INDIANA END STAGE RENAL DISEASE SECTION 1115 DEMONSTRATION WAIVER

Closeout Report

Project Number 11-W-00237/5

Contents

Background Information

Approved on an emergency basis by the Centers for Medicare & Medicaid Services (CMS) on May 30, 2014[1] through December 31, 2014, Indiana's section 1115 End Stage Renal Disease (ESRD) demonstration authorized limited coverage to Medicare-enrolled individuals with ESRD who, at the time, were otherwise ineligible for Medicaid or Medicare supplemental wrap-around coverage, including supplemental coverage for kidney transplant services, and did not have another source of supplemental health coverage. ESRD demonstration enrollees are required to meet a monthly ESRD waiver liability that is calculated based on the phased out spend down methodology prior to being given access to the full range of Medicaid state plan benefits, including dialysis services needed to maintain their condition. The ESRD waiver coverage is not considered minimal essential coverage, but this demonstration allowed individuals with ESRD to remain on transplant lists and receive Medicaid coverage before, during, and after transplant provided they met their monthly ESRD liability amount. At the time of the initiation of the ESRD demonstration, Medicare Advantage excluded individuals from enrollment.

In 2014, a coverage gap was created for spend down enrollees with ESRD when Indiana transitioned from 209(b) to 1634 status and removed the spend down program. At that time, individuals under the age of 65 with ESRD were not allowed to enroll in Medicare Advantage, did not have Special Needs Plans available to them, and the state did not have guaranteed issue rights for Medicare Supplement policies. Without a program to cover them, individuals with ESRD under the age of 65 could not obtain supplemental coverage for 20 percent coinsurance on Medicare Part B, which would be applicable to transplant surgeon fees. These individuals risked not being eligible for a transplant without supplemental coverage. In May 2014, the ESRD population was added to the existing Healthy Indiana Plan waiver and has persisted on that waiver since, even as HIP transitioned to a new 1115 in January of 2015. The original HIP demonstration, now titled HIP 1.0, was ultimately renewed by CMS in July 2016 under the new and current name, "End Stage Renal Disease (ESRD) Section 1115 Demonstration." The program extended the spend down like coverage for this population to ensure the individuals could remain on transplant lists and receive kidney transplants.

Following a request to amend the HIP demonstration, on May 29, 2020, CMS added the "Workforce Bridge Account Program" to the ESRD demonstration, rather than including it in the HIP waiver. The Workforce Bridge Account Program will support the successful transition from HIP to commercial insurance for individuals who lose access to Medicaid coverage due to increased income, thereby reducing healthcare coverage gaps and improving overall access to care. Under this program, certain HIP beneficiaries would be informed that, if they lose their HIP eligibility solely due to an increase in income, they could be eligible for up to $1,000 for the purpose of temporarily paying for costs that include premiums and copayments for health insurance coverage, or the direct costs of health care services that would be covered by HIP. Reimbursement for health insurance premiums will be paid to the individual or to the plan at the request of the individual enrolled in a Marketplace health plan. Indiana has not yet

[1] The emergency ESRD approval was added to the existing original Healthy Indiana Plan Section 1115 waiver, originally approved in December 2007.

implemented this component of the demonstration in compliance with the Families First Coronavirus Response Act (FFCRA), enacted at the beginning of the coronavirus (i.e., COVID-19) pandemic that required states to provide continuous enrollment to Medicaid enrollees until the end of the month in which the PHE ends in order to receive enhanced federal funding to address challenges associated with the COVID-19 pandemic. The Indiana ESRD section 1115 demonstration has otherwise generally operated as renewed annually by CMS, with only slight variations implemented in terms of eligible populations.

In 2021, Medicare Advantage stopped exempting individuals with ESRD from enrollment in these plans, and the Indiana Office of Medicaid Policy and Planning (OMPP), Family and Social Services Administration (FSSA) recognized that Medicare Advantage is a superior coverage option for individuals with ESRD currently enrolled in the ESRD demonstration. Medicare Advantage provides coverage that will cap individual out of pocket responsibilities and will allow individuals with ESRD to remain on transplant lists and receive transplants without requiring a monthly ESRD liability to be met before offering coverage. As a result, individuals enrolled in Medicare Advantage may receive kidney transplants and are no longer at risk of being removed from transplant lists in the absence of the ESRD 1115 demonstration. Additionally, the new Medicare Part B Immunosuppressive Drug (Part B-ID), which became effective on January 1, 2023, includes provisions for continued coverage of transplant drugs. With the new insurance options made available to ESRD patients following the passage of the 21st Century Cures Act, OMPP decided to sunset the ESRD section 1115 demonstration, effective December 31, 2024, after allowing two Medicare open enrollment periods to assist individuals in enrolling in comprehensive coverage through Medicare Advantage.

Over the life of the demonstration, at least 760 individuals received coverage[2], with an approximate average of 400 enrollees receiving ESRD coverage each year. The average number of enrollees covered per year decreased during the public health emergency (PHE), likely due to the requirement to maintain continuous coverage in an MEC category. As of June 2023, a total of 218 individuals were enrolled. The latest interim evaluation included information through March 2020 and indicated that the ESRD program continued to meet the overall Medicaid program objective of the demonstration, which is to provide supplemental health coverage to individuals with a diagnosis of ESRD who meet the income and asset limits of the demonstration. The trend of increasing kidney transplants corresponded with a trend of decreasing enrollment over the course of the demonstration.

The state has continued to operate the current ESRD demonstration in alignment with the original goal of ensuring access to supplemental coverage for a small but highly vulnerable population. Indiana has remained in compliance with all CMS Special Terms and Conditions (STCs) of approval throughout the demonstration. Indiana is current on all quarterly and annual monitoring requirements, including budget neutrality; reporting no complaints, problems, or quality assurance issues identified with the program.

Overall, the ESRD section 1115 demonstration allowed individuals with ESRD who did not have another source of supplemental coverage the ability to remain on transplant lists and receive comprehensive health coverage before, during, and after transplant. In December 2016, Congress enacted the 21st

[2] The ESRD population counts may differ between the monitoring reports and phase-out reports. The monitoring reports include all beneficiaries with an open ESRD Special Medicaid Approval, while phase-out data is limited to individuals actively using the ESRD special budgeting (i.e., ineligible for any other Medicaid without the special budgeting). This data discrepancy was identified during the phaseout process.

Century Cures Act allowing all Medicare-eligible individuals with ESRD to enroll in Medicare Advantage plans beginning January 1, 2021.

Before the passage of this law, patients with kidney failure were one of the only groups unable to enroll in Medicare Advantage with a few exceptions, such as patients who had already enrolled before their diagnosis or those who have successfully received a transplant. The ESRD section 1115 demonstration was the only supplemental coverage option that capped the 20 percent
Part B coverage available to individuals over the Medicaid income limit who had Medicare but were under age 65.

With the new Medicare Advantage enrollment options created by the Cures Act, ESRD patients can enroll in Medicare Advantage which, unlike traditional Medicare Part A and Part B, acts as an “all in one" plan, that includes prescription (Part D) coverage and in some cases additional benefits such as vision, hearing, and dental (which traditional Medicare does not provide). Medicare Advantage provides ESRD patients, such as the individuals currently covered under the demonstration, advantages such as expanded benefits and other care services to improve patient quality outcomes, low premiums, and capped out-of-pocket costs. In light of the availability of comprehensive Medicare Advantage coverage to the individuals served under the ESRD section 1115 demonstration, Indiana decided to phase-out the demonstration over an 18-month period, with a demonstration end date of December 31, 2024.

Summary of Implementation

Between May 2014 and March 2020, the ESRD demonstration ensured coverage to 760 unique enrollees, covering on average approximately 400 unique enrollees per year. Enrollment declined over the course of this time but there continued to be comparable new enrollments—about ten new enrollees per quarter. The program allowed individuals with end-stage renal disease who did not have another source of supplemental coverage the ability to remain on transplant lists and provided comprehensive coverage for enrollees before, during, and after transplant. Through the ESRD demonstration, enrollees accessed the full range of Medicaid State Plan benefits, including dialysis services necessary to manage their condition. Although the ESRD program continued to meet the goals and objectives established at the outset of this demonstration, data challenges persisted. These challenges were a result of multiple factors but can be summarized as the constant uncertainty of the demonstration's outlook and programming throughout the program’s history. An uncertain outlook, combined with changes to the eligibility system and a lack of standardization in reporting measures, created obstacles.

In 2020, when OMPP completed an evaluation of the demonstration, some of the data limitations had been addressed, such as accurate identification and verification of the ESRD enrollees. Similarly, the lack of standardization and competing methodologies were addressed so that the State could move forward with additional comprehensive analyses and answer questions that emerged from this exercise. For example, this led the State to examine whether enrollees would begin to access health care coverage through a Medicare Advantage plan. Although the need for supplemental coverage for the ESRD population was not a common occurrence across states, this demonstration provided strong evidence of the utility of a diagnosis-specific health care program. Of particular importance, the success of Indiana’s §1115 ESRD demonstration waiver had direct policy implications for the COVID-19 pandemic, as health officials evaluated options to best address the unique health care needs within individual states.

Through Indiana's efforts, other states had a blueprint on how to implement a diagnosis-specific health care intervention which state health officials could leverage in their efforts to address COVID-19.

Some additional challenges during the program demonstration were the transition from the Indiana Client Eligibility System (ICES) to the Indiana Enterprise Data System (IEDSS) during the PHE. After the transition to IEDSS, there was no longer a way to identify the ESRD population using CoreMMIS data alone. Instead, in order to identify the population, we had to use data from IEDSS to identify those with an open ESRD Waiver entered on the Special Medicaid Approvals page who were also actively receiving the special income budgeting with the ESRD indicator set to "Yes" on the Eligibility Determinations page. Manual checks were required to make sure the population was accurate, which was time consuming. In addition, staff transition throughout the PHE created a knowledge gap regarding transition activities, and it was also time consuming to piece together the needed systems information by trial and error.

Meanwhile, FSSA was also busy planning the implementation of the Indiana PathWays for Aging program, a managed long-term services and supports program. FSSA launched the PathWays program on July 1, 2024. Along with members in a handful of other waivers and programs, ESRD waiver participants were excluded from the program given the different eligibility criteria and monthly liability requirement. As FSSA prepared to launch the program in May 2024, the members determined to be active on the ESRD waiver at that time were sent to our fiscal agent and Medicaid Management Information System (MMIS) vendor in order to place these members on Permanent Holds to ensure they did not get included in go-live outreach initiatives and ultimately were not enrolled into the program. Shortly after go-live during the post-implementation frenzy, our fiscal agent erroneously removed some of the Permanent Holds from these members as part of cleanup efforts, which led to them getting enrolled in the program. The first case of this issue was not discovered until December 2024, the last month of the ESRD demonstration waiver, and so the decision was made to leave these members in the program, given they would be enrolled in the program come January 1st if they maintained coverage without the ESRD waiver special income budgeting.

Sunset Plan

In 2020, in partnership with the Indiana State Health Insurance Information Program (SHIP), OMPP sent a letter to all ESRD demonstration waiver participants as well as non-waiver participants who were on Medicaid and diagnosed with ESRD. Letters were mailed to 224 waiver and 4,608 non-waiver enrollees. The letters contained information on Medicare Advantage and open enrollment, which took place from October 15, 2020 to December 7, 2020. OMPP also sent written reminders to ESRD demonstration enrollees about the upcoming "Annual Fall Enrollment Period" for first time enrollment in Medicare Advantage (i.e., October 15 through December 7 of each year). Enrollment during the Fall Enrollment Period went into effect on January 1 of the following year.

In November 2023, OMPP notified providers about the sunset of the ESRD section 1115 demonstration and actions required to prepare for the end of the demonstration program. OMPP then sent written notices to ESRD demonstration enrollees regarding the sunset, their beneficiary rights in accordance with federal Medicaid requirements, and likely available options for accessing other healthcare coverage prior to the end of the demonstration. Follow-up and reminder notifications were sent to providers throughout 2024, and final written reminder notices were sent to members.

Over the past 18 months, OMPP has conducted several activities to ensure an orderly sunset of the ESRD section 1115 demonstration and continued beneficiary coverage. The table below describes these activities.

Sunset Activities
Provided tribal notice on the termination and plan to sunset the federal section 1115 authority for the ESRD section 1115 demonstration which was posted on the FSSA website for a 30-day public comment period. FSSA published the notice in state register.
Sent written reminders to ESRD demonstration enrollees and their authorized representatives about the "Open Enrollment Period" for first time enrollment in Medicare Advantage (i.e., October 15 through December 7 of each year).
Notified providers about the sunset of the ESRD section 1115 demonstration and actions required to prepare for the end of the demonstration program effective December 31, 2024.
Sent written notices to ESRD demonstration enrollees about the sunset of the ESRD section 1115 demonstration, to include their beneficiary rights in accordance with federal Medicaid requirements, and available options to access other healthcare coverage (including information on the ex parte redeterminations and open enrollment periods for Medicare Advantage) prior to the end of the demonstration.
Beginning in April 2024, SHIP conducted outreach to members via phone to provide benefits counseling and answer any other questions they have about ESRD Waiver Sunset.
Conducted necessary programming/coding changes, including closure notices to affected beneficiaries with appeal rights, in the state Medicaid Statistical Information System (MMIS), Medicaid eligibility system, and the Indiana Health Coverage Programs (IHCP) provider reference modules for billing and reimbursement.
Provided follow-up/reminder notifications to providers about the sunset of the ESRD section 1115 demonstration and any actions required to prepare for the end of the demonstration program effective December 31, 2024. This included Lunch and Learn presentation, emailing ESRD providers directly, and posting a provider bulletin.
Beginning in August 2023, regularly monitored phaseout progress by reviewing changes in ESRD enrollment counts to ensure that no additional enrollment occurred after July 1, 2024, and MA enrollment counts to ensure that enrollment was increasing ahead of January 1, 2025 effective end date. OMPP met with SHIP regularly to discuss trends they noticed and to adjust member outreach approach as needed.
Sent final written reminder notice to beneficiaries about the sunset of the ESRD section 1115 demonstration and the "Annual Fall Enrollment Period" for first time enrollment in Medicare Advantage (i.e., October 15 through December 7 of each year).
Sent final closure eligibility notices to affected beneficiaries prior to the effective date of closure.
Monitored hearings and appeals through resolution, manually checked each case to ensure MCE exclusion was removed afterward to avoid any future problems with service delivery should they be determined eligible for a managed care program in the future.

Prior to the final sunset, a member's disenrollment from ESRD coverage, FSSA leveraged the eligibility system to explore eligibility for that member in any other Indiana Medicaid categories of assistance. The system reviews potential eligibility based on established categorical requirements, which vary according to specific income and resource requirements, as well as family circumstances, within each category. The hierarchy used for reviewing eligibility employs a failure logic, starting with the most comprehensive scope of coverage available to the member and progressing through lesser levels of coverage. If a

member was deemed ineligible for any category, they receive a notice of closure with their appeal rights listed.

Although the ESRD phaseout plan stipulated that HIP Workforce Bridge authority was to be transferred to the HIP 2.0 Waiver, approved in October 2024, CMS informed OMPP that the Bridge authority could no longer be transferred to the HIP 2.0 waiver due to pending HIP litigation. Indiana was given the option to let the HIP Workforce Bridge authority expire after December 31, 2024, or to be granted a one-year temporary extension, with the option to rename the ESRD waiver to the HIP Workforce Bridge 1115 Waiver, without requiring a renewal application or a public comment period. Indiana opted for the latter. CMS added an STC in the temporary extension that allows Indiana the flexibility to make a midcourse correction to avoid falling outside of budget neutrality.

Program Sunset Successes

During the sunset, OMPP identified several areas for improving processes and collaboration that contributed to the success of the sunset, which are described below.

Collaboration with SHIP

OMPP met with SHIP to determine the support, materials, resources, and other considerations SHIP needed from OMPP in order to conduct member outreach. This included detailed eligibility information for other IHCP programs for which current ESRD recipients may be eligible, guidance on routing ESRD enrollee questions not covered by SHIP, and updates on the plan and timeline for initiating calls. A Business Associate Agreement (BAA) was also created, allowing OMPP to share ESRD member-protected health information (PHI) with SHIP for conducting member outreach and prioritizing outreach efforts. SHIP provided input on communications to ESRD members to better notify them of upcoming calls from SHIP, Medicare Advantage open enrollment periods, notification of ESRD waiver sunset, and the availability of benefits counseling. SHIP identified the benefits and service advantages for individuals who transition from traditional Medicare Part A/B to Medicare Advantage, taking into consideration the combined benefits under Medicare Part A/B and Medicaid under the ESRD demonstration, as well as the benefits under the Medicare Advantage Plan alone. SHIP counseling was not limited to Medicare Advantage—if there were other available resources for which the enrollees may qualify, they were provided with information about those as well. To better inform member outreach efforts, OMPP generated a report of all ESRD members who already had a Medicare Advantage plan, enabling SHIP to discuss with them whether their current plan would meet their needs after waiver sunset. In total, SHIP made outreach calls to 149 ESRD members. Of the total 149 outreach calls, 90 were geared towards members who already had Medicare Advantage plans.

We were able to identify potential issues with Pathways implementation during our calls with SHIP. They informed us that during outreach calls, they were hearing from members who had received Pathways introductory letters, indicating that they would be switched to Pathways soon. Because of that, OMPP was able to adjust the logic they were using to identify ESRD Waiver recipients in order to exclude them from MCE and Pathways assignment.

Collaboration with Division of Family Resources (DFR) Central Authorization Unit (CAU)

When developing the ESRD demonstration sunset plan, it was identified that the eligibility notices generated by IEDSS when coverage is closed and when the category changes were missing elements

required by federal statute. Specifically, notifying members of their right to an expedited appeal if they have a health condition that could be adversely affected by waiting for a hearing for resolution, and providing an explanation of what is included in the coverage to which the member is transitioning. In addition to these issues, OMPP sought to address the following:

- DFR eligibility staff education about and awareness of the sunset of the ESRD Waiver and associated timelines.
- How to document member communication and outreach leading up to the sunset since those documents were not sent through IEDSS and the phone calls were not documented in case notes.
- Sending manual eligibility notices to ensure all required information was included.
- How to ensure no ESRD cases were missed in mass change exceptions since the program eligibility changes were systematically applied via IEDSS.
- How to ensure that claims paid during continued benefits for any appeals were paid through fee-for-service (FFS) and members were not accidentally enrolled in Pathways and assigned to a managed care entity since IEDSS would not recognize the ESRD waiver after December 31, 2024.
- How to clearly identify the status of the member's case for new staff assigned to the case.
- Information to provide to members calling in about loss of ESRD coverage, including how to appeal and the contact information for SHIP for benefits counseling.

OMPP identified that the CAU could provide support in addressing these issues, such as ensuring that all ESRD IEDSS cases are handled so that eligibility can be determined in any other category, that case records include all necessary documentation, and that next actions are clearly identified for staff working on the case. DFR and IEDSS removed the ESRD logic from the IEDSS test system and ran a report to share with OMPP the categories of coverage and closures expected once the system changes went live, in order to inform the types of member outreach needed and to confirm OMPP's assumptions about the impact of sunsetting the waiver.

Additionally, OMPP worked with DFR to engage the CAU for assistance with sending manual notices and developing an interim process for expedited appeals. Since a manual process was required to monitor appeals through their resolution, OMPP opted to provide continued benefits to all former recipients who appealed. OMPP reviewed a daily report from DFR that showed all of the appeals received against the list of ESRD enrollees to identify the appeals from the ESRD population, provided continued benefits within the appeal timeframe, tracked appeals through resolution/decision, placed a managed care exclusion on the cases receiving continued benefits and removed those exclusions after resolution/decision to ensure future coverage can be delivered appropriately.

Program Sunset Challenges

Though the sunset provided opportunities for improvement, it did not come without its challenges. The manual monitoring of appeals to make sure they received coverage was time consuming. Additionally, eligibility had to be determined manually by DFR prior to the transition from ICES to IEDSS. In ICES, all financial calculations, including income, resources, spend-down amount, and allocations, had to be completed offline. If the member passed eligibility, the coverage had to be approved via a fiat, which is a multi-step manual authorization using a specific reason code that allowed the demonstration population to be identified for CMS waiver reporting and program monitoring. When Indiana converted from ICES

to IEDSS, the eligibility determination process for ESRD no longer included consideration for identifying the ESRD demonstration population.

Limited understanding of the impact of PHE on the ESRD program was also a challenge. Cost sharing was paused for ESRD enrollees during PHE. Liabilities differ from cost-sharing, so they should still have been imposed for the same months as all other long-term care programs' liabilities. By the time OMPP discovered that the ESRD enrollees had not been required to pay liabilities by CoreMMIS, the system change required to restart them would have taken longer than the remainder of the demonstration period and may have caused member and provider confusion. Thus, the decision was made to not resume payments for the few remaining months of the program.

Another challenge that presented itself due to the PHE was the lack of reliable contact information for ESRD members. Under normal operations, any member receiving benefits was required to report any changes, including a change of address, within a timely manner for change processing and/or at the time of their annual redetermination. During the PHE, redeterminations were not required to be completed, and closures of coverage were only allowed in the case of death, moving out of state, or voluntary withdrawal from assistance. Due to these requirements for maintenance of eligibility (MOE) coverage regardless of failure to report required changes or a change in circumstances which would make the individual ineligible, opportunities to update contact information were missed. Although reporting changes were still required, negative action could not be taken against a member for failing to report or verify a change. This impacted ESRD phaseout efforts as confidence in the current contact information available for the demonstration population was low. OMPP manually reviewed contact information in the eligibility systems when faced with returned mail sent by OMPP informing members of the phaseout of the ESRD waiver. OMPP tracked returned mail, completed manual research in IEDSS to locate current information via electronic Interface verification, and remailed communications as needed. They also reported changes to DFR so that the correct contact information could be updated.

Budget Neutrality

CMS mandates that any demonstration project under section 1115 of the Act must maintain budget neutrality for the federal government. To determine budget neutrality, CMS applies a budget neutrality test to each demonstration, which sets limits on the federal Medicaid funding a state can receive during the approval period of the demonstration. This test checks whether spending on the demonstration exceeds the predetermined limit. Budget neutrality entails the overall computable state and federal costs for authorized demonstration expenses, which must stay within a specified amount during the approval period. This specified amount is referred to as the budget neutrality expenditure limit and is derived from projections of Medicaid expenditures that would have occurred without the demonstration.[3]

[3] Budget Neutrality for Section 1115(a) Medicaid Demonstration Projects. Accessed at https://www.medicaid.gov/federal-policy-guidance/downloads/smd24003.pdf

Standardized data is collected with a budget neutrality workbook template to determine financial performance for the demonstration in terms of budget neutrality.[4] An actuary subcontractor developed the 1115 waiver budget neutrality report that is submitted on a quarterly basis to CMS by the state. An updated budget neutrality spreadsheet, "04-Q4 2024 IN BN Workbook - ESRD - 1115 PMDA-20240506 v2.13.xlsm" was submitted to the Performance Metrics Database and Analytics (PMDA) portal on April 4, 2025, reflecting data through December 31, 2024.

The workbook has two major groups of tabs: the first group collects and calculates Without Waiver (WOW) numbers, and the second group calculates With Waiver (WW) numbers. Data is collected per demonstration Medicaid Eligibility Group (MEG), by demonstration year (DY). Enrollment and encounter expenditures for DY 9 through DY 17 (Calendar Year [CY] 2016 through CY 2024) were estimated based on enrollment, capitation payment, and claims data reported through the State of Indiana's Enterprise Data Warehouse (EDW) and originally provided by the fiscal agent. FFS enrollment and expenditure data reflect services paid through December 31, 2024. Managed care enrollment and capitation data reflect information paid through December 31, 2024.

ESRD Waiver Population:
Member months were summarized from the EDW according to the list of individuals in the ESRD waiver including their effective dates within the program. These members were stratified by MEG, as described below:

1. Population 1 (Grandfathered) – enrolled in Medicaid spend down effective May 31, 2014.
2. Population 2 – enrolled after May 31, 2014 and have income between 150 and 300% FPL.

Costs of ESRD waiver members include two components: claims expenditures and Medicare Part B premiums. For Grandfathered MEG, the first eight months of DY 17 (January 2024 to August 2024) were utilized to estimate the average per member per month (PMPM) for DY17. Similarly, for the Non-Grandfathered MEG, the first eight months of DY 17 (January 2017 to August 2024) were utilized to estimate the average PMPM for DY 17. In addition to encounter expenditure, there are additional costs for the members in this waiver outside of the claims system. One of these is the payment of the member's monthly Part B premium. The value of this benefit ranges from $121.80 PMPM in CY 2016 to $170.10 PMPM in CY 2022, with the CY 2023 premium decreasing to $164.90 PMPM and the CY 2024 premium increasing to $174.70 PMPM.

The two components described above are summed up to determine overall PMPM costs for each MEG over time. These PMPMs are then multiplied by the total member months to calculate aggregate expenditures for each DY. More detailed descriptions regarding the budget neutrality calculations can be found in the spreadsheet submitted in PMDA.

[4] Budget neutrality workbook template and additional resources can be accessed at https://www.medicaid.gov/medicaid/section-1115-demonstrations/budget-neutrality/index.html