DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, Maryland 21244-1850

Children and Adults Health Programs Group

January 30, 2015

Joseph Moser
Medicaid Director
Indiana Family and Social Services Administration
402 W. Washington St., Room W461
Indianapolis, IN 46204

Dear Mr. Moser:

On January 27, 2015, the Centers for Medicare & Medicaid Services (CMS) approved Indiana's application for a three-year Medicaid demonstration entitled, "Healthy Indiana Plan 2.0" (Project Number 11-W-00296/5). The demonstration is approved in accordance with section 1115(a) of the Social Security Act (the Act) and is effective on the date of this signed approval. Through this demonstration and associated state plan amendments, the state will provide coverage to adults in Indiana with incomes through 133 percent of the federal poverty level (FPL) beginning February 1, 2015.

Under section XII of the Special Terms and Conditions (STCs), the state is required to finalize a budget neutrality agreement with CMS by February 1, 2015. The enclosed document contains technical corrections to reflect this agreement. The award issued on January 27, 2015, requires the state to accept the STCs within 30 days of award. Within this written acceptance, please include any technical changes necessary, including those to the enclosed budget neutrality language. Acceptable technical edits to the attached will serve to replace the appropriate Sections of the Special Terms and Conditions.

Your project officer for this demonstration is Ms. Andrea Casart. She is available to answer any questions concerning your section 1115 demonstration. Ms. Casart's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-0742
Facsimile: (410) 786-5882
E-mail: Andrea.Casart@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Casart and to Mr. Alan Freund, Acting Associate Regional Administrator for the Division of Medicaid & Children's Health in the Chicago Regional Office. Mr. Freund's contact information is as follows:

Mr. Alan Freund
Associate Regional Administrator
Division of Medicaid and Children Health Operations
233 North Michigan Avenue, Suite 600
Chicago, IL 60601
Email: Alan.Freund@cms.hhs.gov

We look forward to continuing to work with you and your staff on the demonstration.

Sincerely,

/s/

Eliot Fishman
Director

Enclosures

cc: Alan Freund, Acting ARA, Region VI

XII. GENERAL FINANCIAL REQUIREMENTS

2. Reporting Expenditures under the Demonstration

d. Use of Waiver Forms. The following six (6) waiver Forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted each quarter (when applicable) to report title XIX expenditures for individuals enrolled in the demonstration. The expressions in quotation marks are the waiver names to be used to designate these waiver forms in the MBES/CBES system.

i. "1931 Parents" expenditures
ii. "New Adult Group" expenditures
iii. "Medically Frail" expenditures
iv. "HIP Link" expenditures
v. "PE Program" expenditures
vi. "Uncompensated Care Program" expenditures

XII. BUDGET NEUTRALITY DETERMINATION

1. Limit on Title XIX Funding. The state shall be subject to a limit on the amount of federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit will be determined by using a per capita cost method. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. Actual expenditures subject to the budget neutrality expenditure limit shall be reported by the state using the procedures described in Section XI paragraph 2(d). The data supplied by the state to CMS to set the annual limits is subject to review and audit, and, if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

2. Risk. Indiana shall be at risk for the per capita cost (as determined by the method described below in this Section) for Medicaid eligibles but not for the number of demonstration eligibles in each of the groups. By providing FFP for HIP enrollees in these eligibility groups, Indiana shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing Indiana at risk for the per capita costs for HIP enrollees, CMS assures that the federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration.

3. Budget Neutrality Annual Expenditure Limits. For each DY, annual limits are calculated.

a. **PMPM Costs.** The following table gives the projected PMPM costs for the calculations described above by DY.

Eligibility Group	Trend Rate	DY 1 (2/1/15 – 1/31/16)	DY 2 (2/1/16 – 1/31/17)	DY 3 (2/1/1 – 1/31/16)
1931 Adults	5.3%	$660.73	$695.75	$732.62
New Adults	1.1%	$540.05	$545.99	$552.00
Medically Frail	4.3%	$1647.13	$1717.96	$1791.83
HIP Link	1.1%	$348.33	$352.17	$356.04

a. If the State's experience of the take up rate for the new adult group and other factors that affect the costs of this population indicates that the PMPM limit described above in paragraph (a) may underestimate the actual costs of medical assistance for the new adult group, the State may submit an adjustment to paragraph (a), along with detailed expenditure data to justify this, for CMS review without submitting an amendment pursuant to Section 3 paragraph 7. Adjustments to the PMPM limit for a demonstration year must be submitted to CMS by no later than October 1of the demonstration year for which the adjustment would take effect.

b. The budget neutrality cap is calculated by taking the PMPM cost projection for the above group in each DY, times the number of eligible member months for that group and DY, and adding the products together across groups and DYs. The federal share of the budget neutrality cap is obtained by multiplying total computable budget neutrality cap by the federal share.

c. The State will not be allowed to obtain budget neutrality "savings" from the New Adults, Medically Frail and HIP Link Groups

4. **Composite Federal Share.** The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the 3-year approval period, as reported on the forms listed in Section XI paragraph 2(d) by total computable demonstration expenditures for the same period as reported on the same forms. Should the demonstration be terminated prior to the end of the 3-year approval period, the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be used.

5. **Future Adjustments to the Budget Neutrality Expenditure Limit.** CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under HIP.

6. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis, by combining the annual limits calculated following paragraph into lifetime limits for the demonstration. The following describes how budget neutrality will be enforced.

    a. If the demonstration is terminated prior to the end of the budget neutrality agreement, an assessment of the state's compliance with these requirements shall be based on the time elapsed through the termination date.

    b. **Interim Checks/Corrective Action Plan.** If the state exceeds the calculated cumulative target limit by the percentage identified below for any of the DYs, the state shall submit a corrective action plan to CMS for approval.

DY	Cumulative Target Definition	Percentage
Year 1	Cumulative budget neutrality expenditure cap plus:	3%
Year 2	Cumulative budget neutrality expenditure cap plus:	1.5%
Year 3	Cumulative budget neutrality expenditure cap plus:	0%

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

Updated February 06, 2015

Without Waiver Summary	DY 01	DY 02	DY 03	DY 01 - DY 03
XIX - HIP Populations				
Section 1931 Caretakers	855,442,506	913,393,819	975,262,279	2,744,098,604
New Adult Population	1,410,186,339	1,944,502,982	2,084,725,704	5,439,415,024
Medically Frail Population	435,649,401	628,725,257	695,393,097	1,759,767,754
HIP Link	39,027,267	345,778,115	370,706,000	755,511,381
Total Without Waiver Costs	***2,740,305,512***	***3,832,400,173***	***4,126,087,079***	***10,698,792,763***

With Waiver Summary	DY 01	DY 02	DY 03	DY 01 - DY 03
XIX - HIP Populations				
Section 1931 Caretakers	*855,442,506*	*897,784,401*	*942,221,944*	*2,695,448,852*
New Adult Population	*1,410,186,339*	*1,944,502,982*	*2,084,725,704*	*5,439,415,024*
Medically Frail Population	*435,649,401*	*628,725,257*	*695,393,097*	*1,759,767,754*
HIP Link	39,027,267	345,778,115	370,706,000	755,511,381
HIP Presumptive Eligibility (extension to day 60)	2,998,517	4,134,673	4,432,799	11,565,989
Section 1931 Uncompensated Care	4,012,115	4,283,860	4,573,996	12,869,971
Total With Waiver Costs	***2,747,316,144***	***3,825,209,288***	***4,102,053,540***	***10,674,578,971***
Waiver Margin	***(7,010,632)***	***7,190,885***	***24,033,539***	***24,213,792***

Coverage Estimates	DY 01	DY 02	DY 03
Anticipated Enrollment			
Section 1931 Caretakers	107,891	109,402	110,933
New Adult Population	217,600	296,786	314,723
Medically Frail Population	22,041	30,498	32,341
HIP Link	9,337	81,821	86,766
HIP Presumptive Eligibility (extension to day 60)	218	297	315
Section 1931 Uncompensated Care	1,079	1,094	1,109
Total	**358,166**	**519,896**	**546,187**