364,460	361,298	
Total Cost Per Eligible	5.30%	$ 3.65	$ 3.84	$ 4.04	
Total Expenditure		$ 1,341,921	$ 1,399,525	$ 1,459,644	$ 4,201,090

APPENDIX 3: WITH WAIVER PROJECTIONS

Healthy Indiana Plan **DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION**

HIP POPULATIONS					
ELIGIBILITY GROUP	**Trend**	**DEMONSTRATION YEARS (DY) DY 01**	**DY 02**	**DY 03**	**TOTAL WW**
Section 1931 Caretakers					
Eligible Member Months		1,126,573	1,378,009	1,406,268	
Total Cost Per Eligible	3.5%	$ 494.88	$ 532.89	$ 551.54	
Total Expenditure		$ 557,518,446	$ 734,327,216	$ 775,613,053	$ 2,067,458,715
New Adult Group					
Eligible Member Months		1,610,152	2,703,861	3,228,174	
Total Cost Per Eligible	1.1%	$ 383.53	$ 474.68	$ 479.90	
Total Expenditure		$ 617,541,597	$ 1,283,468,739	$ 1,549,200,703	$ 3,450,211,039
Medically Frail					
Eligible Member Months		259,024	483,214	554,716	
Total Cost Per Eligible	4.3%	$ 1,867.05	$ 1,227.27	$ 1,280.04	
Total Expenditure		$ 483,610,759	$ 593,034,046	$ 710,058,669	$ 1,786,703,474
HIP Employer Link					
Eligible Member Months		15	1,158	20,357	
Total Cost Per Eligible	1.10%	$ 109.87	$ 57.90	$ 58.54	
Total Expenditure		$ 1,648	$ 67,048	$ 1,191,699	$ 1,260,395
HIP Presumptive Eligibility					
Eligible Member Months		971	933	658	
Total Cost Per Eligible	1.10%	$ 1,959.51	$ 1,073.13	$ 1,084.93	
Total Expenditure		$ 1,902,684	$ 1,001,230	$ 713,884	$ 3,617,798

Healthy Indiana Plan **DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION**

HIP POPULATIONS					
ELIGIBILITY GROUP	**Trend**	**DY 04**	**DY 05**	**DY 06**	**TOTAL WW**
Section 1931 Caretakers					
Eligible Member Months		1,410,807	1,415,708	1,420,901	
Total Cost Per Eligible	3.5%	$ 574.02	$ 594.11	$ 614.90	
Total Expenditure		$ 809,826,690	$ 841,086,280	$ 873,712,025	$ 4,592,083,710
New Adult Group					
Eligible Member Months		3,298,359	3,298,980	3,325,191	
Total Cost Per Eligible	3.0%	$ 502.25	$ 517.32	$ 532.84	
Total Expenditure		$ 1,656,597,280	$ 1,706,628,334	$ 1,771,794,772	$ 8,585,231,425
Medically Frail					
Eligible Member Months		553,922	553,459	556,490	
Total Cost Per Eligible	4.3%	$ 1,342.77	$ 1,400.51	$ 1,460.73	
Total Expenditure		$ 743,788,626	$ 775,124,864	$ 812,881,638	$ 4,118,498,601
HIP Employer Link					
Eligible Member Months		24,125	24,263	24,493	
Total Cost Per Eligible	3.0%	$ 60.30	$ 62.11	$ 63.97	
Total Expenditure		$ 1,454,738	$ 1,506,975	$ 1,566,817	$ 5,788,925
HIP Presumptive Eligibility					
Eligible Member Months		516	405	318	
Total Cost Per Eligible	3.0%	$ 1,117.48	$ 1,151.00	$ 1,185.53	
Total Expenditure		$ 576,620	$ 466,155	$ 376,999	$ 5,037,572

NON-HIP POPULATIONS					
ELIGIBILITY GROUP	**Trend**	**DY 04**	**DY 05**	**DY 06**	**TOTAL WW**
Disabled Children					
Eligible Member Months		793,108	802,886	811,142	
Total Cost Per Eligible	4.3%	$ 1.97	$ 2.05	$ 2.14	
Total Expenditure		$ 1,562,423	$ 1,645,916	$ 1,735,844	$ 4,944,183
Disabled Adults Under 65					
Eligible Member Months		2,614,487	2,673,830	2,734,630	
Total Cost Per Eligible	4.3%	$ 4.30	$ 4.48	$ 4.67	
Total Expenditure		$ 11,242,296	$ 11,978,760	$ 12,770,721	$ 35,991,777
Aged - Age 65 and Over					
Eligible Member Months		1,521,759	1,556,299	1,591,687	
Total Cost Per Eligible	4.3%	$ 0.83	$ 0.87	$ 0.91	
Total Expenditure		$ 1,263,060	$ 1,353,980	$ 1,448,436	$ 4,065,476
HHW Child					
Eligible Member Months		7,784,109	7,861,950	7,940,569	
Total Cost Per Eligible	5.3%	$ 1.97	$ 2.07	$ 2.18	
Total Expenditure		$ 15,334,694	$ 16,274,236	$ 17,310,441	$ 48,919,370
HHW Adult					
Eligible Member Months		367,650	364,460	361,298	
Total Cost Per Eligible	5.3%	$ 3.65	$ 3.84	$ 4.04	
Total Expenditure		$ 1,341,921	$ 1,399,525	$ 1,459,644	$ 4,201,090

APPENDIX 4: DOCUMENTATION ON WITH WAIVER ADJUSTMENTS TO THE SCHEDULE C

ADJUSTMENTS TO HISTORICAL WITH WAIVER EXPENDITURES

This appendix provides additional information on the data, assumptions, and methodology underlying adjustments made to the historical experience in Schedule C filings.

All adjustments described in this report were developed based on data from the State of Indiana's Enterprise Data Warehouse, as reported through October 31, 2016.

Reallocation of HIP presumptive eligibility expenditures

Compliance with original intent

In the most recent CMS Schedule C, as of September 30, 2016, Indiana is reporting *all* presumptive eligibility (PE) expenditures under the "PE Program" eligibility group. However, Indiana is in the process of correcting PE Program reporting in order to comply with the original intent, as clarified by CMS in an addendum to the STCs (Appendix 5). As requested by CMS:

- PE program expenditures for individuals who, after formal submission of a complete application, are found to be fully eligible under the new adult category: will be treated as new adult expenditures. These expenditures will be eligible for the enhanced match and will count on both sides of the budget neutrality agreement.
- PE program expenditures for individuals who are deemed presumptively eligible and do not submit a full application or submit an application but are not eligible for the new adult category: will be eligible for the standard match, but will be excluded from 1115 waiver reporting.
- Any expenses related to extension of the PE period beyond the time period specified in the PE regulations, specifically 42 CFR 435.1101 (CFR PE period), will only appear on the "With Waiver" under "PE Program".

Allocation of PE expenditures into the categories above cannot be completed until each individual's ultimate eligibility is determined under the regular Medicaid process. As a result, the allocation must be done retrospectively, and often several months in arrears. The PE period itself may last up to two months, and if a regular application is submitted during the PE period, the approval process may require two to three additional months, especially if additional information is requested.

Results of allocation analysis for DY 01

We have analyzed the experience during DY 01, and have developed the following allocation groups:

1. 48.3% of DY 01 PE expenditures were for individuals who, after formal submission of a complete application, were found to be fully eligible under the new adult category, either the New Adult Population or the Medically Frail Population.
2. 51.2% of DY 01 PE expenditures were for individuals who did not submit a full application or who, after formal submission of a complete application, were either determined not eligible or found to be fully eligible under a Medicaid category that was not the new adult category.
3. 0.5% of DY 01 PE expenditures did not meet the criteria above, and extended beyond the time period specified in the 42 CFR 435.1101 PE regulations.

The data and process used to generate the allocation is described below.

Data and methodology for allocation of HIP PE expenditures

For this analysis, we used data and information stored in the State of Indiana's Enterprise Data Warehouse (EDW), as reported through September 2016. We began with all HIP PE expenditures incurred in CY 2015. These may be identified by the capitation code 'AP'. For each PE enrollee, the EDW contains the following data fields:

- **HIP PE determination date**: The hospitals and other qualified providers make the original HPE determination. This date is stored in the EDW under Date_PE_Added , and marks the beginning of the CFR PE period.
- **HIP PE application date**: The HPE enrollee has until the end of the months following the HPE determination date to apply for Medicaid eligibility. This date is stored in the EDW under Application_Date. If an application is never filed, the CFR PE period ends at the end of the second month after the determination.
- **Regular Medicaid determination date**: After the HPE enrollee submits a regular Medicaid application, it is processed by FSSA, and a regular Medicaid eligibility determination is made. If the application is approved, this date is stored in the EDW under Date_Medicaid_Determine, and signals an end to the CFR PE period.
- **Denied date:** After the HPE enrollee submits a regular Medicaid application, it is processed by FSSA, and a regular Medicaid eligibility determination is made. If the application is denied, this date is stored in the EDW under Date_Denied, and signals an end to the CFR PE period

For HIP PE enrollees who did not submit a regular Medicaid application, the CFR PE period began on the HIP PE determination date, and ended on the last day of the following month. PE expenditures related to enrollment during the CFR PE period for individuals who did not submit a regular Medicaid application (17.8% of expenditures) were excluded from 1115 waiver reporting.

For those who submitted a regular Medicaid application, the CFR PE period ended on the regular Medicaid determination date. For the last month of PE, we assigned PE capitation payments to the CFR PE period using the logic employed by the fiscal agent. That is, if the CFR PE period included 17 or fewer days during the last month, 0.5 a month of capitation payments was allocated, and if the CFR PE period included 18 or more days, then a full month capitation payment was allocated.

For individuals who received an adverse determination (denied), eligibility should end immediately after the determination. PE expenditures related to enrollment during the CFR PE period for individuals who were denied on the regular process (25.0% of expenditures) were excluded from 1115 waiver reporting.

For individuals who were determined eligible for a HIP or non-HIP program, eligibility may be transitioned immediately. Again, there should be no HIP PE expenditures beyond the CFR PE period.

For individuals who were determined eligible for HIP, it may have been necessary to extend the PE period for the remainder of the month in order to avoid a gap in coverage. In cases where the need to extend the PE period resulted in an additional half month of HIP PE capitation, this will count against the program for purposes of budget neutrality. These PE expenditures beyond the CFR PE period were retained under the PE program heading on the "With Waiver" summary (allocation group 3 above).

Where the enrollee submitted an application before the end of the CFR PE period and was approved for regular HIP or Medicaid eligibility, we have allocated HIP PE expenditures to the recipient's regular eligibility group.

Additional presumptive eligibility payments for DY 02

Starting with DY 02, the State has begun reporting the first two calendar months of presumptive eligibility payments outside of the Schedule C. Approximately $107.9 million in presumptive eligibility payments were paid for the first two months of presumptive eligibility from January 1, 2016 through September 30, 2016. The amount of $33.4 million reported in the Schedule C reflects only the third and later months of presumptive eligibility payments. The total amount of PE payments for the period January 1, 2016 through September 30, 2016 is approximately $141.3 million.

As with DY01 amounts reported on the Schedule C under the PE program, the amounts reported as PE program for DY 02 may be reallocated as newly eligible, Medicaid, or remain in the PE population. The DY 02 PE payments *not* reported on the Schedule C (the first two months) may ultimately remain in Medicaid or be reassigned as newly eligible. Because some of these payments will ultimately be reported as newly eligible, we have also considered the additional presumptive eligibility payments for DY 02 in the overall reallocation.

Re-allocation of Schedule C HIP presumptive eligibility expenditures for DY 01 and DY 02

We have reallocated PE program expenditures reported on the Schedule C in the manner described above. This is illustrated in Table 4.1.

Table 4.1
State of Indiana
Family and Social Services Administration
Allocation of Presumptive Eligibility expenditures

Population	Allocation	DY01	DY02
Section 1931 Parents	5.3%	$ 19,837,308	$ 7,522,326
New Adult Group	34.3%	127,674,797	48,414,407
Medically Frail	14.0%	52,212,437	19,799,007
HIP Employer Link	0.0%	-	-
Remains with PE Program	0.5%	1,883,446	714,205
Other Medicaid (not on 1115)	45.9%	170,952,183	64,825,233
Total PE Program expenditures	**100.0%**	**$372,560,171**	**$141,275,178**

FSSA is in the process of revising reported values to conform to requirements clarified in the addendum to the STCs.

Retroactive payments made in October 2016

Table 4.2 illustrates payments incurred through September 2016, but paid in October 2016. The largest component of the retroactive payments concerned POWER account payments for continuing members, delayed to reflect reconciliation from the prior benefit period. These have been added to Schedule C expenditures for DY 01 and DY 02.

Table 4.2
State of Indiana
Family and Social Services Administration
Additional payments in October 2016

Population	DY 01	DY 02
Section 1931 Parents	$ 4,211,304	$ 76,765,443
New Adult Group	3,288,862	77,315,879
Medically Frail	1,098,168	25,797,621
HIP Employer Link	-	-
HIP Presumptive Eligibility	-	-
Total	**$ 8,598,335**	**$ 179,878,943**

Health insurer fee

The health insurer fee for DY 01 has been paid, but for DY 02, the capitation rates have not yet been retroactively adjusted to reflect the fee, spread over the full contract year. We have estimated the fee will increase rates by 2.0% of capitation. During DY 02, one of the three contracted health plans was not subject to the fee. Due to the moratorium, there is no health insurer fee projected for DY 03. For DY 04 through DY 06, we have estimated the fee will increase capitation rate by approximately 1.7%. During this time period, two of four contracted health plans will not be subject to the fee.

MCO performance payments

Capitation withholds for CY 2015 are anticipated to be paid at the end of CY 2016. The capitation rates assume that approximately half of amounts withheld will be returned to plans. To reflect the 2.0% withhold, we have increased expenditures by 1.0% for DY 01 and DY 02.

Physician specialty network access fee

In the initial filing, Indiana has proposed a physician specialty network access fee to assure continued access to physician specialty networks by providing enhanced reimbursement. The request has not yet been approved by CMS, although it is still under discussion with CMS. We have not adjusted the 'with waiver' rates to reflect this fee.

Annualization of DY 02 expenditures

Schedule C expenditures for DY 02 (January 2016 through December 2016) reflected incurred expenditures paid through September 2016. These have been adjusted for completion through October 2016, allocation of presumptive eligibility expenditures, and payment of the health insurer fee. After these adjustments, we have also annualized expenditures, assuming expenditures incurred in October 2016 through December 2016 will reflect the same PMPM as other DY 02 expenditures.

APPENDIX 5: CMS CLARIFICATION ON BUDGET NEUTRAL PE ACCOUNTING

Presumptive Eligibility (PE) Reporting for the Healthy Indiana Plan 2.0 1115 waiver:

The state will report expenses related to presumptively eligible individuals in the following manner, as discussed with CMS on 12/15/2015. The state will update previous reports delivered to CMS to comply with this change. Please confirm our understanding of the process.

1) Individuals that are deemed presumptively eligible and then after formal submission of a complete application are found to be fully eligible under the new adult category:

a) All expenses for these individuals will be counted on both the "with waiver" and "without waiver" sides of the budget neutrality agreement.
b) As these individuals meet the eligibility requirements of the new adult group, all of their expenses for both the PE period and their regular eligibility period will be eligible for the new adult category enhanced match.

2) Individuals that are deemed presumptively eligible and do *not* submit a full application, or submit an application but are not eligible for the new adult category:

a) All expenses for these individuals will be excluded from reporting of expenses for the 1115 waiver. However, any expenses related to the extension of the PE period, beyond the time period specified in the PE regulations, specifically 42 CFR 435.1101, will be counted in the waiver and will only appear on the "with waiver." The state is not required to track these expenses on an individual member basis and may take a sample or average of this expense that can be extrapolated to the larger group.
b) As these individuals are not eligible for the new adult category, their PE expenses will be matched at the state's FMAP rate.

The points below articulate how the state will report PE expenses.

- All Hospital Presumptive Eligibility capitation payments for the time period specified in 42 CFR 435.1101, the month of PE determination and the following month will initially be included and reported as Base Medicaid expenses.
- PE capitation payments after this period will be reclassified as PE expenses against the HIP 2.0 1115 Waiver and reported on a Medicaid Eligibility Group (MEG) form of the CMS-64 for the PE Program group.
- An analysis of PE capitation payments will be conducted to determine a representative amount of the payments that are for the PE period under 42 CFR 435.1101 and the payments following that period.
- Individuals that are deemed presumptively eligible and then after formal submission of a complete application are found to be fully eligible as Newly Eligible under either the New Adult Group or Medically Frail MEG will have all PE capitation payments reclassified for both the PE period and their regular eligibility period will be eligible for the new adult category enhanced match.
- Individuals that are deemed presumptively eligible and do *not* submit a full application, or submit an application but are not eligible under a Newly Eligible MEG will not have any reclassification of their PE capitation payments

For example,

Individual that are deemed presumptively eligible will have PE capitation payments reported as shown in the table below following disposition for their PE status. The rows represent the individual's status immediately after the PE time period ends while the columns represent the final reporting of their PE capitation payments all reclassifications.

	Medicaid	1115 PE MEG	New Adult Group	Medically Frail
New Adult Goup			All PE payments	
Medically Frail				All PE payments
LIPC	42 CFR 435.1101	After CFR PE period		
Other Medicaid	42 CFR 435.1101	After CFR PE period		
Denied	42 CFR 435.1101	After CFR PE period		
No Application	42 CFR 435.1101	After CFR PE period		

APPENDIX 6: DOCUMENTATION OF SUBSTANCE USE DISORDER ESTIMATES

DOCUMENTATION OF SUBSTANCE USE DISORDER ESTIMATES

This appendix provides additional information on the data, assumptions, and methodology underlying substance use disorder PMPM cost estimates.

Population assumptions

SUD prevalence

Table 6.1 illustrates composite prevalence estimates by population.

Table 6.1
State of Indiana
Family and Social Services Administration
Estimated Substance Use Disorder prevalence

	Projected DY 04 Enrollment	Estimated prevalence	Estimated lives with SUD diagnosis
Disabled Children Population	66,092	2.5%	1,652
Disabled Under 65 Population	217,874	13.0%	28,324
Aged Over 65 Population	126,813	2.5%	3,170
HHW Child Population	648,676	2.5%	16,217
HHW Adult Population	30,637	8.5%	2,604
Section 1931 Caretakers	117,567	8.5%	9,993
Other HIP enrollees	323,077	21.1%	68,169
Composite	1,530,736	8.5%	130,130

Indiana-specific prevalence estimates were provided by the 2013 SAMHSA Behavioral Health Treatment Needs Toolkit for States (http://store.samhsa.gov/shin/content/SMA13-4757/SMA13-4757.pdf). In this report, the prevalence of substance use disorder is 11.0% for the existing Medicaid population and 21.1% for the estimated Medicaid expansion population. Both figures are midpoint estimates for the age 18 to 64 age group. We have redistributed the overall prevalence for existing Medicaid adults to reflect differences by age and disabled status. We have increased the Disabled under 65 prevalence and lowered the HHW adult prevalence in our analysis. The under 18 age group prevalence of 2.5% was estimated using data provided by the Indiana Division of Mental Health and Addiction (DMHA) on the relative prevalence of SUD for children compared with adults. We are also utilizing a 2.5% prevalence estimate for the age 65 and over population to reflect lower benchmark SUD experience relative to other adult populations.

SUD take-up rates

Many individuals with a SUD diagnosis choose not to seek treatment. The overall take-up rates below were selected from a SAMHSA report (http://www.samhsa.gov/data/sites/default/files/1/1/NSDUHsaeIndiana2014.pdf) specifically focused on the State of Indiana. We have stratified the rates by addictive substance, and have reflected a lower take-up rate for marijuana and a higher take-up rate for opiates based upon a report provided by the State Epidemiology and Outcomes Workgroup (SEOW).

Table 6.2
State of Indiana
Family and Social Services Administration
SUD diagnosis take-up rate

	Take-up Rate	% Relapse and Re-Present	Unique Episodes as % of SUD Members
Alcohol	10.00%	20.0% of take-up	12.00%
Marijuana (Adults)	8.30%	20.0% of take-up	10.00%
Opiates	33.30%	20.0% of take-up	40.00%
Illicit Drugs	13.00%	20.0% of take-up	15.60%

Utilization assumptions

Treatment plans

Persons seeking treatment for SUD will receive a treatment plan specific to the needs of the individual. For modeling purposes, we have developed a set of core treatment plans for each primary substance for the adult SUD population. We have also developed a set of core treatment plans for the child population. We did not split the treatment plans by primary disorder for the child population because there is less treatment variation based on primary drug of choice. Table 6.3 illustrates the percentage of individuals entering each treatment plan by diagnosis group for adults and in aggregate for children.

Table 6.3
State of Indiana
Family and Social Services Administration
Percent of Individuals Entering Treatment Plan by Diagnosis Group

	24 Hour Treatment	IOP Treatment	Partial Hospitalization Treatment	Outpatient Treatment Only
Adult				
Alcohol/Depressant disorder	10.00%	30.00%	30.00%	30.00%
Marijuana disorder	10.00%	30.00%	10.00%	50.00%
Opiate disorder	10.00%	8.00%	7.00%	75.00%
Meth/Stimulants	25.00%	30.00%	25.00%	20.00%
All other SUDs	25.00%	30.00%	25.00%	20.00%
Children				
All SUDs	30.00%	25.00%	10.00%	35.00%

Treatment plans are categorized by the highest level of treatment required for an individual after potentially receiving inpatient detoxification treatment. We have used this convention because an individual's treatment plan often begins with inpatient detoxification; however, an individual may transition from detox into several different settings.

- **24 Hour Treatment**: An individual with a 24-hour treatment plan would receive residential treatment either initially or after receiving inpatient detoxification treatment. Individuals then step down to less intensive treatment.
- **Intensive Outpatient Program (IOP) Treatment**: An individual with an IOP treatment plan would receive intensive outpatient treatment either initially or after receiving inpatient detoxification treatment. Individuals then step down to less intensive treatment.
- **Partial Hospitalization Treatment**: An individual with a partial hospitalization treatment plan would receive partial hospitalization either initially or after receiving inpatient detoxification treatment. Individuals then step down to less intensive treatment.
- **Outpatient Treatment Only**: An individual with an outpatient only treatment plan would receive outpatient treatment either initially or after receiving inpatient detoxification treatment. These individuals step down to less intensive outpatient treatment.

Prescribed utilization by treatment plan

For each entering treatment and diagnosis group, DMHA clinicians have assisted us with developing a treatment plan. An example is provided in Table 6.4 for the adult alcohol/depressant disorder 24 hour care treatment plan. The number of hours or days included in the prescribed treatment plan, as listed in the left column of Table 6.4, represents what the prescribing practitioner would suggest at initiation of treatment, and what an individual would receive if he or she completed the full treatment plan and did not opt-out of treatment. The right column illustrates the percentage of each portion of the prescribed treatment plan that may be utilized by an average recipient.

Table 6.4 State of Indiana Family and Social Services Administration Adult Alcohol/Depressant Diagnosis 24 Hour Care Treatment Plan	
Treatment Plan	**% of Services Actually Utilized**
70% - 3 days IP detox	66.00%
28 days of High-Intensity Residential	61.00%
90 days of Low-Intensity Residential	15.00%
2 hours per week for 90 days of Outpatient	5.00%

For an adult with an alcohol or depressant diagnosis in the 24 hour care treatment plan, we assume that 70% of the individuals that have the 24 hour care treatment plan will be prescribed inpatient detoxification first. We are assuming that full treatment for individuals entering/receiving inpatient detoxification on average will be three days. Individuals will then step down (or begin if no inpatient detox) into high-intensity residential services for the next 28 days on average, transition into low-intensity residential services for the next 90 days, and finally step down into outpatient treatment for the next 90 days for two hours per week on average.

Percentage of prescribed utilization received

Individuals who enter into the delivery system and receive a treatment plan do not always complete the treatment plan that was prescribed. As a result, we need to estimate the average percentage of the prescribed utilization that will actually be utilized. Table 6.4 illustrates the estimated percentage of services actually utilized by individuals on average. For example, we estimate that 66% of the prescribed inpatient detoxification utilization (3 days for 70% of the people or 2.1 days) will actually be utilized (66% * 2.1 days = 1.4 days).

Reimbursement assumptions

Unit cost by individual service

We utilized benchmark Medicaid Rehabilitation Option (MRO) services to estimate the cost of the individual components of service that will be provided within the ASAM levels of care. Table 6.5 illustrates the service description and unit cost for the individual components that will be provided as part of each ASAM level of care.

Table 6.5 illustrates unit costs under Medicaid reimbursement. HIP reimbursement is 30% higher.

Table 6.5 State of Indiana Family and Social Services Administration Individual Service Unit Cost Development			
Service Description	**Unit Type**	**Benchmark MRO Service**	**Cost per Unit**
Individual/Family Therapy	Hour	H0004	$ 108.97
Group Therapy	Hour	H0004 group	27.23
Skills Training	Hour	H2014	104.56
Medical Management	Hour	H0034	74.48
Recovery Supports	Hour	H0038	34.20
Case Management	Hour	T1016	58.12
Drug Testing	Encounter	80101	19.03
Room and Board	Day		100.00

Bundled unit cost

In many cases, the daily rate for treatment will include a mix of services. We have estimated daily rates based on the services that may be required.

Table 6.6 illustrates the bundled cost per unit utilized in the cost development for each ASAM level of care.

Table 6.6 State of Indiana Family and Social Services Administration Bundled Cost Per Unit			
ASAM Level of Care	**Unit Type**	**Adult Cost per Unit**	**Child Cost per Unit**
0.5 Early Intervention	Encounter	$117.63	$117.63
1.0 Outpatient Services (First 90 Days)	Hour	$39.08	$101.33
1.0 Outpatient Services (After 90 Days)	Hour	$47.52	$101.27
2.1 Intensive Outpatient Services	Hour	$35.28	$100.88
2.5 Partial Hospitalization	Day	$236.33	$400.87
3.1 Clinically Managed Low-Intensity Residential	Day	$126.13	$137.53
3.3 Clinically Managed Population Specific High-Intensity Residential	Day	$0.00	$0.00
3.5 Clinically Managed High-Intensity Residential	Day	$392.57	$550.75
3.7 Medically Monitored Intensive Inpatient	Day	$800.00	$800.00
4.0 Medically Managed Intensive Inpatient	Day	$900.00	$900.00

Attachment II: Public Notice

Public Notice for Indiana HIP 2.0 1115 Waiver Renewal

Indiana Family and Social Services Administration

Notice of Public Hearing and Public Comment Period

Pursuant to 42 CFR Part 431.408, notice is hereby given that on **January 4, 2017, at 9:00 a.m., at the Indiana Government Center South, Conference Center Rooms 4 and 5, 402 West Washington Street, Indianapolis, Indiana 46204,** the Indiana Family and Social Services Administration (FSSA or State) will hold a public hearing on the Healthy Indiana Plan 2.0 Section 1115 demonstration waiver extension application (HIP Waiver) that will be submitted to the Centers for Medicare and Medicaid Services (CMS) to extend the current program for calendar years 2018 through 2020 with minor technical revisions and several program enhancements. The public hearing will be accessible via web conference at https://indiana.adobeconnect.com/infssa. In addition, FSSA will present the HIP Waiver to the **Medicaid Advisory Committee (MAC) at its meeting on January 5, 2017, at 1:00 p.m., at the Indiana State Library, Room 211, 315 West Ohio Street, Indianapolis, IN 46204.** The public is welcome to attend and comment at the MAC meeting.

This notice also serves to open the 30-day public comment period, which closes January 20, 2017 at 5:00 p.m.

SUMMARY AND OBJECTIVES OF WAIVER

Since 2008, the Healthy Indiana Plan (HIP) model has demonstrated remarkable success in activating beneficiaries into engaged participants and improving outcomes. The expanded HIP 2.0 program has seen consistent results since 2015, proving that HIP's consumer driven model is scalable and remains successful in empowering enrollees to become active consumers of healthcare services. Through the HIP Waiver extension, the State's objective is to continue its highly successful HIP 2.0 program for the maximum waiver renewal period of three (3) years in its current form with the following minor technical revisions and program enhancements:

1. Expand Incentives Program: In general, member incentives in the commercial market carry a substantially higher dollar value than the member incentive programs operated in Medicaid managed care programs. Private sector research has demonstrated that member healthy incentive programs can be effective in reducing individual healthcare claims and overall healthcare spending, resulting in lower-than-industry yearly growth in healthcare costs for the companies utilizing these incentives. Based on this extensive research, the State seeks to significantly enhance its existing member incentive program by removing the current low-dollar incentive limitation (approximately $10-$25 provided through varied managed care entity (MCE) programming), and increase available member healthy incentives to a maximum of $200 per initiative, with a total of no more than $300 per member per year in total incentives. The expanded healthy incentive initiative will target each of the following four focus areas:

    - Tobacco cessation;
    - Substance use disorder;
    - Chronic disease management; and
    - Employment related incentive program.

2. Require Tobacco-User Premium Surcharge: Currently, all HIP members are required to contribute two percent (2%) of income per month to their Personal Wellness and Responsibility (POWER) account to maintain access to the enhanced HIP Plus plan. However, to encourage participation in the expanded

voluntary tobacco cessation incentive initiative described above, and consistent with Marketplace policies, members who are known tobacco users will be required to pay monthly contributions equal to three percent of income after their first year of enrollment in HIP.

3. HIP Plus Incentive: The State will add chiropractic spinal manipulation benefits to the HIP Plus plan to promote participation in HIP Plus through regular contributions to the member's POWER account. Specifically, the HIP Plus alternative benefit plan will be amended to add chiropractic spinal manipulation services, limited to one (1) visit per day and six (6) visits per covered person per benefit year. This benefit modification will further enhance the value proposition underlying the HIP plan structure, which will include vision, dental and chiropractic services.

4. Reestablish an Open Enrollment Period: One of the primary goals of HIP is to promote personal health responsibility. However, personal responsibility for one's healthcare is not limited to responsible utilization of healthcare services, but can also be demonstrated in maintaining health insurance coverage. Improved compliance with eligibility redetermination requirements not only helps to prepare members for participation in the commercial insurance marketplace, but it also results in better continuity of care and improved health outcomes for members. Therefore, to support these important program goals, the State will seek to implement a member specific open enrollment period, whereby members who lose eligibility due to failure to comply with redetermination process will be required to wait six months prior to re-enrolling in coverage. Ultimately, as demonstrated in the original HIP waiver, this policy helps to encourage completion of required redetermination process which results in an increase in continuity of care for members.

5. Facilitate Enrollment for Pregnant Women: Currently, HIP members who become pregnant may choose to remain enrolled in HIP, or may transfer to the Hoosier Healthwise program—Indiana's traditional Medicaid managed care program for children and pregnant women. However, women who choose to remain in HIP are *required* to transfer from HIP to Hoosier Healthwise if they are still pregnant at the time of their annual redetermination period. In addition, individuals who apply for Medicaid coverage while pregnant are automatically enrolled in Hoosier Healthwise, and then transition to HIP following the post-partum coverage period if their income is equal to or less than 138% FPL. HIP provides maternity coverage that is equal to the coverage provided under the Hoosier Healthwise program and, consistent with federal law, there is no cost sharing for pregnant women under either program. Further, the MCEs managing both programs are the same. However, although there is no functional difference between the programs, the required program transfers are burdensome for the member, providers, and the State. Therefore, the State will request to modify eligibility criteria to require enrollment in HIP for pregnant women with income under 138% FPL. The Hoosier Healthwise program will be maintained for pregnant women with income greater than 138% FPL who would not be eligible for HIP following the end of pregnancy. The program consistency resulting from this policy modification would improve continuity of care for the member and reduce the administration for the State and providers, without negatively impacting member care.

6. Technical updates to the 2015 Special Terms and Conditions: In addition to the above program enhancements, the State will seek the following minor technical updates to special terms and conditions (STCs):
   - *Prior Claims Payment Program:* The 2015 HIP 2.0 STCs included a waiver of retroactive coverage for all HIP members, but maintained a one year phase out program for a small subsection of newly enrolled HIP members. This "prior claims payment" program provides retroactive coverage for medical services received during the 90-day period prior to the new member's HIP enrollment. However, this limited program is only available to a small subsection of HIP members. Due to the very small target population as well as the general lack of need for the transition program, the prior claim payment program initiative had very low utilization, as the State anticipated. This program

was designed to help very low-income parents and caretakers transition to coverage without the financial burden of medical claims incurred immediately prior to enrollment. However, as demonstrated by the low utilization, this transitional assistance program is no longer needed for several reasons. First, due to Medicaid expansion and availability of tax credits, more individuals are moving to HIP from other coverage, meaning less individuals are enrolling in HIP with unpaid medical bills. Second, a survey of three of the largest hospital systems in the State (comprising nearly 45% of all hospitals) indicated that HIP 2.0 members are not being billed for claims incurred prior to enrollment. Third, the expanded presumptive eligibility process has been very successful in enrolling uninsured individuals into coverage quickly at the site of care prior to the individual incurring non-covered claims.

- *Copayments for Non-Emergent Use of Hospital Emergency Department:* The State received a two-year waiver to test the application of graduated copayments, whereby HIP members are charged an $8.00 copayment for the first inappropriate emergency department visit, and $25 for each subsequent inappropriate emergency department visit. The State will request renewal of the cost sharing waiver beyond the initial two-year period, which is currently set to expire on January 31, 2018.

- *Non-Emergency Medical Transportation (NEMT):* The 2015 HIP 2.0 STCs only granted the State a one-year waiver of this policy. Based on findings from two separate member surveys conducted as part of the State's independent evaluation of HIP, members with state-provided NEMT benefits do not experience better access to healthcare services than members without the benefit. Therefore, the State will renew its request for a waiver of NEMT for the duration of the HIP extension waiver period.

- *Hepatitis C Drug Coverage:* Effective September 1, 2016, all covered hepatitis C drugs were carved out of managed care, including HIP. HIP members are still able to access all such covered hepatitis C drugs through the Medicaid fee-for-service pharmacy benefit manager, rather than through the member's assigned MCE.

- *Member Transitions & MCE Changes*: Currently, HIP members select an MCE on the application and can change their selection at any time prior to making their initial POWER account contribution. Thereafter, HIP members may change their MCE annually during their redetermination period, or anytime during the 12-month benefit period for one of the specified "for cause" reasons (e.g., quality of care concerns). Many individuals leave and return to the program within a 12-month period. The State will seek to maintain plan choice for members for a 12-month period, regardless of enrollment status. Therefore, if a member selects an MCE and begins eligibility, they will remain with that MCE for the full 12 months even if the individual disenrolls and re-enrolls in HIP coverage within the same 12-month period. Members will continue to have the ability to change plans for "just cause." In addition, rather than providing new POWER accounts, individuals who re-enroll in coverage in the same 12-month period will have their POWER account reinstated rather than receiving a new POWER account. Further, members transitioning from other Medicaid eligibility categories to HIP or between types of HIP coverage will be immediately enrolled in the HIP Basic plan with a 60-day opportunity to make an initial POWER account contribution to move to HIP Plus. This process avoids potential gaps in coverage during the critical transition periods for post-partum women transitioning from Hoosier Healthwise, incarcerated individuals transitioning back to the community, and other similar member transitions. Minimizing changes associated with member transitions will result in improved continuity of care for the member as well as administrative savings for the State.

7. Enhancements to HIP Employer Link: The State will also seek to enhance the HIP Employer Link program through the HIP Waiver. HIP Employer Link allows HIP eligible individuals who have access to qualifying employer sponsored insurance to enroll in the employer's health insurance instead of enrolling in HIP. A primary goal of HIP Employer Link is to increase support for commercial market family coverage. To achieve this goal, the State plans to extend the HIP Employer Link coverage option to all Medicaid eligible family members of HIP Employer Link enrollees. For example, in place of a parent receiving HIP Employer Link premium assistance and the children being mandatorily enrolled in Medicaid, the entire Medicaid-eligible family of the HIP Employer Link enrollee would have the option to participate in the premium assistance program.

8. Substance Use Disorder Enhancements: In addition to the proposed enhancements in HIP, this waiver request will also seek to target substance use disorder (SUD), one of the more pressing health challenges currently facing the State. The State seeks to expand access to critical mental health and substance use disorder services to all Medicaid recipients. Specifically, the State seeks to add new SUD benefits so that all Medicaid recipients can access benefits across the full continuum of care in accordance with best practice standards set forth by the Association of Addiction Medicine (ASAM), including the following:

    - Detoxification Services: Medical necessity for this level of care will be based on ASAM medical necessity criteria.

    - Residential Treatment: Following detoxification, residential treatment facilities provide persons recovering from SUD the opportunity to establish a pattern of healthy behaviors and a meaningful period of sobriety before returning to unsupervised daily living. Currently, Indiana Medicaid does not reimburse for residential treatment. The State will seek to add residential detoxification and SUD treatment services (ASAM levels 3.1, 3.5, and 3.7) as a Medicaid covered benefit.

    - Institutions for Mental Disease (IMD) Exclusion: The State will seek a waiver of the IMD exclusion for Medicaid beneficiaries ages 21-64 with short-term stays up to thirty days, in order to expand access to treatment options.

    - Intensive Outpatient Treatment – Addiction Recovery Supports: After receiving detoxification and/or residential treatment services, it is essential that persons recovering from SUD receive the ongoing treatment and support required to sustain their established period of sobriety. The State will add "Addiction Recovery Management Services" as a Medicaid covered benefit. The new service will provide reimbursement for the essential recovery support services including:
        - Recovery education;
        - Peer recovery support services;
        - Housing support services;
        - Recovery focused case management; and
        - Relapse prevention services.

BENEFICIARIES, ELIGIBILITY, & FINANCING

HIP continues to target non-disabled adults between the ages of 19 and 64 with a household income less than 138% of the federal poverty level (FPL), including individuals eligible for the adult group, low-income parents and caretakers eligible under Section 1931 of the Social Security Act (Section 1931), and individuals eligible for transitional medical assistance. Individuals who become pregnant while on HIP may continue to be covered by the HIP program for the remainder of their current benefit period.

HIP enrollment is projected to expand health coverage to approximately 444,000 members by calendar year 2020, which is demonstration year six. Over the three-year demonstration renewal period (2018 - 2020), HIP 2.0 is expected to cost approximately $1.5 billion in state funds, and $10.1 billion in total combined state and federal funds. The table below provides the estimated state and federal costs divided by year.

Estimated State and Federal Program Costs 2018 – 2020 (in millions)

Calendar Year	Demonstration Year	Expenditures without Waiver	Total HIP Expenditures	State Share of HIP Expenditures	Waiver Margin
2018	4	$4,116.9	$3,243.0	$433.5	$292.1
2019	5	4,284.0	3,357.5	474.7	323.4
2020	6	4,475.9	3,489.3	569.4	357.1

BENEFITS AND HEALTH CARE DELIVERY SYSTEM

All HIP members 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). However, the HIP benefit package is more consistent with commercial plan benefits and does not include non-emergency transportation. Notwithstanding the foregoing, low-income parents and caretakers eligible under Section 1931, 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 is a more limited benefit plan, and does not cover vision and dental services.

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 of $2,500. After the plan deductible is met by way of the $2,500 POWER account, the HIP program includes a comprehensive health plan benefits package.

Individuals enrolled in HIP Employer Link receive the benefits provided by their employer sponsored health plan and not the HIP Basic or Plus benefits. All approved employer sponsored health plans are reviewed by the HIP Employer Link team to ensure compliance with the benefit requirements.

All HIP medical benefits are currently provided through three (3) MCEs: Anthem, MDwise, and Managed Health Services (MHS). Beginning in calendar year 2017, CareSource, the state's newest MCE will also be available to provide health benefits to HIP members. In addition, HIP members have access to enrollment brokers, who provide counseling on the full spectrum of available MCE choices, assist applicants with their MCE selection, and, if applicable, provide counseling regarding the HIP Employer Link option, including assistance evaluating their ESI plan. For HIP members, 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 but will have the opportunity to change the assigned MCE before the first POWER account contribution is made.

COST SHARING REQUIREMENTS

HIP utilizes two forms of cost-sharing: POWER account contributions and co-payments to promote consumerism and personal responsibility. Each HIP member is provided a POWER account valued at $2,500 to pay for the cost of the plan deductible. The POWER account, which operates similarly to a health savings account, contains contributions made by the State as well as the required monthly contributions from the member. Member contributions are equal two percent (2%) of income, but in no event will a member contribute less than $1.00 per month or more than $100.00 per month. By contrast, members not paying monthly POWER account contributions participating in HIP Basic will be required to make copayments for all services. The copayments are established at Medicaid allowable rates, ranging from $4 per office visit up to $75 per hospital stay, making it potentially more expensive than HIP Plus. Consistent with CMS rules, the program ensures that no member pays more than five percent (5%) of their income, except that HIP Plus requires a minimum $1.00 contribution, even among individuals with no reported income.

Consistent with commercial market practices, applicants are required to make their first month's POWER account contribution prior to the start of benefits. Once an individual pays the POWER account contributions, benefits begin the first day of the month in which the contribution was received. However, to expedite coverage, applicants are provided the opportunity to pay a ten dollar ($10.00) fast track POWER account prepayment, while their eligibility application is being processed to accelerate enrollment into the HIP Plus plan. Individuals with income below the federal poverty level who have not made their initial fast track prepayment or first monthly POWER account contribution within 60 days of invoice will be enrolled in the HIP Basic plan beginning the first day of the month of the expiration of the payment period. Individuals above the poverty level who do not make their first monthly POWER account contribution are not enrolled in HIP and must reapply for coverage and make a contribution to access benefits.

Other than the monthly contributions to the POWER account, the only other cost-sharing for HIP Plus members are copayments for non-emergency use of hospital emergency departments. HIP non-emergency use of hospital emergency copayments equal $8.00 for the first inappropriate visit and $25.00 for each subsequent visit.

The State seeks to add a tobacco use surcharge to HIP Plus members in order to encourage participation in the voluntary tobacco cessation initiative. HIP Plus members who are known tobacco users will be required to pay monthly contributions equal to three percent (3%) of income in their second year of eligibility. The tobacco surcharge will be waived for the first year of enrollment in order to provide the individual who identifies as a tobacco user to have the opportunity to take advantage of the robust tobacco cessation benefits offered through HIP. If the member continues to be a tobacco user, their monthly premium will increase beginning in the first month of their renewed benefit period. This proposed change is consistent with ACA rating rules which allow qualified health plans on the Marketplace to charge up to 1.5 times the rate charged to a non-smoker.

Individuals enrolled in HIP Employer Link have the payment for their employer sponsored insurance deducted from their pay check and receive a check in advance from their HIP Employer Link POWER account to cover the difference between their 2% of income contribution, and the amount their employer deducts for insurance. HIP Employer Link enrollees do not have any cost sharing applied to covered services, provided there are funds remaining in the individual's POWER account.

HYPOTHESES & EVALUATION

HIP currently utilizes a CMS-approved comprehensive evaluation plan that has been successful in tracking HIP's progress toward achieving its stated goals. During the new demonstration period, the State will maintain the original evaluation design, but will add new components to assess the impact of the new programs and policies presented within the waiver renewal application. Specifically, the State will include an analysis of the following new components within its updated HIP evaluation plan:

1. Tobacco Cessation
2. Substance Use Disorder (SUD)
3. Chronic Disease Management
4. Employment Related Incentives

The following table outlines the hypotheses for the new program components within the HIP waiver renewal as well as the methodology and data source the State will use for evaluation of each hypothesis:

Hypothesis	Methodology	Data Source
1. Tobacco Cessation		
HIP will increase utilization of tobacco cessation benefits among individuals who use tobacco	Track and compare rates of tobacco cessation utilization among individuals who use tobacco.	Claims Data • Number and percentage of members with tobacco cessation utilization codes MCE Data • Number and percentage of members with tobacco use indicated by MCE health risk assessment Pharmacy Benefit Data • Number and percentage of members with tobacco cessation prescriptions Member Survey Data • Member knowledge of tobacco-cessation benefits; member self-report of tobacco use; member self-report of tobacco cessation utilization
HIP's increased contribution requirement for tobacco users will discourage tobacco use among current smokers	Track and compare rates of tobacco use and tobacco cessation utilization among individuals who use tobacco.	Claims Data • Number and percentage of members with tobacco cessation utilization codes MCE Data • Number and percentage of members with tobacco use indicated by MCE health risk assessment Pharmacy Benefit Data

Hypothesis	Methodology	Data Source
		• Number and percentage of members with tobacco cessation prescriptions Member Survey Data • Member knowledge and perceptions of increased contribution for tobacco users; member self-report of tobacco use; member self-report of tobacco cessation utilization
2. Substance Use Disorder (SUD)		
HIP will increase access to SUD treatment among individuals with SUD	Track and compare rates of SUD treatment engagement among members with SUD	Claims Data • Number and percentage of members with SUD diagnosis codes • Number and percentage of members with SUD treatment codes MCE Data • Number and percentage of members with SUD indicated by MCE health risk assessment Pharmacy Benefit Data • Number and percentage of members with SUD treatment prescriptions Quality measures from the Medicaid Adult and Children's Core Sets for individuals with SUD • Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NQF #0004)
HIP will improve the continuum of care among individuals engaged in SUD treatment	Track and compare SUD treatment engagement following discharge from SUD treatment facilities and hospitals	Quality measures from the Medicaid Adult and Children's Core Sets for individuals with SUD • SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge (NQF #1664)

Hypothesis	Methodology	Data Source
		• SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge (NQF #1664) measures • Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence (NQF #2605) • Timely Transmission of Transition Record (NQF #0648) • Transition Record with Specified Elements Received by Discharged Patients (NQF #0647)
HIP will reduce SUD readmission rates to the same level of care or higher	Track and compare rates of SUD treatment readmission	Claims Data • Number and percentage of members with SUD diagnosis codes • Number and percentage of members with SUD treatment codes Quality measures from the Medicaid Adult and Children's Core Sets for individuals with SUD • Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NQF #0004).
HIP will reduce emergency department utilization due to drug overdose	Track and compare rates of emergency department utilization due to drug overdose	Claims Data • Number and percentage of members with ER visits and admissions with drug overdose codes
HIP will reduce the rate of preventable hospitalization among members with SUD	Track and compare rates of preventable hospitalization among HIP members with SUD	Claims Data • Number and percentage of members with SUD and ambulatory case sensitive conditions who are hospitalized
3. Chronic Disease Management		
HIP's chronic disease management incentive structure will promote active engagement in MCE chronic disease management	Track and compare rates of chronic disease management program participation	MCE Data • Number and percentage of members engaged in chronic disease management programs Member Survey Data

Hypothesis	Methodology	Data Source
programs and activities		• Member knowledge and perceptions of chronic disease management program incentives
HIP's chronic disease management incentive structure will reduce the rate of preventable hospitalization among members enrolled in chronic disease management programs	Track and compare rates of preventable hospitalization among members enrolled in chronic disease management programs	MCE Data • Number and percentage of members engaged in chronic disease management programs Claims Data • Number and percentage of members engaged in chronic disease management with ambulatory case sensitive conditions who are hospitalized
4. Employment Related Incentives		
HIP's employment related incentive structure for MCEs will promote active member engagement the Gateway to Work Program	Track and compare rates of participation in the Gateway to Work Program	Administrative Data • Number and percentage of members enrolled in the Gateway to Work Program MCE Data • Number and percentage of members who earn incentives for engagement in the Gateway to Work program
HIP's employment related incentive structure for MCEs will promote employment among HIP members	Track and compare rates of employment among HIP members	Eligibility and Enrollment Data • Number and percentage of members who earn employment • Number and percentage of members who are disenrolled from HIP due to increased earnings from employment MCE Data • Number and percentage of members who earn incentives for obtaining employment

WAIVER & EXPENDITURE AUTHORITIES

The State is requesting an extension of all currently approved waivers and only requests revisions necessary to implement the proposed program enhancements. A complete list of the existing and proposed HIP waiver and expenditure authorities are as follows:

1. Premiums Section 1902(a)(14) and Section 1916 of the Social Security Act
To enable the State to charge premiums in HIP Plus at levels not more than two percent of household income and not more than three percent of household income for tobacco-users after their first year of HIP enrollment. Total cost-sharing for a household is subject to a quarterly aggregate cap of five percent of household income, except that all HIP Plus households will be required to contribute, at a minimum,

monthly one dollar ($1.00) POWER account contributions. Individuals at or below 100 percent of poverty will not have premiums as a condition of eligibility.

2. Freedom of Choice Section 1902(a)(23)(A) of the Social Security Act
To the extent necessary to enable Indiana to restrict the freedom of choice of providers for HIP Employer Link enrollees to a choice of providers participating in the network of the HIP Employer Link plan. No waiver of freedom of choice is authorized for family planning providers.

3. Amount, Duration, Scope, and Comparability Section 1902(a)(10)(B) of the Social Security Act
To the extent necessary to enable Indiana to permit Medicaid eligible individuals to choose to participate in an employer-sponsored health insurance plan through a HIP Employer Link participating family member, with wrap-around to their existing Medicaid benefits.

4. Reasonable Promptness Section 1902(a)(8) of the Social Security Act
To the extent necessary to enable Indiana to start enrollment in HIP Plus on the first day of the month in which an individual makes their initial contribution to the POWER account, or, for members under 100 percent FPL who fail to make an initial POWER account payment within 60 days following the date of invoice, the first day of the month in which the 60 day payment period expires, except for individuals who apply through presumptive eligibility.

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

To the extent necessary to enable Indiana to establish an open enrollment period for HIP, such that members who are disenrolled for failure to comply with the redetermination process will be required to wait until their next open enrollment period to re-enroll (up to six months).

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 2.0 demonstration populations. No waiver of methods of administration is authorized for pregnant women, individuals determined to be medically frail, and Section 1931 parents and caretaker relatives. This waiver authority will expire January 31, 2016 unless explicitly renewed under the conditions described in the terms and conditions.

6. Comparability Section 1902(a)(17) of the Social Security Act
To the extent necessary to enable the state to vary cost sharing requirements for individuals from cost sharing to which they otherwise would be subject under the state plan such that beneficiaries who are in HIP Plus will be charged only one co-payment (for non-emergency use of the emergency department) and individuals who are in HIP Basic will be subject to copayments at Medicaid permissible levels except for non-emergency use of the emergency department, as described in the terms and conditions.

7. Retroactivity Section 1902(a)(34) of the Social Security Act
To the extent necessary to enable Indiana not to provide medical coverage to HIP members in the HIP Plus plan for any time prior to the first day of the month in which an individual pays the first contribution to the POWER account or fast track prepayment.

To allow Indiana not to provide medical coverage to HIP members under 100 percent FPL who failed to make an initial POWER account payment or fast track payment, as applicable, within 60 days following

the date of invoice, for any time prior to the first day of the month in which the 60 day payment period expired.

8. Cost sharing for Emergency Department Section 1916(f) of the Social Security Act
To the extent necessary to enable Indiana to require a graduated co-payment up to $25 for all HIP 2.0 demonstration populations, for non-emergency use of the emergency department as described in 42 CFR 447.54. This waiver authority will end two years from the effective date of the demonstration.

9. Payment to Providers Section 1902(a)(13) and Section 1902(a)(30) of the Social Security Act
To the extent necessary to permit Indiana to provide for payment to providers that is not more than the rates paid by an employer sponsored insurance (ESI) plan providing primary coverage for services to the HIP Link population, such that payment by the ESI Plan (plus any payment from the individual's POWER account and remaining cost sharing due from the individual under the ESI plan from the beneficiary) serves as payment in full and the state has no further payment obligation to the provider.

10. Cost Not Otherwise Matchable
The State requests that expenditures related to providing services in an IMD be regarded as expenditures under the State's Medicaid Title XIX State Plan.

REVIEW OF DOCUMENTS AND SUBMISSION OF COMMENTS

The proposed HIP Waiver documents are available for public review at the FSSA, Office of General Counsel, 402 W. Washington Street, Room W451, Indianapolis, Indiana 46204. The documents may also be viewed online at www.HIP.in.gov.

Written comments regarding the HIP Waiver will be accepted through 5:00 p.m. on January 20, 2017 and 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 HIP2.0@fssa.in.gov.

FSSA will publish a summary of the written comments, once compiled, for public review at www.HIP.in.gov.