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

Eric J. Holcomb
Governor

July 20, 2017

Secretary Tom Price
Secretary of the Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Health Indiana Plan Section 1115 Demonstration Waiver Amendment to Extension (Project No. 11-W-00296/5)

Dear Secretary Price,

On January 31, 2017, Indiana submitted an application to extend the Healthy Indiana Plan (HIP) through January 31, 2021. Since that submission, your agency has issued additional guidance regarding a new era for federal and state partnership to meet the needs of states' unique populations. With this in mind, we are pleased to submit an amendment to our extension application.

As indicated in my letter to Hoosiers in May, this amendment eases existing administrative burdens for participants, expands treatment options for Hoosiers afflicted by Indiana's drug epidemic, and enhances HIP's existing Gateway to Work program to help transition eligible members to meaningful employment.

Indiana posted this amendment on May 24, 2017 for state public comment, launched a month long stakeholder travel schedule, and participated in several webinars to elicit public input. CMS opened a concurrent federal comment period beginning on June 8, 2017. Due to the overlapping comment periods, Indiana considered more than sixty state and federal comments prior to this submission, several of which have been incorporated into this final submission. We appreciate the opportunity to review federal comments in real time. During this period of active communication, we continued negotiations on the extension application that our teams have been working on together since February.

Please consider this as the state's final submission to amend its existing waiver amendment extension request. We ask that you leave the federal comment period open for thirty days after this submission. Thank you again for the opportunity to partner with your department to focus on health outcomes, increase ease and flexibility within our program, and attack Indiana's opiate epidemic.

Sincerely,

Eric Holcomb

Indiana Family and Social Services Administration

Amendment Request to Healthy Indiana Plan (HIP) Section 1115 Waiver Extension Application (Project Number 11-W-00296/5)

Contents

Section 1. Overview

The Healthy Indiana Plan ("HIP") 2.0 1115 demonstration program was implemented by the State of Indiana ("State") on February 1, 2015, building upon the framework and successes of the original HIP program, which has offered proven consumer driven healthcare to able-bodied low-income Hoosiers since 2008. Over 400,000 individuals are fully enrolled in HIP.

HIP offers low-income Hoosiers a high deductible consumer-driven health plan paired with a Personal Wellness and Responsibility ("POWER") account, which is similar to a health savings account. The POWER account contains contributions made by the State as well as the required monthly contributions from the member currently equal two percent (2%) of income. The POWER account provides a financial incentive for members to become more invested and engaged in their healthcare by adopting healthy behaviors and seeking price transparency to make value conscious decisions. HIP policies are designed to improve member utilization of healthcare services leading to better outcomes.

On January 31, 2017, the State submitted a HIP 1115 waiver extension application ("extension"), seeking to continue the HIP 2.0 demonstration waiver program for three years in its current form with technical revisions and updates, as well as program enhancements aimed at improving member health outcomes through coordinated efforts targeting tobacco cessation, substance use disorder, chronic disease management, and employment.

In addition to the technical changes and program enhancements requested in the original extension request earlier this year, the State now submits this amendment to the state's pending waiver extension application seeking federal approval to strengthen its HIP program through the following program revisions, each of which is described in more detail below:

1. *HIP Gateway to Work Expansion*. The current HIP Gateway to Work initiative is a voluntary program that connects HIP members to available job training and employment services on a voluntary basis. To increase participation and help HIP meet its goal of increasing employment among HIP members, Indiana seeks to require member participation in Gateway to Work as a condition of eligibility for non-disabled working age members.
2. *POWER Account Income Tiers*. Currently HIP requires members to contribute 2% of income to their POWER account monthly. For purposes of easing administrative burden and to facilitate member compliance with POWER account contributions, the State will realign POWER account contributions to pre-defined income tiers that are roughly equivalent to 2% income across each income tier.
3. *HIP Employer Link Closure*. The current HIP Employer Link program puts excessive administrative burden on employers and the state around plan review and benefit wrap. Further, it excludes members whose employers do not take advantage of the optional participation through the employer portal. Finally, there has been minimal engagement in member enrollment. Therefore, the State will close this element of the HIP 2.0 program.

4. *Technical Revisions*. To gain administrative efficiencies, the State also seeks several additional technical revisions to the transitional medical assistance program, benefits provided to refugees, and funding for Medicaid rehabilitation option.

Section 2. Types of Waivers Requested

2.1 Title XIX Waiver Requests

In addition to the revisions to the HIP waivers requested in the January 31, 2017 extension, the State seeks the following Title XIX waivers:

1. Eligibility Section 1902(a)(10)(A)

To the extent necessary to enable the State to require all able-bodied HIP participants, as a condition of eligibility, to: (1) work at least 20 hours per week over eight (8) months of an eligibility cycle; (2) be enrolled in full-time or part-time education, or (3) participate in the Gateway to Work initiative.

2.2 Costs not Otherwise Matchable

The State requests that expenditures related to the Gateway to Work expansion be regarded as expenditures under the State's Medicaid Title XIX State Plan.

Section 3. Discussion

3.1 Gateway to Work Enhancements

Gateway to Work was launched in 2015 to promote the connection between employment and health by integrating the State's various work training and job search programs with HIP. Through this initiative, all eligible HIP members who 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 programs is voluntary. The process to date has not been successful in connecting individuals with sustained employment. One of the main goals of the HIP demonstration project is to "provide HIP members with opportunities to seek job training and stable employment to reduce dependence on public assistance." Therefore, to provide these critical services to more HIP members to help meet one of the foundational goals of the program, the State seeks to strengthen HIP's employment initiative and improve participation rates by making participation in the Gateway to Work program a condition of eligibility for all able-bodied working age adult HIP members who are unemployed or working less than 20 hours per week averaged over eight (8) months of the eligibility period or are a student.

In general, employed individuals are both physically and mentally healthier, as well as more financially stable, as compared to unemployed individuals.[1] Due to the strong connection

[1] F.M. McKee-Ryan, Z. Song, C.R. Wanberg, and A.J. Kinicki. (2005). Psychological and physical well-being during unemployment: a meta-analytic study. *Journal of Applied Psychology*, 90 (1), 53-76.; K.I. Paul, E.

between employment and overall health, people who are unemployed have 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.[2] Additional studies reveal conflicting data in the relationship between employment and health outcomes, including:

1. Increased access to healthcare coverage results in decreasing disability claims in the low-income working poor.[3]
2. There is minimal evidence linking workplace wellness programs with significant ROI. Additionally, wellness programs may have the unintended consequence of targeting those with chronic diseases that disproportionally affect low-income workers.[4]
3. Low-wage workers face numerous obstacles to obtaining recommended health care despite healthcare access.[5]
4. Working long hours undermines health. [6]
5. When unemployment rises, so do deaths from suicide and drug overdoses.[7]

Given this information, a well-designed process to connect individuals to employment in a way that promotes positive health outcomes and financial stability is essential.

Through this HIP extension amendment request, the State seeks to increase participation in the Gateway to Work initiative to connect members to gainful employment, in a way that improves physical and mental health and the individual's overall financial stability and well-being.

To this end, the State will modify the HIP Gateway to Work initiative to require that all able-bodied HIP participants, not otherwise meeting an exemption, will be required to either:

(1) work on average 20 hours per week over eight (8) months during the eligibility period;
(2) be enrolled in full-time or part-time education; OR
(3) participate in Gateway to Work.

This requirement will be operationalized during the first year of the renewal period and phased in during the second year with a member grace period of six (6) months.

Gateway to Work will connect unemployed and under-employed HIP members to available job training, work search, and employment programs that will assist members in securing gainful employment. Qualifying Gateway to Work participation activities include the following:

Geithner, and K. Moser. (2009). Latent deprivation among people who are employed, unemployed, or out of the labor force. *Journal of Psychology*, 143 (5), 477-491.

[2] http://www.commissiononhealth.org/PDF/0e8ca13d-6fb8-451d-bac8-7d15343aacff/Issue%20Brief%204%20Dec%2008%20-%20Work%20and%20Health.pdf

[3] Buchmueller, T.C. and R.G. Valletta, Work, Health, And Insurance: A Shifting Landscape For Employers And Workers Alike. Health Aff (Millwood), 2017. 36(2): p. 214-221.

[4] *Id*.

[5] Workforce Health And Productivity. Health Aff (Millwood), 2017. 36(2): p. 200-201.

[6] Caruso, C.C., Negative impacts of shiftwork and long work hours. Rehabil Nurs, 2014. 39(1): p. 16-25.

[7] Ruhm, C.J., Recessions, healthy no more? J Health Econ, 2015. 42: p. 17-28.

- Employment (subsidized or unsubsidized);
- Managed Care Entities (MCE) employment initiatives;
- Job skills training;
- Job search activities;
- Education related to employment;
- General education (i.e. GED, community college);
- Accredited English as a second language education;
- Vocational education/ training;
- Community work experience;
- Community service/public service;
- Caregiving services for a non-dependent relative or other person with a chronic, disabling health condition, including individuals receiving FMLA to provide caregiving;
- Accredited homeschooling;
- Volunteer work (e.g. classroom volunteer, faith-based internship work or mission trips sponsored by a recognized religious institution, etc.);
- Members of the Pokagon Band of Potawatomi will be considered to meet the Gateway to Work requirement as the tribe's comprehensive Pathways program promotes full employment and meets the goals of the Gateway to Work;
- Participation in work requirements for the SNAP program;
- Exemptions as necessary based on individual review.

In addition, due to the inextricable link between substance use disorder (SUD) and unemployment, Gateway to Work will also encourage members with a drug addiction to seek treatment. Finding a solution for the current drug epidemic requires a multi-faceted approach that not only treats the health-related consequences, but also addresses some of the underlying economic and social root causes of the epidemic, including unemployment. To encourage members to seek treatment for SUD, participation in SUD treatment activities will be included as an exclusion criteria for this program allowing for voluntary participation during recovery.

The Gateway to Work participation requirements will gradually increase from five (5) hours per week up to a maximum of twenty (20) hours per week as follows:

Table 1: Escalated Gateway to Work Participation Hours

HIP Eligibility Period	Required Participation Hours
1-6 months	0 hours per week
7-9 months	5 hours per week
10-12 months	10 hours per week
13-18 months	15 hours per week
18+ months	20 hours per week

Following a six (6) month grace period, HIP members who are unemployed or working fewer than 20 hours per week and not otherwise meeting an exemption listed in *Table 2* will be required to participate in the Gateway to Work program as a condition of eligibility. Members who fail to complete the specified number of required Gateway to Work participation hours will

be suspended from HIP until the member satisfies the Gateway to Work participation requirements for one (1) full month. Members that are suspended and gain an exemption, such as a woman who becomes pregnant during a suspension, will be able to reenter HIP without completing the required Gateway to Work hours. In recognition that members may face barriers including child care and transportation, existing resources, including SNAP, TANF, and CCDF will be leveraged to offer supportive services to qualifying individuals.

HIP members who are either students (full-time or part-time) or who are working at least 20 hours per week are not subject to the Gateway to Work requirements for so long as the member continues their education and/or their 20 hours per week employment. In addition, pregnant women, former foster children under age 26, the chronically homeless, individuals receiving Temporary Assistance for Needy Families (TANF), the medically frail, adults who are the primary caregiver of a dependent (including a minor child less than age 12 or a disabled dependent) or kinship caregivers of abused or neglected children, members receiving treatment for SUD, and members over the age of 60 are exempt from mandatory participation in Gateway to Work. Further, the participation requirements will be suspended temporarily for members who are unable to participate due to temporary illness or incapacity as certified by a licensed physician, advanced practice nurse, licensed behavioral health professional, a licensed physician assistant, or board certified psychologist and will include individuals on medical leave (FMLA).

Table 2: Participation Exemptions

Gateway to Work Participation Exemptions
Students (full-time and part-time)
Members who are employed & working more than 20 hours per week averaged over 8 of 12 months
Pregnant women
Members who are a primary caregiver of a dependent child below the compulsory education age or a disabled dependent, including kinship caregivers of abused or neglected children
Members identified as medically frail (i.e. serious & complex medical conditions, chronic substance use disorder, or disability determination)
Members with a certified temporary illness or incapacity (includes individuals on FMLA)
Members in active substance use disorder (SUD) treatment
Members over the age of 60
Former foster children under age 26
Chronically Homeless Individuals
Temporary Assistance for Needy Families (TANF) recipients
Recent incarceration

Current HIP enrollment reports indicate the strong need for members to receive this enhanced assistance in obtaining or maintaining employment. Recent enrollment numbers show that approximately 40% of HIP members have less than a high school education. Reports also show that 244,000 HIP members were unemployed, while an additional 58,000 members were working fewer than 20 hours per week. Despite these numbers, with a voluntary Gateway to Work initiative, members are not properly incentivized to actively seek employment, resulting in only 580 Gateway to Work orientations being attended during the first fifteen (15) months of the program. The State believes that this data indicates non-exempt able-bodied HIP participants, as

well as the State in general, would benefit from conditioning HIP eligibility on the member: (1) working at least 20 hours per week; (2) being enrolled in full-time or part-time education, or (3) participating in the Gateway to Work initiative. The State believes this will lead to improved overall health for members, as the correlation between employment and better physical and mental health has been documented,[8] as well as a better-trained workforce within the State of Indiana with individuals who are able to transition to the private market.

These changes are necessary to further the HIP program goal of "provid[ing] HIP members with opportunities to seek job training and stable employment to reduce dependence on public assistance." By increasing participation in the Gateway to Work program, more HIP members will be connected and engaged with the critical vocational skills, job training, education and support available to them. Robust participation in Gateway to Work will encourage member self-sufficiency and foster an eventual transition to the private market, ultimately leading to decreased unemployment for Hoosiers and improved health and financial stability for members.

3.2 Income Tiers for POWER Account Contributions

One of the hallmarks of HIP is the POWER Account, a health savings-like account valued at $2,500 which pays for the full cost of the member's deductible. In addition to contributions made by the State, the POWER account contains the required monthly contributions from the member, equal to two percent (2%) of income. As detailed in the waiver extension submission, the POWER account design has been successful in giving members "skin-in-the-game" and providing a financial incentive for members to become more invested and engaged in their healthcare. However, in the interest of continuously seeking to improve upon the success of the HIP program, through this waiver extension amendment, the State seeks to replace the current 2% of monthly income contribution requirement with new tiered member contributions based on federal poverty level ("FPL"). The proposed POWER account contribution amounts are roughly equivalent to 2% of income.

Table 3: Monthly PAC Amounts

FPL	Monthly PAC Single Individual	Monthly PAC Spouses
<22%	$1.00	$0.50
23-50%	$5.00	$2.50
51-75%	$10.00	$5.00
76-100%	$15.00	$7.50
101-138%	$20.00	$10.00

The State seeks to make this change for several reasons. Most importantly, the tiered structure provides more stability for members as it results in fewer changes to contribution requirements than the current structure, which requires a change in contribution amount as a result of even a

[8] *See* F.M. McKee-Ryan, Z. Song, C.R. Wanberg, and A.J. Kinicki. (2005). Psychological and physical well-being during unemployment: a meta-analytic study. *Journal of Applied Psychology*, 90 (1), 53-76.; K.I. Paul, E. Geithner, and K. Moser. (2009). Latent deprivation among people who are employed, unemployed, or out of the labor force. *Journal of Psychology*, 143 (5), 477-491.

small change in monthly income. Additionally, this would ease administrative burden on the State from both a systems and member communication perspective.

3.3 HIP Employer Link

With the HIP 2.0 demonstration program approval, the State also implemented the HIP Employer Link program, which provides HIP eligible individuals support to enroll in their employer-sponsored health insurance ("ESI") instead of HIP coverage. HIP Employer Link currently provides individuals with the benefits available on their 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) individuals receive benefits wrapped to one of the HIP Employer Link alternative benefit plans and the State is required to cover claims beyond the $4,000 limit and provide individuals a chance to transfer back to HIP during their enrollment year should they exhaust their HIP Employer Link POWER account. Utilization of HIP Link has been low and administrative burden has been high.

With this amendment, the State proposes to close the HIP Link program and re-allocate these resources to other components of the program.

3.4 Technical Revisions

3.4.1 Transitional Medical Assistance (TMA)

We request that the Transitional Medical Assistance program requirements per Section 1925 of the Social Security Act be waived for parent/caretakers with minimal increases in income. HIP 2.0 will operate TMA in a manner that will address only those truly at risk of losing coverage. TMA was a vital program when, for example, a family of three on Temporary Assistance for Needy Families ("TANF") whose income increased to over $310 a month would actually lose Medicaid coverage for the parent. However, now that we cover adults up to 138% FPL, the need for the program has lessened. Indiana has found that the vast majority of our Section 1931 parent/caretakers who qualify for TMA coverage per current rules never increase to over 100% FPL, and therefore are in no danger of having their HIP coverage end.

We propose that the new TMA extend coverage only to those who would be closed due to an increase in income that puts them over 138% FPL. All low-income parent/caretakers transitioning out of State Basic coverage due to increased job income above the MAGI-converted need standard will be afforded the opportunity to buy into Plus coverage to retain vision and dental benefits. However, TMA will be reserved for those whose job income increases to over 138% FPL, and will allow them to either attain or remain in PLUS coverage for up to twelve months. If after the first six (6) months of TMA coverage income remains over 138% but below 185% FPL, coverage can extend an additional six (6) months as long as POWER Account contributions are paid. Except for the income limit and frequency of reporting, all other existing TMA rules will be used for the over 138% FPL parent/caretaker group.

3.4.2 Refugees

Refugees are exempt from HIP for the first eight (8) months of arrival. Refugees will qualify for full coverage and will be protected for the first eight (8) months upon entering the United States. Benefits will be covered under traditional Indiana Medicaid Fee-For Service (FFS).

3.4.3 Medicaid Rehabilitation Option

Indiana seeks expenditure authority to reimburse providers of Medicaid Rehabilitation Option ("MRO") services at enhanced HIP 2.0 provider payment rates like all other health care providers as required in state statute at IC 12-15-44.5-5(a)(2)(B). Previous guidance by CMS determined MRO services provided to HIP 2.0 members must be reimbursed at the same rate as the same services to other Indiana Medicaid members, since MRO services are not provided through managed care and are therefore paid through the same fee-for-service codes and claim system as other Indiana Medicaid members. Indiana seeks waiver authority to reimburse MRO services for HIP 2.0 members at the enhanced reimbursement rate outside of the managed care program and at the FMAP rate applicable to the eligible member.

3.4.4 Tobacco Use Question on Application

Indiana seeks the authority to add a tobacco use question to the Indiana Health Coverage Programs application. CMS released guidance on June 18, 2013 regarding the streamlined application for health coverage and state alternative applications for health coverage. In that guidance, CMS indicated that "*States must only ask questions that are necessary for determining eligibility for coverage in a Qualified Health Plan (QHP) and all insurance affordability programs, or for the administration of these programs."* A tobacco use question is necessary for the administration of the HIP program in determining the POWER Account contribution and the application of a tobacco use surcharge.

Section 4. Amendment Process Required Elements

4.1 Public Notice & Comment Summary

On May 24, 2017, FSSA informed the public of its intention to modify the state's pending 1115 demonstration extension application for the Healthy Indiana Plan. The amendment and formal public notice of the amendment were included on the FSSA website, and the notice was published in the Indiana Register on the same date. The public notice served to formally open a 30-day public comment period which ran from May 24, 2017 to June 23, 2017. At the same time the state submitted notice to CMS of its intension to submit a formal amendment. CMS opened a concurrent federal comment period which began on June 8, 2017 and remains open at the time of this amendment.

In addition, the State held open two public hearings: (1) the State's Medicaid Advisory Committee on Thursday, May 25, 2017 at 10:00AM EDT in Conference Room C of the Indiana Government Center South Building located at 402 W. Washington St. Indianapolis, IN 46204; and (2) a public hearing on June 8, 2017 at 1:30PM EDT at the Indiana State Library, History Reference Room, 315 West Ohio Street, Indianapolis, IN 46204. Both hearings provided the public the opportunity to provide verbal comments on the proposal in person as well as via web conference.

Following tribal notification and solicitation for comment on Wednesday, May 24, 2017 with the State's tribe, the Pokagon Band of Potawatomi, a tribal consultation occurred via conference call on June 8, 2017. This consult resulted in productive discussion leading to greater State understanding of the tribal Pathways program that promotes full employment amongst tribal members. The State also received written comment from the Pokagon Band of Potawatomi and has addressed the recommendations and comments from the tribe in the comment response below.

The State received a total of 28 written public comments during the 30-day state public comment period and a total of 31 written comments submitted through July 9, 2017, via the concurrent federal comment period. The State has reviewed all state public comments, all comments from the public hearings, and leveraged the opportunity to review a majority of the federal public comments received via the concurrent federal comment period. The below summary combines the testimony offered at the public hearings, the comments received via mail and email by the State, as well as the comments submitted to CMS through July 9, 2017.

1. Public Comments: Gateway to Work Expansion

Summary of Comments. Most comments received were related to the proposed expansion of the Gateway to Work initiative. There was a broad range of both support and opposition. For example, some commenters believe the Gateway to Work requirement does not align with Medicaid goals of providing medical assistance and improving health outcomes, and should be removed from the amendment. By contrast, some commenters indicated support for the Gateway to Work expansion, with one commenter indicating that most employed individuals obtain insurance through employment and have cost sharing obligations for their health insurance coverage. Further, several commenters suggested the current voluntary Gateway to Work program should be maintained with the State conducting additional outreach efforts to educate enrollees about the availability of the program. In addition, one state commenter urged the State to conduct a robust evaluation of the work requirement to ensure the final policy is obtaining desired outcomes. A federal commenter offered suggestions on how to structure the Gateway to Work evaluation to ensure outcomes and access are given due consideration.

However, a significant portion of the comments related to Gateway to Work were less generalized and addressed specific questions, concerns, and suggestions for improvements to the proposed policies. These comments included suggestions related to (i) expanding activity types and member support services, (ii) adding exemptions, and (iii) modifying the proposal for administrative efficiencies.

- *Activity Types and Member Support Services*. Several commenters raised questions and concerns about the types of activities that would be required, as well as who would be subject to the requirements. One commenter suggested that participation in English as a second language be included as a qualifying activity. Another commenter indicated they were pleased to see the variety of activities that would be recognized as meeting the requirement and supported the initial grace period and graduated levels of required hours. Conversely, one commenter indicated the graduated hours requirement may be confusing to members and administratively burdensome to track. In addition, several commenters (responding to both the state and federal request for comments) expressed concerns related to potential barriers and other burdens on low-income working families in

meeting the requirements, including, but not limited to access to transportation and affordable childcare.

- *Exemptions*. Several commenters raised concerns about who would be included in the definition of "able-bodied" and thus become subject to the requirement. Commenters requested confirmation that children, the elderly, the bed ridden, full-time students and the seriously ill or caregivers would not be subject to the work requirement. Specific conditions were requested to be exempted including individuals with bi-polar disorder and individuals with cystic fibrosis. Commenters suggested that there may be subtle mental health or physical limitations that limit a person's ability to maintain employment that do not necessarily rise to the level of a disability that would qualify an individual as "medically frail." Commenters also suggested the following populations be exempted from the Gateway to Work requirement: (1) former foster care youth, (2) kinship caregivers of abused or neglected children, (3) stay-at-home and homeschooling parents, (4) family planning enrollees, (5) homeless enrollees, (6) individuals with mental illness, (7) caregivers, and (8) primary caregivers of an individual living with a grave condition with the length of the exemption sufficient to meet the needs of cancer patients and caregivers. Further, understanding that pregnant women are exempt from the Gateway to Work requirements, one commenter requested clarification on whether women that are locked-out for non-compliance may re-enter the program upon becoming pregnant. The State's tribal consult resulted in the request that American Indiana's and Alaskan Natives (AI/ANs) be considered an exempt population specifically due to the population's unique characteristics and the fact that the tribe operates a robust comprehensive career and employment program.

- *Process Efficiencies*. One commenter proposed that managed care entities (MCEs) be responsible for operating employment support programs, with those who do not engage with the MCEs being referred to the Gateway to Work program. Another commenter indicated support for the concept of providing referrals and education about employment and training but had concerns that the current employment services infrastructure may not have the capacity to serve an influx of job-seekers. Further, one commenter suggested the colocation of WorkOne Offices and insurance navigators to guide enrollees. Additionally, one commenter requested inclusion of an appeals process for members to demonstrate good cause for not meeting the requirement. Commenters also raised concerns that the program would create administrative complexities. Finally, comments were received requesting the State expand investment in research-based employment programs such as Individual Placement and Support, Clubhouse Transitional Employment, and Coordinated Specialty Care.

State Response. The State appreciates the thoughtful comments received regarding the Gateway to Work initiative. We maintain committed to implementing innovative approaches to improving employment rates among the HIP population and encouraging member self-sufficiency, as improving individual's socioeconomic status is a key driver of health outcomes. Due to the strong connection between employment and overall health, our proposed approach is inherently aligned with the overall goals of the Medicaid program.

The Gateway to Work expansion policy has been thoughtfully crafted to create a breadth of qualifying activities, and specific exemptions that reflect the experience of the population. The qualifying participation activities have specifically been developed to address potential concerns that some enrollees may have subtle mental health or physical limitations that limit their ability to maintain employment. The inclusion of job skills training, education and community service were intentionally included as qualifying activities to provide resources and support to help individuals find suitable employment tailored to their individual needs and potential abilities. In response to comments received, the State will expand the list of qualifying activities and exemptions as described below.

Qualifying Activities. Participation in the following activities qualify for Gateway to Work or are considered to meet the requirement:

- Participation in English as a second language courses will qualify for Gateway to Work requirements.
- In response to the tribal comment received, all members of the Pokagon Band of Potawatomi will be considered to meet the Gateway to Work requirement as the tribe's Pathways program promotes full employment and meets the goals of the program.
- In response to comments on reducing administrative burdens, the State will consider any individual that is meeting a work requirement for Supplemental Nutrition Assistance Program (SNAP) to meet the requirement for Gateway to Work.

Exemptions. The State will add the following exemptions from the requirement to participate in Gateway to Work:

- In response to state and federal comments on the unique challenges of former foster youth, former foster youth under age 26 will be considered exempt.
- In response to state and federal comments, as well as comments received during the State's listening tour, those individuals who are chronically homeless will be considered exempt.
- In response to comments on reducing administrative burdens, individuals receiving TANF will be considered exempt.
- The State will also request authority to add additional exemptions via administrative rule, should the need arise, as commenters requests for exemptions highlight that it is possible additional populations may need to be defined as exempt in the future.

Clarifying language has been added to the submission in response to comments on exempting kinship caregivers of abused or neglected children, and individuals with mental illness, as these populations would be captured under existing exemptions. Further, individuals taking Family or Medical Leave (FMLA) will be eligible to count caretaking hours or temporary exemptions due to medical leave. As requested by one commenter, the State affirms that children, the elderly (including all individuals over age 60), and full-time students are not subject to the Gateway to Work requirements. For the bedridden and seriously ill who are not medically frail, there is an existing proposed exemption for temporary illness and incapacity that would account for these situations. In addition, the State confirms that bipolar disorder and cystic fibrosis are existing specified conditions for the purposes of the medically frail assessment, and notes that individuals that are confirmed medically frail are exempt.

Further, women who are suspended from HIP due to non-compliance with the Gateway to Work requirements will have their suspension period ended upon becoming pregnant and will be exempted from the requirement during her pregnancy and post-partum period. Additionally, if she is the primary caregiver of her child, she will remain exempt from the requirement after the conclusion of the postpartum period.

To address potential barriers to participation, such as transportation and childcare, the State will leverage existing resources including funds available through the Supplemental Nutritional Assistance Program (SNAP) SNAP, Temporary Assistance for Needy Families (TANF), and the Child Care Development Fund (CCDF), to provide supportive services to qualifying individuals.

Finally, in all cases, enrollees will have access to the appeals process in the event of eligibility suspension.

The State agrees with comments indicating the need to conduct a robust evaluation of Gateway to Work, and has included this as a cornerstone of the HIP evaluation plan and will leverage the commenter's suggestions to evaluate the impacts on access, health outcomes, employment and transition from Medicaid to commercial coverage. The State appreciates the feedback received regarding options to operationalize the Gateway to Work requirement and will take this feedback under advisement in the final development of the operational components of the program.

2. Public Comments: POWER Account

Summary of Comments. Multiple comments were received which were supportive of the State realigning POWER account contributions to pre-defined income tiers. Commenters indicated this will ease administrative burdens on members by offering greater predictability and reduced fluctuations in monthly contribution amounts. One commenter also noted this is more aligned with the commercial market contribution policies and will help members better understand their monthly liability. Further, a commenter indicated this new policy will assist members who opt to make an annual upfront contribution. A few commenters expressed concern with the continued use of the POWER account structure, indicating non-payment penalties prevent access to coverage.

State Response. The State has not made any modifications to the waiver as a result of comments received. Data from an independent evaluation of the HIP program indicates that the POWER Account is a successful component of the HIP program and is helping the State achieve its goals in delivering affordable consumer-driven healthcare. For example, an average of 70% of members choose to contribute to the POWER account to enroll into HIP Plus, and over 92% of members continue to contribute throughout their enrollment.[9]

3. Public Comments: HIP Employer Link

Summary of Comments. Two comments were received indicating support for elimination of the HIP Employer Link program, citing low enrollment rates. One commenter during the federal comment period questioned what options will be available to current HIP Link enrollees.

[9] The Lewin Group, Healthy Indiana Plan 2.0 Interim Evaluation Report (2016).

State Response. The State appreciates the support for this programmatic change, which was based on a careful analysis of utilization of HIP Employer Link and its associated administrative burden. To clarify, in response to the federal comment received, the sixty enrollees currently on the program will be offered the opportunity to transition to standard HIP Plus coverage, and will experience a seamless transition and continuation of coverage.

4. Public Comments: Other Technical Revisions

Summary of Comments. One comment was received regarding the proposed TMA modifications. The commenter indicated these modifications will simplify the support provided to families who are at risk of losing their Medicaid coverage due to having an increase in income over 138% FPL. Four comments were received supporting the proposed improvements to mental health and SUD reimbursement. Finally, one commenter indicated providing eight months of traditional Medicaid coverage for refugees will support their transition and allow time for acclimation to their new living environment.

State Response. The State appreciates the support for these technical revisions, and concurs these modifications will provide program simplifications, increased access to critical behavioral health services and additional supportive services for the refugee population.

5. Public Comments: Procedural

Summary of Comments. Three comments were received expressing concern that there was a concurrent state and federal comment process. Additionally, one federal commenter requested information on how many Medicaid members had been consulted.

State Response. The State did not consider the waiver amendment final at the time of CMS submission and initiation of the concurrent comment process. Rather, as evidenced by modifications made to the waiver as a result of comments received, the State carefully reviewed all comments submitted via both the state and federal process. Additionally, the concurrent process allowed the State to consider and review comments submitted to CMS, which is not available when separate, staggered public comment periods are utilized. Medicaid members have been provided with the same opportunity to comment as all other stakeholders. As the State gets closer to implementation, specifically of the Gateway to Work provision, additional outreach to Medicaid members to assess barriers and needs will be undertaken.

4.2 Budget Neutrality Impact

Please see attached the detailed budget neutrality report attached as *Attachment A* analyzing the impact of this amendment.

4.3 CHIP Allotment

This requirement is not applicable to this amendment request, as the demonstration does not impact the CHIP program.

4.4 Evaluation

HIP has a comprehensive, CMS-approved evaluation plan that has been successful in tracking HIP's progress toward achieving its stated goals. In addition to the new components proposed to the original evaluation design that were included in the extension request, the State also proposes the following additions to the evaluation plan in order to assess the impact of the changes

proposed in this extension amendment request. Specifically, Indiana will include an analysis of the following within its evaluation plan:

Hypothesis	Methodology	Data Source
1. Gateway to Work enhancements		
HIP's Gateway to Work initiative 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 or qualifying engagement program that is sustained >90 days • Number and percentage of members who are disenrolled from HIP due to increased earnings from employment
HIP's Gateway to Work participation requirements will encourage HIP members to transition to commercial health insurance coverage	Track and compare rates of HIP members who secure: • Individual private health insurance; • Private health insurance through a partner/spouse; • Individual employer-sponsored insurance; or • Employer-sponsored insurance through a partner/spouse	Eligibility and Enrollment Data • Number and percentage of members who are disenrolled from HIP due to commercial insurance coverage Member Survey Data • Self-reported member description of health insurance coverage upon disenrollment from HIP Recidivism into HIP due to unemployment Analysis of demographic patterns • Age • Gender • Race/ethnicity • Location of residence by population
HIP's Gateway to Work participation requirement will encourage active engagement in job searches among HIP members	Track and compare rates of participation in the Gateway to Work Program Track and compare rates of self-reported job search activities	Administrative Data • Number and percentage of members enrolled in the Gateway to Work program Member Survey Data • Self-reported member description of job search activities
HIP's Gateway to Work participation requirement will encourage active engagement in employment-related	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 Member Survey Data

Hypothesis	Methodology	Data Source
training among HIP members	Track and compare rates of self-reported job training	• Self-reported member description of job training activities
HIP's Gateway to Work participation requirement will positively impact health outcomes of required participants	Track and compare health outcomes for required participants (both participating and out of compliance) and non- required participants.	• Utilization data • Health outcomes data • Administrative Data
HIP's Gateway to Work participation requirement will allow members to maintain access to care	Track and compare access to care for required participants (participating and out of compliance) and non-required participants.	• Utilization data Member Survey Data • Self-reported Access
2. Income Tiers for POWER Account Contributions		
HIP's income tier structure for POWER account contributions will increase member compliance with POWER account payments	Track and compare compliance rates with POWER account payments	Administrative Data • Number and percentage of members making POWER account payments
HIP's income tier structure for POWER account contributions will be easier for members to understand	Track and compare compliance rates with POWER account payments	Administrative Data • Number and percentage of members making POWER account payments Member Survey Data • Member description of their understanding of POWER account contributions before and after tiered structure

Section 5. Conclusion

HIP has proven successful in meeting its program goals since its implementation in 2015. The State appreciates CMS' willingness to further support the goals of the program. The State believes that the changes requested in this waiver extension amendment request are necessary to further its main goals, including: promoting value-based decision-making and personal health responsibility; promoting private market coverage and family coverage options, and; providing HIP members with opportunities to seek job training and stable employment to reduce

dependence on public assistance and improve health outcomes. To assist the State in furthering these goals, Indiana respectfully requests that CMS waive Section 1902(a)(10)(A) to the extent it would enable the State to require all able-bodied HIP participants, as a condition of eligibility, to: (1) work at least 20 hours per week; (2) be enrolled in full-time or part-time education, or (3) participate in the Gateway to Work. Further, Indiana requests increased commitment to substance use disorder treatment access through enhanced reimbursement for MRO services. The State strongly believes that these efforts are consistent with the goals of Medicaid and the HIP demonstration project.

ATTACHMENT A. Budget Neutrality

1115 Waiver – Healthy Indiana Plan

Healthy Indiana Plan – First Renewal, updated

Budget Neutrality Projections

State of Indiana

Family and Social Services Administration

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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.

RENEWAL

The Healthy Indiana Plan (HIP) 1115 Waiver renewal was originally submitted January 31, 2017.

The State has added proposed modifications, posted for public comment on May 24, 2017 and opened for concurrent federal comment on June 8, 2017. This report reflects both the initial proposals, submitted January 31, 2017, and the additional proposals.

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).

This document has been updated from the initial renewal submission, dated January 31, 2017. The updated includes the following additional proposed program revisions:

1. HIP Gateway to Work Expansion
2. POWER Account Income Tiers
3. HIP Employer Link Discontinuation
4. Technical Revisions, affecting the transitional medical assistance program, benefits provided to refugees, funding for Medicaid rehabilitation option services, and the addition of a tobacco use question to the application.

These program revisions are described further in the waiver submission and in the body of this report.

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	$ 2,020.9	$ 1,632.3	$ 388.6	$ 224.9	$ 224.9
2016	2	$ 3,242.2	$ 2,464.7	$ 777.5	$ 305.9	$ 530.8
2017	3	$ 3,884.8	$ 2,939.7	$ 945.1	$ 339.6	$ 870.3
2018	4	$ 4,172.5	$ 3,194.2	$ 978.4	$ 370.1	$ 1,240.4
2019	5	$ 4,337.8	$ 3,352.9	$ 984.9	$ 396.4	$ 1,636.8
2020	6	$ 4,443.0	$ 3,460.2	$ 982.8	$ 417.9	$ 2,054.7

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 stays in an Institution of Mental Diseases (IMD).
6. **HIP Employer Link dependents**: This proposal is no longer relevant due to the decision to discontinue the HIP Employer Link program.
7. **Enhanced health plan incentives**: To tighten focus on outcomes.
8. **HIP Gateway to Work**: The state proposes to require member participation in the Gateway to Work program for non-disabled unemployed members who are not caring for dependents or otherwise exempted.
9. **POWER Account Income Tiers**: To ease the administrative burden, the state proposes realignment of POWER account contributions to pre-defined income tiers.
10. **HIP Employer Link Discontinuation**: The state proposes to end the HIP Employer Link program.
11. Technical Revisions:
    a. **Transitional medical assistance (TMA) program**: The State proposes to limit TMA enrollment to those above 138% FPL. Those otherwise eligible, but below 138% FPL may simply be enrolled in HIP.
    b. **Benefits provided to refugees**: For the first eight months after entering the United States, refugees may receive coverage on a fee-for-service basis. After eight months, refugees may be enrolled in HIP.
    c. **Funding for Medicaid rehabilitation option (MRO) services**: Indiana seeks expenditure authority to reimburse MRO providers as required in state statute at IC 12-15-44.5-5(a)(2)(B).
    d. **Tobacco use question on application**. This is added to allow administration of the proposed tobacco use surcharge, but does not have an independent fiscal impact calculated.

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 March 31, 2017, 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 425,000 enrollees as of March 31, 2017, excluding conditional enrollees. Baseline enrollment (before proposed program changes) is projected to expand to approximately 435,000 by the end of DY 06.

Eligibility data from the State of Indiana's Enterprise Data Warehouse, reported through March 31, 2017, 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

The state is proposing to add a new MEG for the IMD population, which will be discussed in a later section.

Enrollment trends

Enrollment has been projected starting with actual March 31, 2017 enrollment. Enrollment growth rates are consistent with those used in the April 2017 Medicaid forecast, and are illustrated in Table 2. The sixty current HIP Employer Link enrollees will be offered the opportunity to transition to standard HIP Plus coverage as of DY 04. 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	Annual Trend
Section 1931 Parents	0.5%
New Adult Group	1.0%
Medically Frail	1.0%
HIP Employer Link	Program ending
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 March 31, 2017.

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	93,772	114,485	116,434	116,900	117,404	117,911
New Adult Group	133,684	225,726	254,191	256,497	258,179	260,047
Medically Frail	19,887	37,748	53,115	54,088	54,392	54,750
HIP Employer Link	1	36	62	63	64	64
HIP Presumptive Eligibility	68	59	64	53	42	34
Total Healthy Indiana Plan enrollment	**247,411**	**378,054**	**423,866**	**427,601**	**430,081**	**432,806**

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 rate for the Section 1931 Parents population. CMS has requested that we use a trend rate of 3.30% for both the New Adult and Medically Frail populations. The HIP Employer Link trend will no longer be used for the renewal, since the HIP Employer Link program is ending.

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	3.30%	575.59	594.58	614.20
Medically Frail	3.30%	1,868.40	1,930.06	1,993.75

Renewal trend rates for DY are subject to approval by CMS.

WITH WAIVER EXPENDITURES

Historical HIP expenditures – DY 01 and 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 March 31, 2017. These were summarized by demonstration year (calendar year), according to dates of service.

Adjustments to historical expenditures

Historical CMS 64 Schedule C expenditures were adjusted for the following:

1. To estimate reallocation of presumptive eligibility expenditures based on each enrollee's ultimate eligibility population
2. Payment of a portion of the capitation withhold to managed care plans; the plans are estimated to earn back 50% of the amount withheld during DY 02
3. Reimbursement of affected managed care plans for health insurer fee payments paid during calendar year 2016
4. Payment of the physician specialty access fee, which has not yet been paid for DY 02.

These adjustments are described in the next sections

1. Reallocation of HIP presumptive eligibility expenditures

Compliance with original intent

Expenditures reported under the "PE Program" MEG are not currently compliant with CMS instructions. In the most recent CMS Schedule C, as of March 31, 2017, Indiana is reporting *all* presumptive eligibility (PE) expenditures paid through September 2015 of DY 01 under the "PE Program" eligibility group. For DY 01 after September 2015, and for all of DY 02, Indiana has excluded PE expenditures from 1115 waiver reporting if they were incurred during the period specified under 42 CFR 435.1101 (CFR PE period). PE expenditures incurred after the CFR PE period were reported under the "PE Program" eligibility group. The state anticipates correcting PE Program reporting in October 2017 submissions. For this filing, we have adjusted expenditures as requested by CMS in an addendum to the STCs (Appendix 4). This requires reallocation of presumptive eligibility expenditures as follows:

1. To the New Adult MEG: 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.
2. To the Medically Frail MEG: PE program expenditures for individuals who, after formal submission of a complete application, are found to be fully eligible under the medically frail category: will be treated as medically frail expenditures. These expenditures will be eligible for the enhanced match and will count on both sides of the budget neutrality agreement.
3. Excluded from 1115 waiver reporting: PE program expenditures that do not meet either of the conditions above, but were incurred during the normal CFR PE period will be eligible for the standard match, and will be excluded from 1115 waiver reporting.
4. PE Program: Any expenses related to extension of the PE period beyond the time period specified in the PE regulations, specifically 42 CFR 435.1101 are "PE Program" expenditures. These expenditures will only appear on the "With Waiver" side 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.

Percentage allocation

We have analyzed the PE experience during DY 01, and have estimated the following allocation percentages:

1. Approximately **33%** of PE expenditures are for individuals who, after formal submission of a complete application, were found to be fully eligible under the new adult category.
2. Approximately **10%** of PE expenditures are for individuals who, after formal submission of a complete application, were found to be fully eligible under the medically frail category.
3. **56.5%** of PE expenditures did not meet the two conditions above, but were incurred during the CFR PE period. Most of these expenditures were for individuals who either did not submit an application or were deemed ineligible under the regular process. Some of these individuals were deemed eligible for Medicaid, but not under the new adult or medically frail category.
4. The remaining **0.5%** of 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.

Presumptive eligibility payments that were removed from the Schedule C

Starting with October of DY 01, the State has begun reporting the first two calendar months of presumptive eligibility payments outside of the Schedule C. In this manner, $22.4 million was removed from DY 01 and $157.0 million was removed from DY 02. These amounts were added back before reallocation. The total amount of PE payments for DY 01 was approximately $358.0 million, and for DY 02 was $194.6 million.

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 5.

Table 5
State of Indiana
Family and Social Services Administration
Allocation of Presumptive Eligibility expenditures

Population	Allocation	DY01	DY02
New Adult Group	33.0%	$ 118,155,276	$ 64,225,784
Medically Frail	10.0%	35,804,629	19,462,359
Remains with PE Program	0.5%	1,810,073	983,903
Other Medicaid (not on 1115)	56.5%	202,276,313	109,951,541
Total PE Program expenditures	**100.0%**	**$ 358,046,291**	**$ 194,623,587**

Table 5 represents our best estimate of how presumptive eligibility expenditures will be reported after systems have been revised to conform to requirements clarified in the addendum to the STCs.

2. MCO performance payments

Capitation withholds for CY 2016 have not yet been paid, and are anticipated to be paid at the end of CY 2017. 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 02.

3. 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, which will be 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.

4. Physician specialty network access fee

The HIP rates include a physician specialty network access fee to assure continued access to physician specialty networks by providing enhanced reimbursement. The fee has been paid for DY 01, but has not yet been paid for DY 02. Based on amounts paid in DY 01, we have estimated the fee at approximately 0.7% of total expenditures.

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 3.3% 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.

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 6.

Table 6
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 6 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 6, 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 7, which may be compared with Table 3 (baseline enrollment). The table also reflects discontinuation of the HIP Link program.

Table 7
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	93,772	114,485	116,434	116,900	117,404	117,911
New Adult Group	133,684	225,726	254,191	254,693	254,486	256,331
Medically Frail	19,887	37,748	53,115	53,817	53,848	54,202
HIP Employer Link	1	36	62	-	-	-
HIP Presumptive Eligibility	68	59	64	53	42	33
Total Healthy Indiana Plan enrollment	**247,411**	**378,054**	**423,866**	**425,463**	**425,780**	**428,477**

HIP EMPLOYER LINK DEPENDENTS

This proposal is no longer relevant due to the State's decision to discontinue the HIP Employer Link program.

The State had previously proposed to allow all Medicaid-eligible family members of HIP Employer Link enrollees to enroll in HIP Employer Link.

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 majority of expanded benefits will be provided under state plan authority. However, in addition, the State is requesting a waiver to provide Institution of Mental Diseases (IMD) services for all Medicaid populations.

Estimated increase in state plan substance abuse expenditures

Table 8 illustrates the estimated PMPM cost increase for enhanced SUD services available under the state plan to HIP members. (Although enhanced SUD services will be available to all Medicaid members under the state plan, only the fiscal impact to HIP members is reflected on the 1115 waiver filing.) The PMPM amounts illustrated in Table 8 have been added to with waiver and without waiver expenditures.

Table 8 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
Section 1931 Caretakers	116,900	5,126,372	3.65
Other HIP enrollees	308,563	33,583,997	9.07
Composite	425,463	$ 38,710,369	$ 7.58

The assumptions and methodology used to develop these assumptions are described in Appendix 5:

Institution of Mental Disease utilization

Indiana is requesting the authority to extend coverage for services in inpatient and residential settings to include settings that are within the definition of Institution of Mental Diseases (IMDs). Under CMS guidance to State Medicaid Directors, dated July 27, 2015, the state proposes to allow IMDs to be reimbursed for the following services to all Medicaid members:

- Inpatient services described by the ASAM Criteria as occurring in Level 4.0 settings for up to 15 days
- Residential services described the ASAM Criteria as occurring in Level 3.1, 3.3, 3.5, or 3.7 settings, limited to an average length of thirty days

At CMS' suggestion, the 1115 waiver renewal adds an IMD MEG. This MEG is intended to be a pass-through, to allow expenditure reporting, but with no financial risk to the state of Indiana. It represents the cost for months during which adult non-elderly members received service from an IMD. Our estimates of the number of recipient months and cost per month were developed as follows:

Estimated number of recipient months

The number of IMD recipient months for members aged 21 to 64 has been estimated using three components:

1. Current inpatient psychiatric experience. During CY 2016, there were 16,658 months during which Medicaid and HIP members, aged 21 through 64, received inpatient psychiatric services. Based on experience for other age groups, we have assumed that 25% of this utilization, or approximately 4,000 member months, may shift to IMDs.
2. Projected demand for inpatient substance abuse treatment under ASAM criteria Level 4.0. Using prevalence, take-up rates, and treatment plan assumptions in Appendix 5 (Table 5.1, 5.2,, and 5.3), we have estimated demand for inpatient SUD treatment, not followed up by residential treatment, at approximately 6,000 member months. We have assumed that approximately 50% of this utilization will be provided by IMDs.
3. Projected demand for residential substance abuse treatment under ASAM criteria Level 3.1, 3.3, 3.5 or 3.7. Using the assumptions in Appendix 5, we have estimated demand for residential treatment at approximately 2,000 member months. We have assumed that all of this utilization will be provided by IMDs.

Estimated cost per recipient month

The estimated cost per recipient month was developed by summarizing expenditures for all Medicaid members, aged 21 – 64, who used inpatient psychiatric services during CY 2016. Expenditures include all expenditures for the members, including both inpatient psychiatric services and all other state plan services. In aggregate, inpatient psychiatric services represented approximately 70% of total expenditures. Cost per month was developed by dividing expenditures by the number of affected member months. As the experience was developed using CY 2016 experience, the raw PMPM cost of $6,164.01 was trended for two years to arrive at an estimated DY 04 cost of $6,834.71.

We anticipate that both the with waiver and without waiver cost per eligible will be replaced by actual experience as it emerges. Actual IMD experience is expected to include both inpatient and residential experience. We do not have residential experience from which to develop a credible cost per day estimate. Although the residential experience is expected to have a lower cost per day, the number of days utilized is expected to be higher, so total monthly costs may be higher or lower than the estimate provided for this waiver filing.

GATEWAY TO WORK

The HIP Gateway to Work (GTW) program was launched in 2015 on a voluntary basis. It provides various work training, educational, and job search programs for unemployed or underemployed HIP members. To improve participation rates, the State proposes to make the program mandatory for able-bodied eligible members.

We have estimated that the program will be mandatory for approximately 30% of current HIP members; the remainder are exempted from mandatory participation, but may participate on a voluntary basis. The table below estimates the number of members who will be exempted from the program and reasons for the exemptions. The table is developed on a cumulative basis, so as not to double count members who may qualify under multiple exemptions.

Table 9
State of Indiana
Family and Social Services Administration
Healthy Indiana Plan
Gateway to Work Target Population Estimate

	January 31, 2017	
	Enrollees	Percentage
Total HIP Enrollment	438,604	100.0%
Exemption Hierarchy		
1 - Over age 60	21,143	4.8%
2 - Students	38,440	8.8%
3 - Pregnant Women	5,849	1.3%
4 - Medically Frail	54,891	12.5%
5 - Average 20+ hrs/wk: 8 out of 12 months	140,650	32.1%
6 - Average 20+ hrs/wk: Current month	2,479	0.6%
7 - Recent Incarceration	560	0.1%
8 - HIP Link	5	0.0%
9 - Primary Caretaker	41,883	9.5%
12 - Former Foster Child	949	0.2%
13 - TANF Program	71	0.0%
14 - SNAP program	1,456	0.3%
Total Exempted Members	308,376	69.7%
Gateway to Work Target Population	**130,228**	**29.7%**

Those required to participate will be referred to GTW on their anniversary date during the second year of the renewal. Those who are still enrolled in HIP one year after referral will be evaluated for compliance with GTW participation requirements, beginning in the third year of the renewal. Any member suspended from HIP due to non-compliance may be re-enrolled one month after meeting GTW participation requirements. Based on current lapse rates, we have estimated that approximately 75% of those referred to the program will still be enrolled one year later. Of those, we have estimated that approximately 25% will choose not to participate, and will have HIP eligibility suspended until compliance has been demonstrated.

Of those who elect to participate, improved employment outcomes may be anticipated. Compared with the status quo, additional members may lose eligibility each year due to gainful employment with income above 138% FPL, starting during the third year of the renewal.

Table 10 projects HIP enrollment before and after implementation of the Gateway to Work program. The impact is phased in over redeterminations that will occur during DY 06. Resulting enrollment in Table 10 may be compared with Table 3 (baseline enrollment) and Table 7 (after reflecting Open Enrollment policy).

Table 10 State of Indiana Family and Social Services Administration Actual and Projected Enrollment - Healthy Indiana Plan with Gateway to Work and Open Enrollment Policy						
Population	**DY 01**	**DY 02**	**DY 03**	**DY 04**	**DY 05**	**DY 06**
Section 1931 Parents	93,772	114,485	116,434	116,900	117,404	115,942
New Adult Group	133,684	225,726	254,191	254,693	254,486	247,008
Medically Frail	19,887	37,748	53,115	53,817	53,848	54,202
HIP Employer Link	1	36	62	-	-	-
HIP Presumptive Eligibility	68	59	64	53	42	33
Total Healthy Indiana Plan enrollment	**247,411**	**378,054**	**423,866**	**425,463**	**425,780**	**417,185**

The state requests that expenditures related to the Gateway to work program be regarded as expenditures matchable under the State's Medicaid Title XIX State Plan. These expenditures include costs for providing orientation, assessment, job skills training, job search assistance, and tracking member progress under the Gateway to Work program, and are estimated at $90 per month per enrolled member. These costs are included in the cost neutrality exhibit, phasing in during DY 05 and fully implemented during DY 06.

POWER ACCOUNT INCOME TIERS

The POWER account income tiers have been proposed as an administrative simplification, and have been developed so as to avoid increasing participant contributions. The reduction in average contributions is illustrated below by income tier.

Table 11 State of Indiana Family and Social Services Administration Proposed HIP contribution tiers Estimated change in average contributions					
	January 2017	**Current contributions**		**Under Proposed tiers**	
FPL	**HIP Plus members**	**Dollars**	**Average**	**Dollars**	**Average**
0% to 22%	132,603	$ 147,200	$ 1.11	$ 124,292	$ 0.94
23% to 50%	21,745	225,563	10.37	97,471	4.48
51% to 75%	28,736	493,704	17.18	255,785	8.90
76% to 100%	32,924	763,920	23.20	435,641	13.23
101% to 138%	40,615	1,247,547	30.72	716,638	17.64
Total	256,623	$ 2,877,933	$ 11.21	$ 1,629,827	$ 6.35

HIP EMPLOYER LINK DISCONTINUATION

The state has decided to discontinue the HIP Employer Link program. As of March 2017, there were 60 members enrolled in HIP Employer Link. They will be offered the opportunity to transition to other HIP coverage. The 1115 waiver exhibits reflect transition of projected HIP Employer Link members to the New Adult Group.

TRANSITIONAL MEDICAL ASSISTANCE (TMA)

TMA members with income at or below 138% FPL are eligible for the HIP program. The State proposes to enroll these members in the HIP program appropriate to their current income. These members will be afforded the opportunity to buy into Plus coverage to retain dental and vision benefits. TMA members above 138% FPL are not otherwise eligible for the HIP program and will remain in TMA (no change is proposed to how benefits are currently provided for those above 138% FPL).

As of the May 4, 2017, there were approximately 19,000 TMA members with income at or below 138% FPL, and an additional 3,500 with income above 138% FPL. Under the State's proposal, no change is anticipated for the 3,500 members who will remain in the TMA program. For those under 138% FPL the State may realize a small savings due to transition to the regular HIP program. Those who do not choose to remain in Plus may lose the enhanced benefits. For this population, the savings may be estimated at approximately $20 per month for each member who loses enhanced benefits.

The 19,000 affected members represent approximately 16.2% of the Section 1931 Caretaker MEG, and assuming 25% of affected members choose not to make contributions, the overall impact is estimated at $0.81 PMPM.

REFUGEES

There is no material projected fiscal impact for postponing refugee enrollment in HIP until eight months after arrival. Refugees will have access to all state plan benefits through the fee-for-service program for the first eight months after arrival, and after that time, will be enrolled in HIP.

There were an average of just over 400 refugees enrolled in Indiana's Medicaid program during the two years prior to HIP expansion (calendar years 2013 and 2014). The data is not fully credible, but per member per month costs do not appear to be materially different from other HIP members, so we have not made any adjustments to PMPM projections.

MEDICAID REHABILITATION OPTION (MRO)

Indiana is currently reimbursing MRO providers at 130% of Medicaid reimbursement, as required in state statute at IC 12-15-44.5-5(a)(2)(B). However, reimbursement above the regular Medicaid reimbursement level is being paid using state only dollars. The State also proposes to reimburse Substance Use Disorder (SUD) providers according to state statute. Enhanced payments for MRO and SUD are projected at $11.4 million for CY 2018. These amounts are not currently reflected in Schedule C reporting, but have been added to with waiver projections.

Table 12
State of Indiana
Family and Social Services Administration
DY 04 Enhanced Reimbursement Projections - MRO and SUD

Population	Projected Enhanced MRO/SUD Expenditures	PMPM
Section 1931 Parents	$ 2.6	$ 1.85
New Adult Group	$ 4.7	$ 1.54
Medically Frail	$ 4.1	$ 6.27
Total	**$ 11.4**	

PROJECTED EXPENDITURE IMPACT SUMMARY

Table 13 illustrates the impact of each proposed HIP program enhancement on projected With Waiver expenditures.

Table 13 State of Indiana, Family and Social Services Administration 1115 HIP Waiver - Impact of Changes on With Waiver Expenditures HIP Waiver Renewal (11-W-00296/5) (Values in $Millions)			
	Demonstration Year		
Enhancement	DY04	DY05	DY06
Member Incentives	$ 2.6	$ 2.7	$ 2.8
Tobacco user surcharge	(6.9)	(7.1)	(7.4)
HIP Plus Enhancements	1.8	1.9	2.0
Substance use disorder program and IMDs	114.0	119.6	125.4
HIP Employer Link elimination	0.2	0.2	0.2
Open Enrollment	(15.3)	(31.8)	(33.0)
Gateway to work	0.0	48.0	22.9
POWER account income tiers	17.6	18.1	18.3
Transitional Medical Assistance	(1.1)	(1.2)	(1.2)
Refugees	0.0	0.0	0.0
Mental Health Rehabilitation funding	11.4	11.8	12.0
Total change in waiver expenditures	**$ 124.3**	**$ 162.2**	**$ 141.9**

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 July 20, 2017

Without Waiver Summary	DY 01	DY 02	DY 03	DY 01 - DY 03
XIX - HIP Populations				
Section 1931 Caretakers	749,593,947	963,680,479	1,032,030,763	2,745,305,189
New Adult Group	874,515,769	1,492,881,185	1,699,623,260	4,067,020,213
Medically Frail	396,776,459	785,530,737	1,152,837,389	2,335,144,584
HIP Employer Link	5,225	151,081	265,250	421,556
IMD	-	-	-	-
Total Without Waiver Costs	***2,020,891,400***	***3,242,243,482***	***3,884,756,660***	***9,147,891,542***
With Waiver Summary	**DY 01**	**DY 02**	**DY 03**	**DY 01 - DY 03**
XIX - HIP Populations				
Section 1931 Caretakers	*522,898,463*	*656,768,867*	*691,322,567*	*1,870,989,898*
New Adult Group	*621,484,672*	*1,229,323,216*	*1,399,565,937*	*3,250,373,824*
Medically Frail	*486,059,216*	*577,504,202*	*847,538,263*	*1,911,101,681*
HIP Employer Link	1,648	80,442	141,230	223,320
HIP Presumptive Eligibility	1,827,715	1,021,206	1,132,447	3,981,368
IMD	-	-	-	-
Total With Waiver Costs	***1,632,271,714***	***2,464,697,933***	***2,939,700,444***	***7,036,670,091***
Total Waiver Margin	*388,619,686*	*777,545,549*	*945,056,216*	*2,111,221,451*
Waiver Margin excluding Newly Eligible	***224,867,769***	***305,890,405***	***339,575,749***	***870,333,923***
Coverage Estimates	**DY 01**	**DY 02**	**DY 03**	
Anticipated Enrollment				
Section 1931 Caretakers	93,772	114,485	116,434	
New Adult Group	133,684	225,726	254,191	
Medically Frail	19,887	37,748	53,115	
HIP Employer Link	1	36	62	
HIP Presumptive Eligibility	68	59	64	
IMD	-	-	-	
Total Enrollment	**247,411**	**378,054**	**423,866**	

Healthy Indiana Plan	*Summary Budget Neutrality Estimates - 1115 Waiver Application*			
	Updated July 20, 2017			
Without Waiver Summary	**DY 04**	**DY 05**	**DY 06**	**DY 01 - DY 06**
XIX - HIP Populations				
Section 1931 Caretakers	1,096,204,032	1,159,281,374	1,205,525,776	6,206,316,371
New Adult Group	1,788,737,161	1,846,255,817	1,851,133,487	9,553,146,678
Medically Frail	1,212,481,391	1,253,205,362	1,303,080,958	6,103,912,295
HIP Employer Link	-	-	-	421,556
IMD	75,124,733	79,106,348	83,299,003	237,530,084
Total Without Waiver Costs	***4,172,547,317***	***4,337,848,901***	***4,443,039,224***	***22,101,326,984***
With Waiver Summary	**DY 04**	**DY 05**	**DY 06**	**DY 01 - DY 06**
XIX - HIP Populations				
Section 1931 Caretakers	*725,133,444*	*762,142,339*	*786,992,805*	*4,145,258,485*
New Adult Group	*1,493,039,660*	*1,580,725,037*	*1,622,127,893*	*7,946,266,415*
Medically Frail	*899,925,455*	*930,151,671*	*967,168,967*	*4,708,347,773*
HIP Employer Link	-	-	-	223,320
HIP Presumptive Eligibility	969,594	786,515	637,328	6,374,805
IMD	75,124,733	79,106,348	83,299,003	237,530,084
Total With Waiver Costs	***3,194,192,886***	***3,352,911,910***	***3,460,225,995***	***17,044,000,882***
Total Waiver Margin	*978,354,431*	*984,936,991*	*982,813,228*	*5,057,326,101*
Waiver Margin excluding Newly Eligible	***370,100,994***	***396,352,520***	***417,895,644***	***2,054,683,081***
Coverage Estimates	**DY 04**	**DY 05**	**DY 06**	
Anticipated Enrollment				
Section 1931 Caretakers	116,900	117,404	115,942	
New Adult Group	254,693	254,486	247,008	
Medically Frail	53,817	53,848	54,202	
HIP Employer Link	-	-	-	
HIP Presumptive Eligibility	53	42	33	
IMD	916	916	916	
Total Enrollment	**426,379**	**426,695**	**418,101**	

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		1,125,263	1,373,821	1,397,204	
Total Cost Per Eligible	5.30%	$ 666.15	$ 701.46	$ 738.64	
Total Expenditure		$ 749,593,947	$ 963,680,479	$ 1,032,030,763	$ 2,745,305,189
New Adult Group					
Eligible Member Months		1,604,204	2,708,715	3,050,293	
Total Cost Per Eligible	1.10%	$ 545.14	$ 551.14	$ 557.20	
Total Expenditure		$ 874,515,769	$ 1,492,881,185	$ 1,699,623,260	$ 4,067,020,213
Medically Frail					
Eligible Member Months		238,641	452,980	637,381	
Total Cost Per Eligible	4.30%	$ 1,662.65	$ 1,734.14	$ 1,808.71	
Total Expenditure		$ 396,776,459	$ 785,530,737	$ 1,152,837,389	$ 2,335,144,584
HIP Employer Link					
Eligible Member Months		15	429	745	
Total Cost Per Eligible	1.10%	$ 348.33	$ 352.17	$ 356.04	
Total Expenditure		$ 5,225	$ 151,081	$ 265,250	$ 421,556
IMD					
Eligible Member Months					
Total Cost Per Eligible	5.30%				
Total Expenditure					

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		1,402,800	1,408,844	1,391,307	
Total Cost Per Eligible	5.30%	$ 781.44	$ 822.86	$ 866.47	
Total Expenditure		$ 1,096,204,032	$ 1,159,281,374	$ 1,205,525,776	$ 6,206,316,371
New Adult Group					
Eligible Member Months		3,056,312	3,053,833	2,964,090	
Total Cost Per Eligible	3.30%	$ 585.26	$ 604.57	$ 624.52	
Total Expenditure		$ 1,788,737,161	$ 1,846,255,817	$ 1,851,133,487	$ 9,553,146,678
Medically Frail					
Eligible Member Months		645,806	646,172	650,425	
Total Cost Per Eligible	3.30%	$ 1,877.47	$ 1,939.43	$ 2,003.43	
Total Expenditure		$ 1,212,481,391	$ 1,253,205,362	$ 1,303,080,958	$ 6,103,912,295
HIP Employer Link					
Eligible Member Months		-	-	-	
Total Cost Per Eligible	0.00%	$ 356.04	$ 356.04	$ 356.04	
Total Expenditure		$ -	$ -	$ -	$ 421,556
IMD					
Eligible Member Months		10,992	10,992	10,992	
Total Cost Per Eligible	5.30%	$ 6,834.71	$ 7,196.95	$ 7,578.39	
Total Expenditure		$ 75,124,733	$ 79,106,348	$ 83,299,003	$ 237,530,084

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		1,125,263	1,373,821	1,397,204	
Total Cost Per Eligible	3.50%	$ 464.69	$ 478.06	$ 494.79	
Total Expenditure		$ 522,898,463	$ 656,768,867	$ 691,322,567	$ 1,870,989,898
New Adult Group					
Eligible Member Months		1,604,204	2,708,715	3,050,293	
Total Cost Per Eligible	1.10%	$ 387.41	$ 453.84	$ 458.83	
Total Expenditure		$ 621,484,672	$ 1,229,323,216	$ 1,399,565,937	$ 3,250,373,824
Medically Frail					
Eligible Member Months		238,641	452,980	637,381	
Total Cost Per Eligible	4.30%	$ 2,036.78	$ 1,274.90	$ 1,329.72	
Total Expenditure		$ 486,059,216	$ 577,504,202	$ 847,538,263	$ 1,911,101,681
HIP Employer Link					
Eligible Member Months		15	429	745	
Total Cost Per Eligible	1.10%	$ 109.89	$ 187.51	$ 189.57	
Total Expenditure		$ 1,648	$ 80,442	$ 141,230	$ 223,320
HIP Presumptive Eligibility					
Eligible Member Months		812	702	770	
Total Cost Per Eligible	1.10%	$ 2,250.88	$ 1,454.71	$ 1,470.71	
Total Expenditure		$ 1,827,715	$ 1,021,206	$ 1,132,447	$ 3,981,368
IMD					
Eligible Member Months					
Total Cost Per Eligible	5.30%				
Total Expenditure					

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		1,402,800	1,408,844	1,391,307	
Total Cost Per Eligible	3.50%	$ 516.92	$ 540.97	$ 565.65	
Total Expenditure		$ 725,133,444	$ 762,142,339	$ 786,992,805	$ 4,145,258,485
New Adult Group					
Eligible Member Months		3,056,312	3,053,833	2,964,090	
Total Cost Per Eligible	3.30%	$ 488.51	$ 517.62	$ 547.26	
Total Expenditure		$ 1,493,039,660	$ 1,580,725,037	$ 1,622,127,893	$ 7,946,266,415
Medically Frail					
Eligible Member Months		645,806	646,172	650,425	
Total Cost Per Eligible	3.30%	$ 1,393.49	$ 1,439.48	$ 1,486.98	
Total Expenditure		$ 899,925,455	$ 930,151,671	$ 967,168,967	$ 4,708,347,773
HIP Employer Link					
Eligible Member Months		-	-	-	
Total Cost Per Eligible	0.00%	$ 189.57	$ 189.57	$ 189.57	
Total Expenditure		$ -	$ -	$ -	$ 223,320
HIP Presumptive Eligibility					
Eligible Member Months		638	501	393	
Total Cost Per Eligible	3.30%	$ 1,519.74	$ 1,569.89	$ 1,621.70	
Total Expenditure		$ 969,594	$ 786,515	$ 637,328	$ 6,374,805
IMD					
Eligible Member Months		10,992	10,992	10,992	
Total Cost Per Eligible	5.30%	$ 6,834.71	$ 7,196.95	$ 7,578.39	
Total Expenditure		$ 75,124,733	$ 79,106,348	$ 83,299,003	$ 237,530,084

APPENDIX 4: 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 5: 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 5.1 illustrates composite prevalence estimates by population.

Table 5.1
State of Indiana
Family and Social Services Administration
Estimated Substance Use Disorder prevalence

	Projected DY 04 Enrollment	Estimated prevalence	Estimated lives with SUD diagnosis
Section 1931 Caretakers	116,900	8.5%	9,937
Other HIP enrollees	308,563	21.1%	65,107
Composite	425,463	17.6%	75,043

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 5.2
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, but these were not used for modeling HIP populations. Table 5.3 illustrates the percentage of individuals entering each treatment plan by diagnosis group for adults.

Table 5.3 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%

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 5.4 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 5.4, 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 5.4 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 5.4 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 5.5 illustrates the service description and unit cost for the individual components that will be provided as part of each ASAM level of care.

Table 5.5 illustrates unit costs under Medicaid reimbursement. HIP reimbursement is 30% higher.

Table 5.5
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 5.6 illustrates the bundled cost per unit utilized in the cost development for each ASAM level of care.

Table 5.6
State of Indiana
Family and Social Services Administration
Bundled Cost Per Unit

ASAM Level of Care	Unit Type	Adult Cost per Unit
0.5 Early Intervention	Encounter	$117.63
1.0 Outpatient Services (First 90 Days)	Hour	$39.08
1.0 Outpatient Services (After 90 Days)	Hour	$47.52
2.1 Intensive Outpatient Services	Hour	$35.28
2.5 Partial Hospitalization	Day	$236.33
3.1 Clinically Managed Low-Intensity Residential	Day	$126.13
3.3 Clinically Managed Population Specific High-Intensity Residential	Day	$0.00
3.5 Clinically Managed High-Intensity Residential	Day	$392.57
3.7 Medically Monitored Intensive Inpatient	Day	$800.00
4.0 Medically Managed Intensive Inpatient	Day	$900.00