Overview: The Monitoring Report for the section 1115 eligibility and coverage demonstrations consists of a Monitoring Report Workbook (Part A), Monitoring Report Template (Part B), and a Budget Neutrality Workbook (Part C). Each state with an approved eligibility and coverage policy in its section 1115 demonstration should complete only one Monitoring Report Template (Part B) that encompasses all eligibility and coverage policies approved in its demonstration as well as the demonstration overall, in accordance with the demonstration's special terms and conditions (STC). This state-specific Part B Template reflects the composition of the eligibility and coverage policies in the state's demonstration. If the eligibility and coverage policies are part of a broader section 1115 demonstration, the state should report on the entire demonstration in the sections that apply to all eligibility and coverage demonstrations.

CMS will work with the state to ensure there is no duplication in the reporting requirements for different components of the demonstration. For more information and any questions, the state should contact the section 1115 demonstration team.

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Report Template

Note: PRA Disclosure Statement to be added here

1. Title page for the state's eligibility and coverage demonstration or eligibility and coverage policy components of the broader demonstration

This section collects information on the approval features of the state's section 1115 demonstration overall, followed by information for each eligibility and coverage policy. The state completed this title page at the beginning of its demonstration as part of its monitoring protocol(s). The state should complete this table using its monitoring protocol(s) and submit this as the title page of all monitoring reports. The content of this table should stay consistent over time. Definitions for certain rows are below the table.

For non-eligibility periods, the state should use the policy-specific rows to enter implementation dates for each applicable non-eligibility period. If the state has non-eligibility periods for premiums, it should only include a non-eligibility period implementation date for these policies if it differs from the implementation date for premiums. The state should include implementation dates for all other non-eligibility periods individually if the dates differ by policy. If the state has a non-eligibility period for a policy that is not listed in the table, the state should use the "other policy" row to specify the implementation date of that policy. In this row, the state should also replace "[enter here]" with the name of the policy to which the non-eligibility period implementation date applies.

Overall section 1115 demonstration	
State	*Indiana*
Demonstration name	*Healthy Indiana Plan (HIP) (Project Number 11-W-00296/5)*
Approval period for section 1115 demonstration	*01/01/2021 to 12/31/2030*
Demonstration year and quarter	*DY11Q1*
Reporting period	*01/01/2025-03/31/2025*
Premiums or account payments	
Premiums or account payments start date	*This waiver authority was suspended during the COVID-19 PHE unwind and was expected to resume July 1, 2024. The official cost share restart date and plan for reimplementation was announced to stakeholders in January 2024. However, due to litigation, plans to restart HIP cost-sharing were canceled in the final days of Q2 2024. As of Q1 2025, HIP cost-sharing continues to be suspended.*
Implementation date, if different from premiums or account payments start date	
Healthy behavior incentives	
Healthy behavior incentives start date	*01/01/2021*
Implementation date, if different from healthy behavior incentives start date	
Retroactive eligibility waiver	
Retroactive eligibility waiver start date	*01/01/2021*

Implementation date, if different from retroactive eligibility waiver start date	
Non-eligibility periods	
Non-eligibility periods start date	*This waiver authority is withdrawn.*
Implementation date for premiums and account payments non-eligibility periods, if different from non-eligibility periods start date	
Implementation date for non-eligibility periods for failure to complete annual eligibility renewal process, if different from non-eligibility periods start date	
Implementation date for non-eligibility periods for failure to report change in income or other change in circumstance, if different from non-eligibility periods start date	
Implementation date for other non-eligibility periods, if different from non-eligibility periods start date. Policy: *[enter here]*	

Notes:

1. **Eligibility and coverage demonstration start date:** For monitoring purposes, CMS defines the start date of the demonstration as the *effective* date listed in the state's STCs at time of eligibility and coverage demonstration approval. For example, if the state's STCs at the time of eligibility and coverage demonstration approval note that the demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of the demonstration. Note that that the effective date is considered to be the first day the state may begin its eligibility and coverage demonstration. In many cases, the effective date is distinct from the approval date of a demonstration; that is, in certain cases, CMS may approve a section 1115 demonstration with an effective date that is in the future. For example, CMS may approve an extension request on December 15, 2020, with an effective date of January 1, 2021 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration.
2. **Implementation date of policy:** The date of implementation for each eligibility and coverage policy in the state's demonstration.

2. Executive summary

The executive summary should be reported in the fillable box below. It is intended for summary-level information only. The recommended word count is 500 words or less.

During Q1 2025, all cost sharing, including POWER Account Contributions and copays, remains suspended. All members who apply, and are eligible for HIP, will continue to automatically enroll in HIP Plus during this time.

3. Narrative information on implementation, by eligibility and coverage policy and reporting topic

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
Premiums and account payments (PR)			
PR.Mod_1. Eligibility and payment amounts			
PR.Mod_1.1 Metric trends			
1.1.1 Discuss any data trends related to beneficiaries subject to premiums or account payments. Describe and explain changes (+ or -) greater than two percent.		*PR_1; PR_8-10*	**PR 1**: Between DY10Q4 and DY11Q1, the avg. number of beneficiaries subject to the premium policy that aren't exempt, decreased 21.7%, from 3,369 to 2,638. Although there are beneficiaries captured in PR1, there are no HIP members subject to cost-sharing due to ongoing litigation. Due to its suspension status, HIP beneficiaries are set to have met cost sharing obligations in the State's system. PR1 results may be attributed to a delay in setting the member's flag to have met cost sharing.
1.1.2 Discuss any data trends related to changes in premium amounts after mid-year change in circumstance or renewal.	X	*PR_11-14; PR_18-20*	

	Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
1.1.3	Discuss any data trends related to beneficiaries who are granted exemptions from premiums or account payments. Describe and explain changes (+ or -) greater than two percent.		*PR_2*	Between DY10Q4 and DY11Q1, the avg. number of beneficiaries who were exempt from premiums for the quarter increased 0.16% from 581,354 to 582,259.
1.1.4	Discuss any data trends related to beneficiaries who paid a premium or account payment during that month. Describe and explain changes (+ or -) greater than two percent.		*PR_3; PR_21*	**PR 3:** Between DY10Q4 and DY11Q1, the avg. number of beneficiaries who paid a premium during the quarter increased 3.64%, from 256 to 266. **PR 21**: Between DY10Q4 and DY11Q1, third party premium payments decreased 50%, from four to two. All payments are reimbursed to members and third parties due to paused cost sharing.
1.1.5	Discuss any data trends related to beneficiaries who were subject to premiums or account payments but declared hardship. Describe and explain changes (+ or -) greater than two percent.	X	*PR_4*	
PR.Mod_1.2 Implementation update				
1.2.1	Compared to the demonstration design details outlined in the implementation plan, describe any changes or expected changes to how the state defines: 1.2.1.a Beneficiaries exempt from premiums or account payments	X		POWER Account Contributions were planned to resume July 1, 2024, but due to litigation, on June 28, 2024, it was necessary to cancel that plan, and the pause on monthly PACs will continue until further notice. As of Q1 2025, PACs remain paused.
	1.2.1.b Beneficiaries subject to premiums or account payments but exempt from compliance actions	X		

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
1.2.1.c	Process for claiming financial hardship	X		
1.2.1.d	Process for determining premium or account contribution amounts beneficiaries will pay	X		
1.2.1.e	Process for determining that beneficiaries have reached the aggregate spending cap specified in the STCs	X		
1.2.1.f	Other policy changes	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
PR.Mod_2. Beneficiary account operations			
PR.Mod_2.1 Metric trends – ***No metric trend analysis is required for this reporting topic.***			
PR.Mod_2.2 Implementation update			
2.2.1 Compared to the demonstration design details outlined in the implementation plan, describe any changes or expected changes to how beneficiary health accounts are administered, including the role of vendors.	X		
2.2.2 Compared to the demonstration design details outlined in the implementation plan, describe any changes or expected changes to how beneficiary health accounts work, including state contributions, use of account funds to pay for services, and rules for account rollovers and balances.	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
PR.Mod_3. Invoicing and payments			
PR.Mod_3.1 Metric trends – ***No metric trend analysis is required for this reporting topic.***			
PR.Mod_3.2 Implementation update			
3.2.1 Compared to the demonstration design details outlined in the implementation plan, describe any changes or expected changes to invoicing and payment processes (including invoicing, beneficiary payments, grace periods, and deadlines for reporting a change in circumstance that would affect premium liability, and compliance actions).	X		
3.2.2 Compared to the demonstration design details outlined in the implementation plan, describe any changes or expected changes to procedures for beneficiaries to pay premiums or account payments, or for third parties to pay premiums or account payments on behalf of beneficiaries.	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
PR.Mod_4. Reduction to premiums for non-income related reasons			
PR.Mod_4.1 Metric trends -- ***No metric trend analysis is required for this reporting topic.***			
PR.Mod_4.2 Implementation update			
4.2.1 Compared to the demonstration design details outlined in the implementation plan, describe any changes or expected changes to incentives or rewards related to premium or account payments (if applicable).	X		During the pause on PACs, members cannot earn member rollover, since members are not making monthly contributions to their power account. Members can still earn a discount on the following year's PAC contributions for completing preventive care services.

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
PR.Mod_5. Operationalize strategies for noncompliance			
PR.Mod_5.1 Metric trends			
5.1.1 Discuss any data trends related to the number of beneficiaries who have experienced the below. Describe and explain changes (+ or -) greater than two percent. 5.1.1.i New disenrollments	X	*PR_15*	During Q1 2025, no beneficiaries were disenrolled from HIP for failure to pay a premium.
5.1.1.ii New suspensions	X	*PR_17*	
5.1.2 Discuss any data trends related to beneficiaries in grace periods, non-eligibility periods, and/or other statuses. Describe and explain changes (+ or -) greater than two percent.	X	*PR_5-6;* *PR_16*	During Q1 2025, no beneficiaries were subject to premiums and therefore were in short or long-term arrears.
5.1.3 Discuss any data trends related to the number of beneficiaries who had collectible debt. Describe and explain changes (+ or -) greater than two percent.	X	*PR_7*	During Q1 2025, no beneficiaries enrolled in HIP were subject to the premium policy and had collectible debt.
PR.Mod_5.2 Implementation update			
5.2.1 Compared to the demonstration design details outlined in the implementation plan, describe any changes or expected changes to: 5.2.1.a Implementation of compliance actions	X		
5.2.1.b Processes for identifying and tracking beneficiaries at risk of noncompliance	X		
5.2.1.c Process for providing advance notice to beneficiaries at risk of suspension or disenrollment for noncompliance	X		

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
5.2.1.d	Processes for tracking and pursuing collectible debts (if applicable)	X		
5.2.1.e	Processes for screening those at risk of disenrollment for other Medicaid eligibility groups or exemptions	X		
5.2.1.f	Appeals processes for beneficiaries subject to premium requirements	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
PR.Mod_6. Develop comprehensive communications strategy			
PR.Mod_6.1 Metric trends – ***No metric trend analysis is required for this reporting topic.***			
PR.Mod_6.2 Implementation update			
6.2.1 Compared to the details outlined in the implementation plan, describe any change or expected changes to the state's strategy to communicate with beneficiaries about:	X		
6.2.1.a Compared to the details outlined in the implementation plan, describe any change or expected changes to the state's strategy to communicate with beneficiaries about:			
6.2.1.b Payment process	X		
6.2.1.c Rewards for payment (if any)	X		
6.2.1.d Processes for reporting changes in income, making hardship claims, and filing appeals	X		
6.2.1.e Consequences of nonpayment	X		
6.2.1.f Non-eligibility periods	X		
6.2.2 Compared to the details outlined in the implementation plan, describe any change or expected changes to the information provided on beneficiary invoices.	X		

	Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
6.2.3	Describe any communication or outreach that was conducted with partners, such as managed care organizations or other contractors, during this reporting period.			During DY11Q1, the OMPP regularly communicated with the MCEs. OMPP conducts ongoing document reviews of member flyers, postcards, clinical and reimbursement documents, educational materials, preventive care materials, and other member materials. OMPP also updates the MCEs weekly on new provider bulletins and conducts callouts for urgent updates. OMPP Compliance sends out an email every Friday containing provider bulletins and any urgent updates and requests to ensure this information is communicated to the MCEs timely. OMPP Compliance holds monthly compliance meetings with each MCE to discuss compliance concerns, share updates, and address outstanding member and provider inquiries.
6.2.4	Compared to the details outlined in the implementation plan, describe any changes or challenges with how materials or communications were accessible to beneficiaries with limited English proficiency, with low literacy, and in rural areas, and other diverse groups.	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
PR.Mod_7. Develop and modify systems			
PR.Mod_7.1 Metric trends – ***No metric trend analysis is required for this reporting topic.***			
PR.Mod_7.2 Implementation update			
7.2.1 Describe whether the state has developed or enhanced its systems capabilities as described in the implementation plan for: 7.2.1.a Accepting premiums or account payments	X		
7.2.1.b Tracking premiums or account payments	X		
7.2.1.c Establishing beneficiary accounts (if applicable)	X		
7.2.1.d Operationalizing compliance actions (if applicable)	X		
7.2.2 Describe any additional systems modifications that the state is planning to implement.	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
PR.Mod_8. State-specific metrics			
PR.Mod_8.1 Metric trends			
8.1.1 Discuss any data trends related to state-specific metrics. Describe and explain changes (+ or -) greater than two percent.	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
Healthy behavior incentives (HB)			
HB.Mod_1. Healthy behavior incentives			
HB.Mod_1.1 Metric trends			
1.1.1 Discuss any data trends related to the enrollment among beneficiaries subject to healthy behavior incentives. Describe and explain changes (+ or -) greater than two percent.		*HB_1*	Between DY10Q4 and DY11Q1, the avg. number of beneficiaries subject to healthy behavior incentive policies decreased 1.53% from 694,475 to 683,846. All HIP beneficiaries are eligible for healthy incentives. Due to this, HB_1 will match the greatest demonstration population in AD1.
1.1.2 Discuss any data trends related to the below. Describe and explain changes (+ or -) greater than two percent. 1.1.2.a Beneficiaries using all incentivized healthy behaviors, by service		*HB_2*	Between DY10Q4 and DY11Q1, the avg. number of beneficiaries enrolled in HIP who utilized financially incentivized, documented through claims, decreased 4.42%, from 200,015 to 191,180.

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
1.1.2.b Beneficiaries using incentivized healthy behaviors documented through claims, by service	X	*HB_3*	
1.1.2.c Beneficiaries using incentivized behaviors not documented through claims, by service	X	*HB_4*	
1.1.3 Discuss any data trends related to beneficiaries granted a reward, such as premium reductions, financial rewards, or additional covered benefits, for completion of incentivized healthy behaviors. Describe and explain changes (+ or -) greater than two percent.		*HB_5-7*	**HB 5:** While the incentive is related to rollover of unused member portion of POWER Account Contributions and cost-sharing is not currently being imposed, thus members cannot earn incentives, this information is reflective of who would have qualified for an incentive for completing a health behavior. Between DY10Q4 and DY11Q1, there was a 23% decrease from 62,703 to 48,282. Healthy behavior incentives are based on a calendar year, and January and March were the members' first chance to earn the incentive in CY 2024, therefore a decrease is observed as the year continues.
HB.Mod_1.2 Implementation update			
1.2.1 Compared to the demonstration design details outlined in the STCs, describe any changes or expected changes to how the state identifies and defines: 1.2.1.a Beneficiaries subject to healthy behavior incentives	X		
1.2.1.b Beneficiaries exempt from healthy behaviors incentives	X		
1.2.1.c Incentivized healthy behaviors that beneficiaries can complete	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
1.2.1.d Rewards granted for the completion of incentivized healthy behaviors	X		
1.2.1.e Other policy changes	X		
1.2.2 Describe any communication with beneficiaries about healthy behavior incentives.	X		
1.2.3 Describe any outreach or educational activities to providers, managed care organizations, or other partners about programs that incentivize particular healthy behaviors.	X		
1.2.4 Highlight significant demonstration operations or policy considerations that impacted or could impact beneficiary participation, demonstration enrollment or rewards granted for completion of incentivized healthy behaviors. Note any activity that may accelerate or impede the policy's implementation.	X		One of the member incentives for receiving preventative care services during the year is the state's match of POWER Account rollover amount. Since there is no cost-sharing during Q1 2025, there are no unused member POWER Account contributions to rollover to 2025, thus the State rollover match will be $0, and HIP Plus members would not be able to roll over the unused portion of their POWER Account Contributions.

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
HB.Mod_2. State-specific metrics			
HB.Mod_2.1 Metric trends			
2.1.1 Discuss any data trends related to state-specific metrics. Describe and explain changes (+ or -) greater than two percent.	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
Retroactive eligibility waiver (RW)			
RW.Mod_1. Retroactive eligibility waiver and demonstration requirements			
RW.Mod_1.1 Metric trends			
1.1.1 Discuss any data trends related to beneficiaries subject to retroactive eligibility waivers. Describe and explain changes (+ or -) greater than two percent.		*RW_1-3*	**RW 2:** Between DY10Q4 and DY11Q1, there was one beneficiary that was subject to the waiver of retroactive eligibility policy who re-enrolled in the demonstration within 90 days after their previous spell ended because the beneficiary did not comply with renewal processes on time. **RW 3:** Between DY10Q4 and DY11Q1, there were no beneficiaries who had claims denied. This metric is a subset of RW_2
RW.Mod_1.2 Implementation update			

	Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
1.2.1	Compared to the demonstration design details outlined in the implementation plan, describe any changes or expected changes to how the state will determine whether beneficiaries are exempt from the retroactive eligibility waiver.	X		
1.2.2	Compared to the demonstration design details outlined in the implementation plan, describe any modifications or expected modifications to Medicaid applications to reflect the retroactive eligibility waiver.	X		
1.2.3	Report any modifications to the appeals processes for beneficiaries subject to retroactive eligibility waivers.	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
RW.Mod_2. Develop comprehensive communications strategy			
RW.Mod_2.1 Metric trends – ***No metric trend analysis is required for this reporting topic.***			
RW.Mod_2.2 Implementation update			
2.2.1 Compared to the details outlined in the implementation plan, describe any change or expected changes to the state's strategy for communicating to beneficiaries about changes to retroactive eligibility policies.	X		
2.2.2 Describe any communication or outreach that was conducted with partner organizations, including managed care organizations and community organizations.	X		
2.2.3 Describe any communication or outreach that was conducted with providers.	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
RW.Mod_3. State-specific metrics			
RW.Mod_3.1 Metric trends			
3.1.1 Discuss any data trends related to state-specific metrics. Describe and explain changes (+ or -) greater than two percent.	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
Non-eligibility periods (NEP)			
NEP.Mod_1. Non-eligibility periods and demonstration requirements			
NEP.Mod_1.1 Metric trends			
1.1.1 Discuss any data trends related to individuals in non-eligibility periods. Describe and explain changes (+ or -) greater than two percent.	X	*AD_3*	
NEP.Mod_1.2 Implementation update			
1.2.1 Compared to the demonstration design details outlined in the implementation plan, describe any changes or expected changes to how the state defines: 1.2.1.a Non-eligibility periods	X		
1.2.1.b Processes by which beneficiaries satisfy demonstration requirements to avoid non-eligibility periods	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
NEP.Mod_2. Exemptions from non-eligibility periods			
NEP.Mod_2.1 Metric trends – ***No metric trend analysis is required for this reporting topic.***			
NEP.Mod_2.2 Implementation update			
2.2.1 Compared to the demonstration design details outlined in the implementation plan, describe any changes or expected changes to: 2.2.1.a How the state will identify beneficiaries that are exempt from non-eligibility periods, or that have good cause exemptions	X		
2.2.1.b How the state identifies, and/or how beneficiaries report exemptions or good cause circumstances from non-eligibility periods, and what documentation is necessary	X		
2.2.2 Describe any modifications to the appeals processes for individuals subject to non-eligibility periods, including what happens to individuals while appeals cases are pending or in the appeals/fair hearing process.	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
NEP.Mod_3. Re-enrollment after non-eligibility periods			
NEP.Mod_3.1 Metric trends – ***No metric trend analysis is required for this reporting topic.***			
NEP.Mod_3.2 Implementation update			
3.2.1 Compared to the demonstration design details outlined in the implementation plan, describe any changes or expected changes to what actions individuals will need to take to re-enroll after a non-eligibility period ends.	X		
3.2.2 Compared to the demonstration design details outlined in the implementation plan, describe any changes or expected changes to how the state will process new applications for individuals who were disenrolled due to a non-eligibility period.	X		
3.2.3 Compared to the demonstration design details outlined in the implementation plan, describe any changes or expected changes to how the state will handle applications for individuals who reapply for coverage before the end of their non-eligibility period.	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
NEP.Mod_4. Develop comprehensive communications strategy			
NEP.Mod_4.1 Metric trends – ***No metric trend analysis is required for this reporting topic.***			
NEP.Mod_4.2 Implementation update			
4.2.1 Compared to the details outlined in the implementation plan, describe any change or expected changes to the state's plan for communicating to current beneficiaries and new applicants/beneficiaries about the demonstration's non-eligibility period provision(s).	X		
4.2.2 Compared to the details outlined in the implementation plan, describe any change or expected changes to the state's strategy for communicating to individuals when and how they can re-enroll after non-eligibility periods.	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
NEP.Mod_5. Develop and modify systems			
NEP.Mod_5.1 Metric trends – ***No metric trend analysis is required for this reporting topic.***			
NEP.Mod_5.2 Implementation update			
5.2.1 Compared to the demonstration design details outlined in the implementation plan, describe any changes or expected changes to how the state will identify and track individuals in non-eligibility periods.	X		
5.2.2 Describe any systems modifications that the state has implemented or is planning to implement to operationalize non-eligibility periods, and/or to re-enroll beneficiaries after non-eligibility periods end.	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
NEP.Mod_6. State-specific metrics			
NEP.Mod_6.1 Metric trends			
6.1.1 Discuss any data trends related to state-specific metrics. Describe and explain changes (+ or -) greater than two percent.	X		

4. Narrative information on implementation for any demonstration with eligibility and coverage policies

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
AD.Mod_1 Metrics and operations for any demonstrations with eligibility and coverage policies (Any demonstration topics are applicable for reporting on the state's broader section 1115 demonstration. In support of CMS's efforts to simplify data collection and support analysis across states, report for <u>all beneficiaries in the demonstration</u>, not only those subject to eligibility and coverage policies.)			
AD.Mod_1.1 Metric trends			

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
1.1.1 Discuss any data trends related to overall enrollment in the demonstration. Describe and explain changes (+ or -) greater than two percent.		*AD_1-5*	**AD 1:** Between DY10Q4 and DY11Q1, avg. enrollment in HIP decreased 1.42% from 692,783 to 682,964. **AD 4:** Between DY10Q4 and DY11Q1, avg. new enrollment decreased 14.11% from 4,591 to 3,943. While completing the Q4 2024 report, the State identified an inaccuracy in the logic behind the age brackets. In the Q4 2024 report, ages were reported using a future eligibility period, primarily impacting beneficiaries under 19. As a result, the State underreported the <19 age bracket. The logic update was implemented in this Q1 2025 report. Previous quarters can be submitted if requested by CMS. Impacted metrics include AD1-AD22.

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
1.1.2 Discuss any data trends related to mid-year loss of demonstration eligibility. At a minimum, changes (+ or -) greater than two percent should be described.		*AD_6-10*	**AD 6:** Between DY10Q4 and DY11Q1, avg. re-enrollments or re-instatements for beneficiaries not using defined pathways after disenrollment or suspension of benefits for noncompliance, decreased 0.56% from 3,093 to 3,075. **AD 7:** Between DY10Q4 and DY11Q1, the avg. number of beneficiaries determined ineligible for Medicaid, any reason, other than at renewal decreased 1.37% from 3,458 to 3,411. **AD 8:** Between DY10Q4 and DY11Q1, the avg. number of beneficiaries no longer eligible for Medicaid for failure to provide timely change in circumstance information decreased 4.58% from 3,054 to 2,914. **AD 9:** Between DY10Q4 and DY11Q1, the avg. number of beneficiaries who were enrolled in HIP and lost eligibility for Medicaid because they were determined ineligible after the state processed a change in circumstance, such as income or family household increased 6.10% from 2,135 to 2,266. **AD 10:** Between DY10Q4 and DY11Q1, the avg. number of beneficiaries who were enrolled in HIP and transferred to another Medicaid eligibility group increased 4.92%, from 1,953 to 2,049.

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
1.1.3 Discuss any data trends related to enrollment duration at time of disenrollment. Describe and explain changes (+ or -) greater than two percent.		*AD_11-13*	**AD 12:** Between DY10Q4 and DY11Q1, the avg. number of beneficiaries who lost eligibility for Medicaid and whose enrollment spell had lasted 3 or fewer months at the time of disenrollment, increased 5.34% from 743 to 783. **AD 13**: Between DY10Q4 and DY11Q1, the avg. number of beneficiaries who lost eligibility for Medicaid and whose enrollment spell had lasted between 4 and 6 months at the time of disenrollment, increased 2.69%, from 1,017 to 1,044.

1.1.4	Discuss any data trends related to renewals. Describe and explain changes (+ or -) greater than two percent.		*AD_14-21*	**AD 14:** Between DY10Q4 and DY11Q1, the avg. number of beneficiaries who lost eligibility for Medicaid whose enrollment spell had lasted 7 or more months (up to 12 months) at the time of disenrollment, decreased 6.77%, from 1,699 to 1,584. **AD 15:** Between DY10Q4 and DY11Q1, the avg. number of beneficiaries enrolled in HIP who were due for renewal increased 5.70%, from 50,864 to 53,762. **AD 16:** Between DY10Q4 and DY11Q1, the avg. number of beneficiaries determined ineligible for HIP at renewal and disenrolled from Medicaid decreased 12.66%, from 629 to 550. **AD 17:** Between DY10Q4 and DY11Q1, the avg. number of beneficiaries determined ineligible for HIP at renewal and transferred to another Medicaid eligibility category, decreased 2.58%, from 1,032 to 1,005. For metrics 19-21, Month 3, March, is significantly bigger than January and February since less time has occurred between March and May (submission) for renewal updates to occur in our eligibility system. **AD 19:** Between DY10Q4 and DY11Q1, the avg. number of beneficiaries who did not complete renewal and disenrolled from Medicaid increased 72.66%, from 4,326 to 7,470. **AD 20:** Between DY10Q4 and DY11Q1, the avg. number of beneficiaries who had pending/uncompleted renewals and were still enrolled increased 149.52%, from 1,454 to 3,628.

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
			AD 21: Between DY10Q4 and DY11Q1, the avg. number of beneficiaries who retained eligibility in HIP after completing renewal forms increased 343.5%, from 617 to 2,737.
1.1.5 Discuss any data trends related to cost sharing limits. Describe and explain changes (+ or -) greater than two percent.		*AD_22*	Between DY10Q4 and DY11Q1, the avg. number of beneficiaries who renewed ex-parte, decreased 10.36%, from 42,805 to 38,372.

1.1.6	Discuss any data trends related to appeals and grievances. Describe and explain changes (+ or -) greater than two percent.		*AD_23-28*	**AD 23:** Between DY10Q4 and DY11Q1, the avg. number of beneficiaries enrolled in HIP who reached the 5% of income limit on cost sharing and premiums decreased 0.36%, from 682,420 to 679,956. HIP members will appear to have met cost sharing in state systems but aren't expected to make payments. Setting it up in this manner, prevented non-compliance notices from going out to members on behalf of the MCEs. Further, AD 23 previously had an age limitation 19-64, that was removed to include eligible members in HIP. **AD 24:** Between DY10Q4 and DY11Q1, the number of appeals filed by HIP beneficiaries regarding Medicaid eligibility increased 29.2% from 1,007 to 1,301. **AD 25:** Between DY10Q4 and DY11Q1, the number of appeals filed by beneficiaries regarding denial of benefits decreased 60%, from 10 to 4. **AD 26:** Between DY10Q4 and DY11Q1, the number of grievances filed by beneficiaries enrolled in HIP for quality of care or services provided decreased 17.71%, from 175 to 144. **AD 27:** Between DY10Q4 and DY11Q1, the number of grievances filed by beneficiaries regarding a provider or MCE increased 39.9%, from 436 to 610. **AD 28:** Between DY10Q4 and DY11Q1, there were no grievances filed by beneficiaries regarding other matters that are not subject to appeal. All grievances are subject to appeal.

1.1.7	Discuss any data trends related to access to care. Describe and explain changes (+ or -) greater than two percent.		*AD_29-36*	**AD 29:** Between DY10Q4 and DY11Q1, the number of primary care providers enrolled to deliver Medicaid services at the end of the quarter increased 1.65%, from 11,437 to 11,626. **AD 30:** Between DY10Q4 and DY11Q1, the number of primary care providers enrolled to deliver Medicaid services with service claims for 3 or more HIP beneficiaries during the quarter increased 12.61%, from 6,513 to 7,334. **AD 31**: Between DY10Q4 and DY11Q1, the number of specialty physician and non-physician medical practitioners enrolled to deliver Medicaid services at the end of the quarter increased 2.38%, from 11,587 to 11,863. **AD 32**: Between DY10Q4 and DY11Q1, the number of specialty physician and non-physician medical practitioners enrolled to deliver Medicaid services with service claims for 3 or more HIP beneficiaries increased 13.38%, from 6,575 to 7,455. **AD 33:** Between DY10Q4 and DY11Q1, the rate of utilization of preventive care and office visits per 1,000 beneficiary months decreased 1.13%, from 394.7 to 390.2. **AD 34:** Between DY10Q4 and DY11Q1, the rate of utilization of 30-day prescription fills per 1,000 beneficiary months increased 0.07%, from 1,693 to 1,694.

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
			AD 35: Between DY10Q4 and DY11Q1, the rate of emergency department (ED) visits per 1,000 demonstration beneficiary months decreased 3.50%, from 68.6 to 66.2. **AD 36:** Between DY10Q4 and DY11Q1, the rate of ED visits for non-emergency conditions per 1,000 beneficiary months decreased 3.42%, from 66.1 to 63.9.
1.1.8 Discuss any data trends related to quality of care and health outcomes. Describe and explain changes (+ or -) greater than two percent.		*AD_37-43*	**AD 37:** Between DY10Q4 and DY11Q1, the rate of inpatient admissions per 1,000 beneficiary months decreased 4.85%, from 6.47 to 6.15.
1.1.9 Discuss any data trends related to administrative costs. Describe and explain changes (+ or -) greater than two percent.	X	*AD_44*	
AD.Mod_1.2. Implementation update			
1.2.1 Highlight significant demonstration operations or policy considerations that could positively or negatively impact beneficiary enrollment, compliance with requirements, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or impediments in achieving the demonstration's approved goals or objectives, if not already reported elsewhere in this document. See Monitoring Report Instructions for more detail.	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
AD.Mod_2. State-specific metrics			
AD.Mod_2.1 Metric trends			
2.1.1 Discuss any data trends related to state-specific metrics. Discuss each state-specific metric trend in a separate row. Describe and explain changes (+ or -) greater than two percent.	X		

5. Narrative information on other reporting topics

Prompt	State has no update to report (place an X)	State response
1. Budget neutrality		
1.1 Current status and analysis		
1.1.1 Discuss the current status of budget neutrality and provide an analysis of the budget neutrality to date. If the eligibility and coverage policy component is part of a comprehensive demonstration, the state should provide an analysis of the eligibility and coverage policy related budget neutrality and an analysis of budget neutrality as a whole.		The budget neutrality template has been updated to include actual experience for January 1, 2021 - March 31, 2025. For POWER account payments, since the amount of the POWER account remains unchanged throughout the reporting period at $2,500 and DY 9 (CY 2023) POWER account payments include the reconciliation customarily performed after the completion of every year, the DY 9 per-recipient-per month amount has been added to DY 10 and DY 11 projections. The amount is estimated at approximately $205.
1.2 Implementation update		
1.2.1 Describe any anticipated program changes that may impact financial/budget neutrality.	X	

Prompt	State has no update to report (place an X)	State response
2. Eligibility and coverage demonstration evaluation update		
2.1 Narrative information		
2.1.1 Provide updates on eligibility and coverage policy evaluation work and timeline. The appropriate content will depend on when this report is due to CMS and the timing for the demonstration. There are specific requirements per 42 Code of Federal Regulations (CFR) § 431.428a(10) for annual [monitoring] reports. See Monitoring Report Instructions for more details.	X	

Prompt	State has no update to report (place an X)	State response
2.1.2 Provide status updates on deliverables related to the demonstration evaluation and indicate whether the expected timelines are being met and/or if there are any real or anticipated barriers in achieving the goals and timeframes agreed to in the STCs.	X	On July 15, 2024, OMPP emailed CMS to receive guidance on suspended HIP policies due to the PHE and their impact on research questions during the evaluation period. Research questions include cost sharing, tobacco surcharges, etc. due to their suspension during the COVID-19 PHE. Due to inactivity, the state has limited data on these policies, limiting the contractor's ability to evaluate corresponding research questions. Guidance on inactive policies for future evaluations remains pending. The independent evaluator, in Q1 2024, identified language that was incorrect in the latest approved HIP Evaluation Plan (for 2021-2030). Due to the language's minimal impact, at the request of CMS, Indiana is noting the deviations in this Part B instead of amending the evaluation plan. **Error #1:** Page 6 of the PDF (Section: General Background Information): "Given the 10-year span of the waiver and the potential future programmatic changes (e.g., six-month non-eligibility period for non-payment of POWER Account contribution), this evaluation plan focuses on analysis for the first Interim Evaluation Report scheduled for submission to CMS in June 2024." **Error #2:** Page 93 of the PDF (Section: WBA Methodology): The footnote states the interim evaluation is due June 2024. **Error #3:** Page 61 of the PDF (Section: Analytic Tables): Several of the exhibits in this section, in the data source column, says the evaluator will use "claims data (2015- 2022)." The correct timeframe is 2015-2023.
2.1.3 List anticipated evaluation-related deliverables related to this demonstration and their due dates.	X	

Prompt	State has no update to report (place an X)	State response
3. Other eligibility and coverage demonstration reporting		
3.1 General reporting requirements		
3.1.1 Describe whether the state foresees the need to make future changes to the STCs, implementation plan, or monitoring protocol, based on expected or upcoming implementation changes.	X	
3.1.2 Compared to the details outlined in the STCs and the monitoring protocol, describe whether the state has formally requested any changes or whether the state expects to formally request any changes to: 3.1.2.a The schedule for completing and submitting monitoring reports	X	
3.1.2.b The content or completeness of submitted monitoring reports and or future monitoring reports	X	On May 28, 2024, CMS emailed Indiana on their reporting expectations for metric RW_1. CMS proposed two alternative approaches to report data on unpaid medical bills or medical debt. Indiana will likely opt towards option #2, a beneficiary survey. Further clarification surrounding collection remains pending from CMS as of Q1 2025. This is likely the result of the ongoing HIP litigation. In the meantime, RW_1 will remain unreportable in the monitoring workbook, despite a DY10Q1 phase in date. Indiana will continue to report a deviation for this metric.
3.1.3 Describe whether the state has identified any real or anticipated issues submitting timely post-approval demonstration deliverables, including a plan for remediation.	X	
3.1.4 Provide updates on the results of beneficiary satisfaction surveys, if conducted during the reporting year, including updates on grievances and appeals from beneficiaries, per 42 CFR 431.428(a)5	X	

Prompt	State has no update to report (place an X)	State response
Eft 3.2 Post-award public forum		
3.2.1 If applicable within the timing of the demonstration, provide a summary of the annual post-award public forum held indicating any resulting action items or issues. A summary of the post-award public forum should be included here for the period during which the forum was held and in the annual monitoring report.	X	

Prompt	State has no update to report (place an X)	State response
4. Notable state achievements and/or innovations		
4.1 Narrative information		
4.1.1 Provide any relevant summary of achievements and/or innovations in demonstration enrollment, benefits, operations, and policies (1) pursuant to the eligibility and coverage policy hypotheses (or if broader demonstration, then eligibility and coverage policy related) or (2) that served to provide better care for individuals, better health for populations, and/or reduce per capita cost. Achievements should focus on significant impacts to beneficiary outcomes. Whenever possible, the summary should describe the achievement or innovation in quantifiable terms (e.g., number of impacted beneficiaries).	X	

*The state should remove all example text from the table prior to submission.

Note: States must prominently display the following notice on any display of measure rates based on NCQA technical specifications for 1115 eligibility and coverage demonstration monitoring metrics:

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