DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

State Demonstrations Group

May 22, 2023

Allison Taylor
Medicaid Director
Indiana Family and Social Services Administration
402 W. Washington Street, Room W461, MS25
Indianapolis, IN 46204

Dear Ms. Taylor:

The Centers for Medicare & Medicaid Services (CMS) approved the Evaluation Design for Indiana's COVID-19 Public Health Emergency (PHE) Managed Care Rate Differential amendment to the section 1115 demonstration entitled, "Healthy Indiana Plan (HIP)" (Project No: 11-W-00296/5). We sincerely appreciate the state's commitment to efficiently meeting the requirement for an Evaluation Design as was stipulated in the approval letter for this amendment dated July 26, 2022, especially under these extraordinary circumstances.

The approved Evaluation Design may now be posted to the state's Medicaid website within 30 days, per 42 CFR 431.424(c). CMS will also post the approved Evaluation Design on Medicaid.gov.

Consistent with the approved Evaluation Design, the draft Final Report will be due to CMS 18 months after either the expiration of the demonstration approval period or the end of the latest rating period covered under the state's approved expenditure authority, whichever comes later.

We look forward to our continued partnership with you and your staff on the Healthy Indiana Plan section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

Danielle Daly -S

Digitally signed by Danielle Daly -S
Date: 2023.05.22 12:37:30 -04'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

cc: Mai Le-Yuen, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

Indiana HIP COVID-19 PHE Managed Care Rate Differential Amendment

Evaluation design

11-W-002965

May 17, 2023

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I. General Background

The Healthy Indiana Plan (HIP), a key feature of the Indiana Medicaid program since 2008, currently covers over 700,000 individuals. Enrollment in HIP has substantially increased under the COVID-19 Public Health Emergency (PHE) Maintenance of Effort. As mandated by state statute, HIP pays for services at the Medicare rates or 130 percent of the established Indiana Medicaid rate. This enhanced rate was considered critical to gain provider participation in the HIP program and ensure access to services for HIP members. The final managed care rule, published in November of 2020, requires a change to this long-established practice as the HIP population has higher average federal financial participation than Hoosier Care Connect and Hoosier Healthwise.

The Centers for Medicaid and Medicare Services (CMS) asked Indiana to eliminate the difference in rates between managed care programs. However, changing HIP rates from the statutorily mandated Medicare rates to be in alignment with Medicaid rates would result in an average decrease of 32-percent to the current physician and ancillary provider rates. This rate decrease was expected to negatively impact access to services in HIP, especially if it occurred during the PHE as enrollment in HIP has increased disproportionally to other Medicaid programs. This could be expected to negatively impact provider financials during a period where providers already face unprecedented stress.

On March 13, 2020, pursuant to section 1135(b) of the Social Security Act (the Act), the Secretary of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences of the COVID-19 pandemic.

In response to the section 1115(a) demonstration opportunity announced to states on March 22, 2020, in State Medicaid Director Letter (SMDL) #20-002, on January 28, 2022, Indiana submitted a request for an amendment to the "Healthy Indiana Plan (HIP)" section 1115(a) demonstration (Project Number 11-W-00296/5) due to the COVID-19 PHE.

Approval of this amendment request will: (1) allow the state to avoid a large rate decrease to providers during or immediately following the COVID-19 PHE when the emergency 1115 authorization expires; (2) allow an implementation runway to equalize rates; and (3) continue to support access for HIP members, especially those with chronic conditions requiring access to specialty physician services during a period of historically high enrollment linked to the COVID-19 PHE Maintenance of Effort.

II. Purpose of the Demonstration

This expenditure authority will test whether, in the sole context of the current COVID-19 PHE, an exemption from the regulatory prohibition in 42 CFR 438.4(b)(1), promoted the objectives of Medicaid. As a result, the expenditure authority is expected to support the state in making payments during the PHE to help maintain beneficiary access to care.

The expenditure authority provided the state a transition period to comply with 42 CFR 438.4(b)(1) which was revised as part of the 2020 Medicaid and Children's Health Insurance

Program Managed Care Rule (CMS-2408-F) published on November 13, 2020 and took effect on December 14, 2020.

Consistent with CMS requirements for monitoring and evaluation of section 1115 demonstrations, Indiana is required to develop this Evaluation Design as well as a Final Report, which will consolidate the monitoring and evaluation requirements for this demonstration amendment.

III. Evaluation Questions and Hypotheses

Figure 1 outlines the hypotheses and research questions (RQs) this evaluation will follow to understand the successes, challenges, and lessons learned pre-and post- demonstration implementation.

Figure 1: Hypothesis and Research Questions

Hypothesis 1: Delaying implementation of the regulations outlined in Section 438.6(b)(1) allowed Indiana to focus efforts on continuing access to health coverage and to address the unique challenges of the pandemic.
RQ 1.1: What problems does the state anticipate would have been caused by the application of section 438.6(b)(1) during the PHE that would have undermined the objectives of Medicaid?
RQ 1.2: How did the exemption address or prevent the problems in RQ 1.1?
RQ 1.3: What were the principal challenges associated with implementing rate equalization from the perspectives of the state Medicaid agency?
RQ 1.4: What actions did the state take to address challenges presented by the implementation of rate equalization? To what extent were those actions successful in the context of the public health emergency?
RQ 1.5: What were the principal lessons learned for any future public health emergencies in implementing the demonstration flexibilities?
Hypothesis 2: The expenditure authority provided by CMS during the public health emergency allowed beneficiaries to maintain access to health coverage.
RQ 1.6: What were the costs associated with the operation of Medicaid during the public health emergency?
RQ 1.7: How did the costs and expenditures in RQ 1.6 impact Indiana's response to the public health emergency?
RQ 1.8: How did the capitation rates change during the public health emergency? How did the changes, if any, impact the public health emergency?

IV. Methodology

CMS expects Indiana to undertake data collection or analyses that are meaningful, but not unduly burdensome for the state, the state will focus on qualitative methods and descriptive data to address evaluation questions that will support understanding the successes, challenges, and lessons learned in implementing the demonstration amendment. The following sections describe the anticipated data sources.

1. Document Review

Indiana will conduct a review of relevant documentation and will explain observable trends through narrative description. Documents may include legislative actions, IHCP provider bulletins and public comments from the rate equalization public comment period.

2. Interviews

Indiana will conduct staff interviews within FSSA OMPP to evaluate whether the amendment to the demonstration facilitated achieving the objectives of Medicaid during the public health emergency. Participants will be identified based on their state position and whether a direct relationship with this implementation exist. The state may potentially use surveys to collect information. FSSA OMPP may interview Managed Care Organizations and providers should their availability allow it.

3. Claims Data

Indiana will use claims cost data, collected and validated regularly by the state's actuaries, to estimate the unforeseeable impact of COVID-19 on utilization patterns. Indiana will calculate standard summary statistics to report findings.

V. Evaluation Design

Consistent with CMS requirements, Indiana is required to develop an Evaluation Design and a Final Report. This report will respond to the hypothesis and research questions outlined in Figure 2.

Figure 2: Analytic Table

Research question	Outcome meansure(s)	Data Source(s)	Analytic approach
Hypothesis 1: Delaying implementation of the regulations outlined in Section 438.6(b)(1) allowed Indiana to focus efforts on continuing access to health coverage and to address the unique challenges of the pandemic.			
RQ 1.1: What problems does the state anticipate would have been caused by the application of section 438.6(b)(1) during the PHE that would have undermined the objectives of Medicaid?	Explanation of challenges that would have undermined Indiana's ability to deliver Medicaid's objectives Explanation of challenges that would have undermined Indiana's ability to meet the unique challenges of the PHE	Staff interviews & Claims data	Qualitative & Quantitative Analysis
RQ 1.2: How did the exemption address or prevent the problems in RQ 1.1?	Explanation of challenges that were avoided due to the exemption	Staff and stakeholder interviews, Claims data	Qualitative & Quantitative Analysis

RQ 1.3: What were the principal challenges associated with implementing rate equalization from the perspectives of the state Medicaid agency?	Description of challenges, if any, related to implementing rate equalization	Staff and stakeholder interviews	Qualitative Analysis
RQ 1.4: What actions did the state take to address challenges presented by the implementation of rate equalization? To what extent were those actions successful in the context of the public health emergency?	Explanation of actions taken by Indiana to address the challenges described in RQ 1.3 and whether those actions were successful	Staff and stakeholder interviews	Qualitative Analysis
RQ 1.5: What were the principal lessons learned for any future public health emergencies in implementing the demonstration flexibilities?	Explanation of lessons learned for future public health emergencies	Staff and stakeholder interviews	Qualitative Analysis
Hypothesis 2: The expenditure authority provided by CMS during the public health emergency allowed beneficiaries to maintain access to health coverage.			
RQ 1.6: What were the costs associated with the operation of Medicaid during the public health emergency?	Explanation of the administrative and health services costs required to address the public health emergency	Administrative data	Quantitative Analysis
RQ 1.7: How did the costs and expenditures in RQ 1.6 impact Indiana's response to the public health emergency?	Explanation of the benefits, if any, the incurred costs had on the state's response to the public health emergency	Document Review, Staff interviews	Qualitative Analysis
RQ 1.8: How did the capitation rates change during the public health emergency? How did the changes, if any, impact the public health emergency?	Explanation of the benefits, if any, the capitation rate had on the state's response to the public health emergency	Document Review	Qualitative Analysis

VI. Methodological Limitations

Possible limitations the state may encounter include bias due to reliance on staff's memory and ability to recall information from prior years, staff turnover, and limited data.

VII. Preparing the Final Report

The draft Final Report will be delivered to CMS no later than 18 months after either the expiration of the approval period of this expenditure authority or the end of the latest rating period covered under the state's approved expenditure authority.