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	*DY9Q4*
Reporting period	*10/01/2023-12/31/2023*
Premiums or account payments	
Premiums or account payments start date	*This waiver authority is suspended during the COVID-19 PHE unwind and will resume July 1, 2024. The official cost share restart date and plan for reimplementation was announced to stakeholders in January 2024.*
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.

The Public Health Emergency (PHE) for the COVID-19 pandemic ended in Indiana during the 2nd Quarter of 2023. During Q4, OMPP continued the PHE unwind in collaboration with CMS. Eligibility redetermination actions began in April 2023, with a 12-month plan to return to normal operations. Individuals for which all eligibility determination is known and verified and have remained eligible under normal rules during the public health emergency were subject to standard requirements starting in April 2023. Individuals who have only remained eligible due to the special rules effective since March 2020 will be reevaluated when their annual redetermination comes due and cannot be disenrolled until after such time. During Q4 2023, all cost sharing, including 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. Due to the end of continuous enrollment provisions, HIP enrollment has begun to decrease, as reflected in the HIP Monitoring Workbook (Part A).

There have not been a significant number of complaints about the health care delivery system under the demonstration with respect to member issues. The most frequent issue brought to the office's attention includes difficulty filling prescriptions during/after transition from HIP to Medicare coverage, an issue which is partially caused by the continuous enrollment requirements delaying category change.

The *Rose v Azar* lawsuit continued to be on hold during this time due to the PHE. There was a routine internal audit of one of the managed care entity's HIP contracts (CareSource, Contract #18313), and there were no findings as a result.

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*	Between DY9Q3 and DY9Q4, metric PR_1 had a percent change of 8.52%. Beneficiaries are exempt from premiums during the PHE unwind.
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*	
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 DY9Q3 and DY9Q4, metric PR_2 had a decrease of 2.45%. Beneficiaries are exempt from premiums during the PHE unwind.
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*	Between DY9Q3 and DY9Q4, metric PR_3 had a percent change of -24.15%. During Q4, beneficiaries were not expected to pay premiums.
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*	

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
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			Cost sharing for HIP is suspended for a portion of the COVID-19 PHE unwind. Premiums and POWER Account contributions will resume July 1, 2024.
1.2.1.b Beneficiaries subject to premiums or account payments but exempt from compliance actions			The continuous enrollment provisions that Indiana Medicaid has been following since March 2020 ended as of March 31, 2023. For the duration of the COVID-19 PHE unwind, HIP members are not disenrolled for failing to pay premiums or account payments.
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.			Cost sharing for HIP is suspended for the remainder of the COVID-19 PHE unwind. Premiums and POWER Account contributions will resume July 1, 2024. Any contributions made will be refunded to third parties and beneficiaries.

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 COVID-19 PHE unwind, members cannot earn member rollover, because members are not making monthly contributions to their power account. Members can still earn state rollover 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		*PR_15*	Metric #15 increased by 80% in Q4. The increase appears to be significant due to the small data results. For example, in Q3, five beneficiaries disenrolled from the demonstration for failure to pay and therefore disenrolled from Medicaid. In Q4, the beneficiaries disenrolled from the demonstration for failure to pay and therefore disenrolled from Medicaid increased to nine. These disenrollments are likely due to system errors.
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*	
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*	
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		

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
5.2.1.c	Process for providing advance notice to beneficiaries at risk of suspension or disenrollment for noncompliance	X		
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: 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:	X		
6.2.1.b Payment process			Cost sharing for HIP is suspended for a portion of the COVID-19 PHE unwind. Premiums and POWER Account contributions will resume July 1, 2024. Members are advised either on the POWER Account statement or via an insert sent with the statement from the MCE that no payments are required at this time and that they will be notified in advance before they must resume making contributions or copayments.
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		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
6.2.1.e Consequences of nonpayment			Cost sharing for HIP is suspended for a portion of the COVID-19 PHE unwind. Premiums and POWER Account contributions will resume July 1,2024. There are no consequences for non-payment until cost-sharing has resumed.
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.	X		Between DY9Q3 and DY9Q4, the OMPP compliance officers 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 twice/week on new provider bulletins and conducts callouts for urgent updates. OMPP started an MCE PHE Unwind Q&A document and sent it out to MCEs on a weekly basis when there were updates/additions beginning 01/27/2023. Questions were collected directly from MCEs, during bi-weekly PHE Unwind meetings (which include MCEs, State staff from various divisions and sections, and systems contractors) and stakeholder engagement meetings, and also via email. OMPP coordinated with and communicated guidance to MCEs for member outreach efforts related to end of continuous enrollment requirements. Specifically, in order to support member outreach efforts during PHE Unwind, the state provided monthly data pulls of their members who are due for redetermination, members who have closed at redetermination and have entered the 90-day reconsideration period, and members who have closed at redetermination because they no longer meet eligibility requirements. OMPP held monthly Stakeholder engagement meetings to share information, progress, and updates regarding redetermination processes, the State's plans and timelines for PHE Unwind activities, and other related topics as appropriate, and to direct them to useful tools and resources available on the Indiana Medicaid website.

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
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.			The MCEs are required to aid beneficiaries where English is not their primary language. During Q4, the Burmese-speaking requirement identified during Q2 was closed. The state identified two MCEs failed to have a Burmese-speaking customer service representative employed and scheduled during all MCE call center live operating hours. These gaps in coverage were identified for two MCEs through the course of the State's regular contract compliance oversight activities.

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 DY9Q3 and DY9Q4, metric HB_1 had a 3.70% decrease.
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 DY9Q3 and DY9Q4, metric HB_2 had a 3.76% decrease.
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*	Between DY9Q3 and DY9Q4, metric HB_5 had a 12.39% decrease. Since this metric has a 90-day claims lag, this measurement period is the third quarter of 2023. Because healthy behavior incentives are based on a calendar year, this is members' first chance to earn the incentive this year. Because of this, more members earn their incentives between January and March than the remainder of the year.

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
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		
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		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
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 the PHE Unwind period, there are no unused member POWER Account contributions to rollover to the next year, thus the State rollover match will be $0, and HIP Plus members will be responsible for the full amount of their POWER Account Contributions once cost sharing restarts.

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.	X	*RW_1-3*	
RW.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 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			
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*	Between DY9Q3 and DY9Q4, AD_1 had a decrease of 3.59%. Between DY9Q3 and DY9Q4, AD_4 had an increase of 16.74%. The continuous enrollment provisions that Indiana Medicaid has been following since March 2020 due to the COVID-19 PHE ended as of March 31, 2023. Regular determinations of coverage began again and actions to adjust, reduce or eliminate coverage were allowed beginning April 1, 2023. Because of the end of the continuous enrollment provisions, Indiana is now able to take adverse actions against members, impacting HIP enrollment counts.

	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*	Between DY9Q3 and DY9Q4, AD_6 had a decrease of 21.19%. Between DY9Q3 and DY9Q4, AD_7 had a decrease of 26.38%. Between DY9Q3 and DY9Q4, AD_8 had a decrease of 9.29%. Between DY9Q3 and DY9Q4, AD_9 had a decrease of 6.88%. Between DY9Q3 and DY9Q4, AD_10 had a decrease of 5.75%. Since continuous enrollment provisions ended on April 1, 2023, Indiana could act on changes that result in adverse action for members whose eligibility information is known and verified. If the member had been flagged as someone who should have been disenrolled during the PHE but could not have been due to continuous enrollment provisions, they cannot be disenrolled until they have had an opportunity to complete their redetermination.
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*	Between DY9Q3 and DY9Q4, AD_12 had a decrease of 23.70%. Between DY9Q3 and DY9Q4, AD_13 had a decrease of 30.53%.

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
1.1.4 Discuss any data trends related to renewals. Describe and explain changes (+ or -) greater than two percent.		*AD_14-21*	Between DY9Q3 and DY9Q4, AD_14 had a decrease of 1.80%. Between DY9Q3 and DY9Q4, AD_15 had an increase of 9.83%. Between DY9Q3 and DY9Q4, AD_16 had an increase of 2.77. Between DY9Q3 and DY9Q4, AD_17 had a decrease of 31.66%. Between DY9Q3 and DY9Q4, AD_19 had a decrease of 9.66%. Between DY9Q3 and DY9Q4, AD_20 had an increase of 400.18%. Between DY9Q3 and DY9Q4, AD_21 had an increase of 13.75%.
1.1.5 Discuss any data trends related to cost sharing limits. Describe and explain changes (+ or -) greater than two percent.		*AD_22*	Between DY9Q3 and DY9Q4, AD_22 had an increase of 14.53%.
1.1.6 Discuss any data trends related to appeals and grievances. Describe and explain changes (+ or -) greater than two percent.		*AD_23-28*	Between DY9Q3 and DY9Q4, AD_23 had a decrease of 4.27%. Between DY9Q3 and DY9Q4, AD_24 had a decrease of 12.07%. Between DY9Q3 and DY9Q4, AD_25 had a decrease of 48.28%. Between DY9Q3 and DY9Q4, AD_27 had a decrease of 26.48%.

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
1.1.7 Discuss any data trends related to access to care. Describe and explain changes (+ or -) greater than two percent.		*AD_29-36*	Between DY9Q3 and DY9Q4, AD_32 had a decrease of 9.85%. Between DY9Q3 and DY9Q4, AD_33 had a decrease of 2.17%. Between DY9Q3 and DY9Q4, AD_35 had an increase of 4.43%. Between DY9Q3 and DY9Q4, AD_36 had an increase of 4.45%.

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*	Between DY9Q3 and DY9Q4, AD_37 had an increase of 4.62%. **#38:** Percentage of beneficiaries aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation intervention if identified as a tobacco user decreased 7.30% in the reporting period. **#39**: Percentage of ED visits for beneficiaries age 18 and older who have a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, and who had a follow-up visit with a corresponding principal diagnosis for AOD: Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 30 days of the ED visit (31 total days) increased 62.67% in the reporting period. Percentage of ED visits for beneficiaries age 18 and older who have a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, and who had a follow-up visit with a corresponding principal diagnosis for AOD: Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 7 days of the ED visit (8 total days) increased 64.95% in the reporting period. The percentage of ED visits for beneficiaries age 18 and older who have a principal diagnosis of mental illness or intentional self-harm, and who had a follow-up visit with a corresponding principal diagnosis for mental illness within 30 days of the ED visit (31 total days) decreased 3.81% in the reporting period. The percentage of ED visits for beneficiaries age 18 and older who have a principal diagnosis of mental illness or intentional self-harm, and who had a follow-up visit with a corresponding principal diagnosis for mental

			illness within 7 days of the ED visit (8 total days) decreased 9.14% in the reporting period. **#40:** The percentage of beneficiaries age 18 and older with a new episode of AOD abuse or dependence who received initiation of AOD Treatment - Opioid abuse or dependence (rate 1, cohort 2) increased 7.83% in the reporting period. The percentage of beneficiaries age 18 and older with a new episode of AOD abuse or dependence who received initiation of AOD Treatment - Other drug abuse or dependence (rate 1, cohort 3) increased 2.99% in the reporting period. The percentage of beneficiaries age 18 and older with a new episode of AOD abuse or dependence who had engagement of AOD Treatment - Opioid drug abuse or dependence (rate 2, cohort 2) increased 39.41% in the reporting period. The percentage of beneficiaries age 18 and older with a new episode of AOD abuse or dependence who had engagement of AOD Treatment - Other AOD abuse or dependence (rate 2, cohort 3) increased 62.03% in the reporting period. The percentage of beneficiaries age 18 and older with a new episode of AOD abuse or dependence who had engagement of AOD Treatment - Total AOD abuse or dependence (rate 2, cohort 4) increased 17.73% in the reporting period. **#41:** The number of inpatient hospital admissions for diabetes short-term complications per 100,000 beneficiary months for beneficiaries age 18 and older increased 24.15% in the reporting period. **#42:** The number of inpatient hospital admissions for chronic obstructive pulmonary disease or asthma per

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
			100,000 beneficiary months for beneficiaries age 40 and older increased 158% in the reporting period. **#43:** The number of inpatient hospital admissions for heart failure per 100,000 beneficiary months for beneficiaries age 18 and older decreased 11.32% in the reporting period.
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			

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
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.			During Q3, OMPP continued the COVID-19 PHE unwind process. As a result of the recently passed federal spending bill, the continuous enrollment provisions that the Indiana Health Coverage Programs (IHCP) has been following since March 2020 ended as of March 31, 2023. This means that regular determinations of coverage began again and actions to adjust, reduce or eliminate coverage were allowed beginning in April 2023. Effective July 1, 2023, Prior Authorization timeliness standards were updated per Indiana Senate Bill 400 (IC 27-1-37.5-11). The change includes standard Prior Authorization adjudication in five business days and urgent Prior Authorization adjudication within 48 hours. Effective July 1, 2023, a Statewide Uniform Preferred drug list was implemented for Indiana Medicaid. In addition, the SPA revises the supplemental drug rebate contract to allow the State to collect rebates on all outpatient drug MCO and FFS utilization. In 2023, there were many activities and CMS submissions in relation to the 1115 demonstration amendment approved on July 26, 2022, in order to come into compliance with 42 CFR 438.4(b)(1) which may have an impact on beneficiaries beginning in 2024.

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- December 31, 2023. The "Total Adjustments" tab reflects adjustments made to Schedule C expenditures for this timeframe. This adjustment is necessary as Schedule C reporting has a lag of six months. For POWER account payments, since the amount of the POWER account remains unchanged throughout the reporting period at $2,500 and DY 8(CY 2022) POWER account payments include the reconciliation customarily performed after the completion of every year, the DY 8 per-recipient-per month amount has been added to DY 9 projections.
1.2 Implementation update		
1.2.1 Describe any anticipated program changes that may impact financial/budget neutrality.		As a result of the recently passed federal spending bill, the continuous enrollment provisions that the Indiana Health Coverage Programs (IHCP) has been following since March 2020 ended as of March 31, 2023. This means that regular determinations of coverage began again and actions to adjust, reduce or eliminate coverage were allowed beginning in April 2023. These changes will likely be reflected in the budget neutrality report.

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.		Indiana is currently working on the interim evaluation that will report on CY 2021-2023, DY7-DY9. Indiana has not deviated from the timeline and will submit the interim evaluation no later than December 31, 2024.

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.		The State and CMS discussed the language of the longitudinal survey in the HIP 2021-2030 Summative Evaluation. It was concern of the state's independent evaluator, that the State would be wasting resources surveying beneficiaries on reason for leaving the plan, tobacco surcharge, power accounts, and medical debt, which are all less applicable during the PHE. Due to this, CMS and the State agreed to proceed with an abbreviated 2023 survey followed up with a second, longer survey in 2024.The 2024 survey will account for the questions that could not be asked during the 2023 survey due to the PHE. The State and CMS agreed the language in the HIP evaluation design accounted for implications to the goals, research questions, and hypotheses. On March 21, 2023, Indiana received CMS' feedback on the 2018-2020 HIP Summative Evaluation. In agreement with the STC's, Indiana addressed the feedback within 60 calendar days and resubmitted it on May 18, 2023. In July 2023, CMS shared with Indiana that CMS would be supplementing the HIP summative evaluation with additional HIP data request from the state. On September 14, 2023, Indiana returned the data to CMS and awaited feedback into Q4. Throughout Q4, Indiana continued work on the 2021- 2023 HIP Interim Evaluation Report due to CMS no later than 60 days after December 31, 2024. No barriers are anticipated currently. The evaluator, in Q1 2024, identified language that was incorrect in the latest approved HIP Evaluation Plan. Due to the language's minimal impact, at the request of CMS, Indiana is noting the incorrections in the Q4 2023 Part B. At this time, Indiana will not amend 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." As agreed in the STCs, and reflected in PMDA, the first interim is due by Dec 31, 2024. **Error #2:** Page 93 of the PDF (Section: WBA Methodology): The footnote states the interim evaluation is due June 2024.

Prompt	State has no update to report (place an X)	State response
		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	The 2021- 2023 HIP Interim Evaluation Report is due to CMS no later than December 31, 2024.

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.		Due to the end of the PHE and the return to normal operations in HIP, in 2024 Indiana expects to be able to report some of the monitoring metrics that have not had any data to report since 2020.
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	The State is in the process of updating the application so that RW_1 can be collected. There is no data available for this metric currently. Otherwise, the monitoring reports will be submitted complete.
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		No beneficiary satisfaction surveys were conducted during the reporting quarter. Appeals regarding eligibility decreased from 1143 in Q3 to 1005 in Q4. Appeals regarding denial of benefits decreased from 29 in Q3 to 15 in Q4. Grievances regarding care quality remained the same in Q4 (186). Grievances regarding provider or MCEs decreased from 457 in Q3 to 336 in Q4.

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.		The 1115 demonstration waiver post award forum was held on July 26, 2023, during a special meeting of the Medicaid Advisory Committee and was open to the public. Due to the ongoing nature of the COVID-19 PHE, this meeting was offered in a hybrid format. The state presented on HIP eligibility and enrollment and gave an update of the operational status. The FSSA OMPP Director of HIP and Hoosier Healthwise presented a summary of the Healthy Indiana Plan (HIP), Serious Mental Illness (SMI) waiver and the substance use disorders (SUD) waiver. As a result of the special meeting, three managed care entities (MCEs) provided written comments in support of the HIP, SMI, and SUD waivers. One MCE shared that they receive feedback from stakeholders that shows "HIP affords eligible Hoosiers access to benefits, services and a greater quality of healthcare from providers and community-based organizations, which these individuals might not otherwise experience." The same MCE further commented on the expansion of crisis services in Indiana, specifically how the 988 Crisis Centers have already helped thousands of Hoosiers. A second MCE commented they continue to see "positive outcomes thanks to HIP, SMI, and SUD." The second MCE shared that their members have increased engagement with their primary care providers, leading to a decrease in emergency department usage. In addition to sharing member success stories, this MCE attested that their members have expanded access to behavioral health services thanks to the SMI and SUD waivers. The last MCE to provide written comment, highlighted the importance of collaboration between physical and behavioral health care. This MCE wrote that the 1115 waivers allow them to "form relationships and partnerships with the providers who service our members in the various treatment settings." One organization expressed concern about POWER accounts, and whether the state could investigate the cost of administering these accounts versus allowing Hoosiers to access HIP benefits without the POWER accounts. A second organization commented on the improvements made to increase retention of the workforce and telehealth. Additionally, the organization commented on emergency room usage decreasing and the resulting cost savings to the state. Lastly, two politicians that attended the special meeting and provided the following comments. The first politician expressed concern surrounding POWER accounts and whether the state could investigate if the cost of administering POWER accounts was more burdensome than allowing Hoosiers to access HIP benefits without the additional burden. Lastly, one representative

Prompt	State has no update to report (place an X)	State response
		looks forward to the innovations the 10-year HIP waiver approval will allow for and potentially revisiting codification around the HIP waiver.

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).		In 2023, we strived to provide as much information as possible to members in a variety of modalities leading up to the end of continuous enrollment provisions in order to reduce gaps in coverage for those who remain eligible. Any considerations for significant program changes are on hold until after the return to normal process is complete in order to avoid unintended consequences of making multiple simultaneous process and/or systems changes.

*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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