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February 2018 | Issue Brief

Approved Changes in Indiana's Section 1115 Medicaid Waiver Extension

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On February 1, 2018, the Centers for Medicare and Medicaid Services (CMS) approved an amended extension of Indiana's Healthy Indiana Program 2.0 (HIP 2.0) Section 1115 demonstration waiver. Indiana's waiver initially implemented the ACA's Medicaid expansion from February, 2015 through January, 2018 by modifying Indiana's pre-ACA limited coverage expansion waiver (HIP 1.0). Unlike other states that implemented the ACA's Medicaid expansion through a waiver, Indiana's demonstration also changes the terms of coverage for non-expansion adults (low-income parents and those eligible for Transitional Medical Assistance, TMA). The February, 2018 extension continues most components of HIP 2.0 and adds some new provisions.

Key provisions of HIP 2.0 that continue under the waiver extension include:

- Charging monthly premiums, paid into a health account, for expansion adults and low-income parents;
- Disenrolling and imposing a 6-month coverage lock-out on those with incomes from 101-138% FPL who fail to pay premiums after a 60-day grace period;
- Delaying coverage until the 1st premium payment, or for those from 0-100% FPL, after the expiration of the 60-day payment period; and
- Enrolling adults who pay premiums in HIP Plus, an expanded benefit package with co-payments only for non-emergency use of the ER. Beneficiaries at or below 100% FPL who fail to pay premiums receive HIP Basic, a more limited benefit package with state plan level co-payments for most services.

Key changes to HIP 2.0 approved on February 1, 2018 include:

- Increasing premiums by 50% for all tobacco users beginning in their second year of enrollment;
- Conditioning Medicaid eligibility for most adults on meeting a work requirement beginning in 2019;
- Disenrolling most adults who do not timely complete the eligibility renewal process; in addition, expansion adults are locked out of coverage for 3 months;
- Changing premiums to a tiered structure instead of a flat 2% of income; and
- Restricting TMA eligibility to 139-185% FPL; those who otherwise would have qualified for TMA up to 138% FPL instead will be treated like expansion adults under the waiver for premiums and benefits.

The February, 2018 waiver extension also waives the "institution for mental disease" (IMD) payment exclusion for short-term SUD treatment services for all Medicaid adults ages 21-64.

The waiver extension does not continue the demonstration authority to test graduated copayments up to $25 for non-emergency use of the ER (instead, non-emergent use of the ER is subject to an $8 copay, which is within statutory limits with no waiver required). The waiver extension also does not continue the previous authority to use Medicaid as premium assistance for those with employer-sponsored insurance.

Indiana is the first state to receive approval to impose a premium surcharge for tobacco users. Indiana is the second state to receive authority to impose a work requirement as a condition of Medicaid eligibility following CMS's guidance released on January 11, 2018, and approval of the Kentucky waiver on January 12, 2018. Similar to Kentucky, Indiana requires payment of the initial premium (or expiration of the 60-day payment period for those at or below 100% FPL) prior to starting coverage and imposes a lock-out for failure to pay premiums as well as a lock-out for failure to timely renew coverage.

As with Kentucky's waiver, no operational protocols are required for Indiana to implement the new work requirement, a provision that is likely to have significant implications for beneficiaries' ability to retain coverage for which they are eligible. While Indiana's waiver includes numerous exemptions for certain individuals and good cause exceptions, as well as "state assurances" about implementation, these provisions are complex and will require administrative staff time and resources and sophisticated systems to implement. In addition, Indiana had requested changes to its healthy behavior incentive program that would include "completion of specified outcome milestones and targets"; however, these provisions are not discussed in the waiver renewal so it is unclear if these state is planning to move ahead with these changes. Implementation of new waiver provisions and understanding the impact of the waiver on enrollment, program costs and administrative costs will be important areas to watch. This fact sheet summarizes key provisions of Indiana's approved waiver. Specific details are included in Table 1.

Table 1: Indiana's Section 1115 Medicaid Expansion Demonstration Waiver Provisions	
Element	**Indiana Waiver Provision, as approved and amended, 2/1/18**
Overview:	Indiana's waiver initially implemented the ACA's Medicaid expansion from February, 2015 through January, 2018, by requiring most expansion adults with incomes from 101-138% FPL to pay monthly premiums by contributing to a Personal Wellness and Responsibility (POWER) health account. Coverage does not start until the 1st premium payment, or, for those from 0-100% FPL, after the expiration of the 60-day payment period. All expansion adults who pay premiums are eligible for HIP Plus, an expanded benefit package with co-payments only for non-emergency use of the ER. Those with incomes from 101-138% FPL who fail to pay premiums after a 60-day grace period are disenrolled from coverage and barred from re-enrolling for 6 months. Beneficiaries with incomes at or below 100% FPL who fail to pay premiums after a 60-day period receive HIP Basic, a more limited benefit package with state plan level co-payments. The waiver also allowed non-expansion parent/caretakers to pay premiums in lieu of co-payments for state plan. Indiana's waiver was extended and amended for February, 2018 through December, 2020. Key changes to the main demonstration program, HIP 2.0, for expansion adults and low-income parent/caretakers include conditioning Medicaid eligibility on meeting a work requirement, imposing a 3-month coverage lockout on beneficiaries who do not timely complete the eligibility renewal process, increasing premiums by 50% for tobacco users beginning in their second year of enrollment, changing premiums to a tiered structure instead of a flat 2% of income, requiring parents who would have qualified for Transitional Medical Assistance up to 138% FPL to pay premiums like expansion adults, and eliminating demonstration authority to test graduated copays up to $25 for non-emergency use of the ER. (Instead, non-emergent use of the ER is subject to an $8 copay which is within statutory limits with no waiver required). The waiver extension also waives the IMD payment exclusion for short-term SUD treatment services for all Medicaid adults ages 21-64.
Duration:	2/1/18 to 12/31/2020
Coverage Groups:	Covers adults ages 19-64 with incomes from 0-138% FPL, including non-expansion (§ 1931) parent/caretakers, those eligible for Transitional Medical Assistance (TMA, formerly eligible as § 1931parent/caretakers), pregnant women, and adults newly eligible through the ACA's Medicaid expansion (nearly 397,000 beneficiaries statewide as of Dec. 17, 2017). Under the waiver extension, the TMA group now includes former parent/caretakers with incomes from 138-185% FPL (instead of all those above the § 1931parent/caretaker income limit up to 185% FPL). Former parent/caretakers up to 138% FPL who otherwise would have qualified for TMA will instead enroll in HIP Basic or HIP Plus like expansion adults. The extension also adds pregnant women up to 138% FPL to HIP 2.0. Excludes children, seniors, and dual eligible beneficiaries. American Indian/Alaska Natives may opt out of the demonstration 30 days after enrollment. Newly eligible AI/ANs who remain in the demonstration have the more generous (HIP Plus) benefit package, with coverage effective on the date of application, and no premiums or co-payments.
Coverage Effective Date:	Waives reasonable promptness so that HIP Plus coverage begins on the first day of the month in which a beneficiary makes an initial premium payment instead of the date on which beneficiary is determined eligible for Medicaid (retroactive to the application date). Beneficiaries have 60 days from the date of their eligibility determination to make this payment. However, different provisions apply to individuals determined presumptively eligible (described below). For those at or below 100% FPL who do not pay premiums, HIP Basic coverage begins on the first day of the month in which the 60-day premium payment period expires. Once in HIP Basic, beneficiaries cannot move to HIP Plus until eligibility renewal, receipt of rollover funds (described below) or at other times designated by the state. Under the waiver extension, those who move from another Medicaid coverage group (not subject to the waiver) into HIP 2.0, will immediately be enrolled in HIP Basic and then have 60 days to choose to pay a premium and enroll in HIP Plus.
Fast Track Payments:	Effective April 1, 2015, state allows for an optional $10.00 fast track initial POWER account pre-payment that makes enrollment effective the first day of the month in which payment is received, once a beneficiary is determined eligible. However, the beneficiary cannot change MCOs for a year after making a fast track payment. The fast track payment is refundable if the applicant is determined ineligible. If the beneficiary's regular monthly premium is less than $10.00, the MCO shall credit the remaining portion of the fast track payment to subsequent premium payments. If the

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	beneficiary's regular monthly premium is more than $10.00, the beneficiary will be billed the difference on the next POWER account invoice.
Presumptive Eligibility:	State shall include FQHCs, RHCs, CMHCs, and health department sites in an expanded presumptive eligibility program. Presumptive eligibility enables applicants to receive Medicaid-covered services as of the date that a qualified provider entity preliminarily determines that the applicant is financially and categorically eligible for Medicaid, while the final eligibility determination is pending with the state Medicaid agency. Under the waiver extension, individuals determined presumptively eligible will maintain Medicaid coverage until the last day of the month following the presumptive eligibility determination, unless they submit an application for a full Medicaid eligibility determination. Those who receive a full Medicaid eligibility determination after having been determined presumptively eligible will move to HIP Basic on the first of the month following their application approval, with no gap in coverage, and will have 60 days from the date that they were eligible to make a Fast Track payment (following application filing) to pay a premium. The state has the option to reclassify presumptively eligible individuals as eligible in the expansion group for up to 3 months prior to their effective coverage date (date of first premium payment or for those at or below 100% FPL, the expiration of 60-day payment period), and terminate eligibility for premium non-payment within 60 days for those above 100% FPL.
Retroactive Coverage Transition Program:	Waives retroactive coverage of services incurred during the 90 days prior to Medicaid eligibility except for pregnant women. The waiver extension eliminates the prior claims payment program that previously covered retroactive bills for non-expansion parent/caretakers.
Lock-Out for Noncompliance with Renewals*:*	Under the waiver extension, all beneficiaries (except those who are pregnant or 60 days post-partum) who do not provide necessary information or documentation to complete the eligibility renewal process are disenrolled from coverage but can re-enroll without a new application if they provide verification within 90 days of disenrollment. After 90 days of disenrollment, expansion adults are locked out of coverage for another 3 months and cannot re-enroll unless they are exempt or provide verification of good cause. People who are medically frail, those who become pregnant, and non-expansion low-income parents are disenrolled for failure to comply with redeterminations but not subject to the 3-month lockout. Qualifying good cause events include: obtained and subsequently lost private coverage; lost income after disqualification due to increased income; moved to another state and then returned; domestic violence; residing in disaster area in 60 days prior to disenrollment; hospitalized, otherwise incapacitated, or has a disability and as a result was unable to comply during the entire 90-day period, or did not receive needed reasonable modifications, or there were no reasonable modifications that would have enabled compliance; an immediate family member in the home was institutionalized or died during the reporting period, or caretaking or other disability-related responsibilities for an immediate family member living in the home prevented compliance; and additional circumstances deemed necessary by the state.
Delivery System and Health Savings Accounts:	Services provided by MCOs. MCOs also must bill and collect premiums from beneficiaries. Each demonstration enrollee has a health account called a POWER account. POWER accounts are jointly funded by beneficiary premiums and the state. POWER account funds are used to fund the first $2,500 of covered claims, except for preventive services required by 42 USC § 300gg-13,[i] the cost of which are not charged against POWER account funds. Other preventive services are covered, subject to a $500 annual cap, and are charged against POWER account funds. Enrollees have a Jan.-Dec. calendar year benefit period. MCO selection and the POWER account remain active for the entire calendar year, even if individuals experience a gap in coverage. State pays capitated rate to MCOs for services after the $2,500 POWER account funds are exhausted. The process for collecting POWER account contributions is governed by an operational protocol.
Beneficiary Premiums:	Monthly premiums apply to all beneficiaries from 0-138% FPL based on income and are at least $1.00. Premiums are a condition of eligibility only for non-medically frail, non-pregnant beneficiaries from 101-138% FPL. Under the waiver extension, tobacco users will have a premium surcharge equal to a 50% increase in their monthly contribution amount after the 1st year of enrollment. Health plans shall conduct active outreach and member education related to tobacco-cessation benefits. The tobacco surcharge will

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	be removed from the following benefit year's contribution amount if a beneficiary informs the state that they have stopped using tobacco. Under the waiver extension, premiums change to the following tiered structure (instead of flat 2% of income): 0-22% FPL (0-$223/month for an individual in 2018) = $1.00/individual, $1.00/spouse 23-50% FPL ($233-$506/month) = $5.00/individual, $2.50/spouse 51-75% FPL ($516-$759/month) = $10.00/individual, $5.00/spouse 76-100% FPL ($769-$1,012/month) = $15/individual, $7.50/spouse 101-138% FPL ($1,022-$1,397/month) = $20/individual, $10.00/spouse Cost-sharing (both premiums and co-payments) limited to 5% of quarterly household income. Beneficiary premium amounts are adjusted at annual renewal and anytime the state is made aware of an income change during the current coverage period. Beneficiary premiums shall be reduced by any POWER account contributions made by third parties, such as employers or non-profit organizations.
State Contributions:	The state funds the difference between the beneficiary's monthly premiums and the full $2,500 POWER account value. The state will make an initial $1,300 account contribution upon the beneficiary's MCO enrollment, and any additional amount owed by the state to the MCO for services provided to the beneficiary shall be reconciled after 12 months.
Consequences of Premium Non-Payment:	Expansion adults from 101-138% FPL who do not make a premium payment within a 60-day grace period are disenrolled from coverage and locked out for six months. Prior to disenrollment, the state shall review all other bases of Medicaid eligibility and notify the beneficiary about the option to request a medical frailty determination, and the MCO must provide 2 written notices about the delinquent payment. Beneficiaries who are disenrolled for non-payment of premiums are not subject to the lock-out if they re-apply with verification of non-payment due to a "qualifying event," such as obtaining and subsequently losing private coverage, losing income after disqualification due to increased income, moving to another state and then returning, experiencing domestic violence, residing in a county subject to a disaster declaration in the 60 days prior to termination for non-payment, medical frailty, or other circumstances deemed necessary by the state. Individuals who never make their initial premium payment are not subject to the 6 month lock-out. Expansion adults from 101-138% FPL who are medically frail who do not pay premiums are not terminated from coverage. Instead, these beneficiaries must continue to have access to the state plan benefit package,[ii] are subject to state plan co-payments for services, and continue to be billed for premiums. Expansion adults at or below 100% FPL who do not make an initial premium payment within 60 days of their eligibility determination or who do not make a subsequent premium payment within the 60-day grace period are automatically enrolled in the HIP Basic plan. These beneficiaries will be subject to state plan co-payments for services, which may exceed the cost of monthly premiums applicable under HIP Plus. Non-expansion parent/caretakers and newly eligible adults at or below 100% FPL who are medically frail who do not pay premiums retain their existing benefit package (described below) and are subject to state plan co-payments. Pregnant women who do not pay premiums retain access to the state plan benefit package and do not have copays. Under the wavier extension, low-income parent/caretakers who previously would have qualified for TMA (based on income above the parent/caretaker limit) up to 138% FPL instead must pay premiums to access HIP Plus. TMA is restricted to enrollees from 139-185% FPL; this group qualifies for HIP coverage for up to 12 months. If their income remains between 139-185% FPL after the first 6 months of TMA eligibility, they can continue to receive HIP for another 6 months as long as they pay premiums.
Debts/Refunds Upon Disenrollment:	Payment of unpaid premiums is not a condition of Medicaid re-enrollment but may be owed as a debt.[iii] MCOs may attempt to collect unpaid premiums from beneficiaries but may not report debt to collection agencies, place a lien on beneficiary's home, refer cases to debt collectors, file a lawsuit, seek a court order to garnish wages, or sell the debt to a third party for collection.

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	If beneficiaries have paid excess premiums,[iv] they are owed a refund, subject to a 25% penalty if the beneficiary is terminated for non-payment of premiums.
Healthy Behavior Incentives:	HIP Plus beneficiaries who make timely premium payments will be eligible to rollover their share of the unused POWER account balance at the end of 12 months. If the beneficiary completes age and gender appropriate preventive services, the rollover balance for HIP Plus beneficiaries will be doubled by the state, not to exceed the beneficiary's total premium payments for the year. HIP Basic beneficiaries can rollover unused POWER account funds, up to 50% of the amount of premiums required for HIP Plus, if they obtained unspecified age and gender appropriate preventive services. Rollover funds can be used to reduce the required beneficiary premiums in the subsequent year. Debts may be collected from rollover account balances.
Co-Payments for Non-Emergency Use of the ER:	Enrollees who pay premiums are not subject to copayments except for non-emergency use of the ER at the state plan amount ($8). The waiver extension eliminates the Section 1916 (f) authority to test graduated copays up to $25 for non-emergency use of the ER.
Work Requirement:	Under the waiver extension, meeting a work requirement in 8 out of 12 months is a condition of eligibility as of 2019 for most HIP adults. Those eligible for Medicaid for less than a full year will still have 4 months of the year in which they do not have to comply. Required participation hours are as follows: 1-6 months – no weekly hour requirement 7-9 months – 5 hours/week 10-12 months – 10 hours/week 13-18 months – 15 hours/week 18+ months – 20 hours/week If enrollees exceed their hourly requirement in a week, they can apply extra hours to other weeks in the same month. Non-exempt beneficiaries must document their participation online, by phone, by mail, in person or by other commonly available electronic means and can use self-attestation at state option. Work activities include but are not limited to: -Subsidized or unsubsidized employment -Job search -General education (high school, GED, community college, college, graduate education) -Accredited ESL education -Accredited homeschooling -MCO employment initiatives -Job skills training -Education related to employment (e.g., employer subsidized classes) -Vocational training/education -Community work experience -Participation in Gateway to Work (referral to available employment, work search, and job training programs) -Community/public service -Volunteer work (e.g., classroom volunteer, faith-based internship work or mission trips sponsored by recognized religious institution) -Caregiving for nondependent relative or other person with chronic disabling health condition, including those receiving FMLA -Meeting or exempt from SNAP work requirements -Members of the Pokagon Band of Potawatomi and participating in the tribe's Pathways program -Any other beneficiary participating in a workforce participation program that the state has determined will promote full employment and meet the goals of Indiana's community engagement initiative Enrollees are exempt from the work requirement for a given month if they are: -Full or part-time students -Pregnant -Primary caregiver of dependent child below mandatory education age or dependent with a disability -Medically frail (serious & complex medical condition, chronic SUD, disability determination)

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	-Have a temporary illness or incapacity documented by a third party -In active substance use disorder treatment -Over age 59 -Homeless -Incarcerated in the last 6 months -Eligible for Medicaid in a coverage group other than parent/caretakers, expansion adults, TMA, or pregnant women -Meet or exempt from TANF work requirements -Receiving Medicaid premium assistance for ESI -Determined eligible for a good cause exemption Good cause exemptions will include at least the following verified circumstances: -People with disabilities defined by the ADA/504/1557 who were unable to comply for a reason related to the disability -People with an immediate family member in the home with a disability who were unable to comply for a reason related to the family member's disability -Beneficiary or immediate family member in the home has a hospitalization or serious illness -Victim of domestic violence -Additional circumstances as the state deems necessary. Work requirement hours for the prior year will be reviewed for all enrollees each December. Medicaid coverage for non-exempt beneficiaries who do not comply with work requirements will be suspended effective the 1st day of the new calendar year and remain suspended until the beneficiary's renewal date at which point they will be disenrolled if they are not meeting the requirement or exempt. Those with suspended eligibility can reactivate eligibility by becoming eligible in a Medicaid coverage group that is exempt from the work requirement; meeting an exemption or good cause; or by completing 1 month of required hours. Those who complete 1 month of required hours have eligibility re-established in the month following notice to the state of their compliance. The state must provide reasonable accommodations for people with disabilities under the ADA, Section 504 and Section 1557 to enable them to have an equal opportunity to participate in the work requirement. The state also must provide reasonable modifications to program procedures, such as assistance with demonstrating good cause, appealing suspensions, providing documentation, understanding notices and rules. Reasonable modifications must include exemptions for people unable to participate due to disability-related reasons, modifications to the number of hours required, and the provision of support services necessary to participate. The state should evaluate individuals' ability to participate and the types of reasonable modifications and supports needed. The state must make good faith efforts to connect enrollees with existing community supports that are available to assist in meeting the work requirement, including available non-Medicaid assistance with transportation, child care, language access services and other supports, and make good faith efforts to connect people with disabilities with services and supports necessary to enable them to comply. According to CMS guidance, Medicaid funds cannot be spent on employment support services. The state must assess areas that experience high rates of unemployment, areas with limited economies and/or educational opportunities, and areas with lack of public transportation to determine whether there should be further exemptions and/or additional mitigation strategies so that the work requirement will not be impossible or unreasonably burdensome for beneficiaries to meet. The state must assess whether people with disabilities have limited job or other opportunities for reasons related to a disability and address those barriers. The state shall provide timely written notice about when the work requirement begins; whether an enrollee is exempt, how to indicate to the state that they are exempt, and under what conditions the exemption would end; the specific number of hours per week required and how and when the beneficiary must report participation; specific information about how participation will be assessed at the end of the calendar year; the specific activities to satisfy the work requirement; resources that help connect beneficiaries to opportunities for activities that would meet the work requirement and community supports available to assist beneficiaries in meeting the requirement; how hours will be counted and documented; what gives rise to a suspension and how it could affect renewal, how to apply for good cause; how eligibility will be denied and terminated at renewal if in suspension status; how to appeal disenrollment; whether a beneficiary is out of compliance and the

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	consequences; how to appeal a suspension and have a suspension lifted; any differences between TANF and SNAP requirements and the Medicaid work requirement; whether a good cause exemption has been approved or denied, the explanation for good cause decisions, and how to appeal.
Benefit Packages:	Expansion adults 0-138% FPL who pay premiums receive HIP Plus, an ABP that includes the ACA's essential health benefits and covers more services (including vision, dental, and chiropractic coverage, and more generous prescription drug coverage) than HIP Basic. Expansion adults at or below 100% FPL who do not pay premiums (other than American Indian/Alaska Natives) receive HIP Basic, an ABP that includes the ACA's essential health benefits but with fewer covered services (no vision or dental and less generous prescription drug coverage) compared to HIP Plus. HIP Basic includes all EPSDT services for 19 and 20 year olds, consistent with federal law. Expansion adults who are medically frail receive an ABP that is equivalent to the state plan benefit package.[v] Non-expansion parent/caretaker relatives and those receiving Transitional Medical Assistance (139-185% FPL in their 1st 6 months of TMA) receive the Medicaid state plan benefit package. Those receiving TMA (139-185% FPL in their 2nd 6 months of TMA) must pay premiums and receive HIP Plus. Pregnant women receive state plan benefits during their pregnancy and 60 days post-partum and then transition back to HIP Plus (if they pay premiums) or HIP Basic. (Benefit package contents are specified in state plan amendments, not the waiver terms and conditions.)
SUD Services in IMDs:	The waiver extension includes an SUD program that applies to all Indiana Medicaid enrollees. Specifically, the IMD payment exclusion is waived for "short-term residents" who are primarily receiving SUD treatment and withdrawal management services provided in IMDs to adults ages 21-64 (no explicit day limit). These provisions are effective upon CMS approval of the SUD implementation protocol (approved 2/1/18). IMD services will include residential treatment, withdrawal management, and contingent on SPA approval, opioid treatment program services and addiction recovery management services.
Non-Emergency Medical Transportation:	Waives non-emergency medical transportation (NEMT) for expansion adults, except 19 and 20 year olds subject to EPSDT, pregnant women and those who are medically frail.
Process for Waiver Amendments:	Waiver amendments are subject to guidance published in a 1994 Federal Register public notice, instead of the ACA public notice and comment process. The 1994 public notice requires the state to do one of the following: (1) hold at least one public hearing with time for comment on the "most recent working proposal"; (2) use a commission or similar process with an open public meeting in proposal development; (3) submit results from enactment of a proposal by the state legislature that includes an "outline" of the proposal; (4) provide for formal notice and comment of at least 30 days under the state administrative procedures act; (5) post a notice of intent to submit a proposal in newspapers of general circulation and provide a mechanism for receiving a copy of the proposal and at least 30 days to comment; or (6) any other similar process for public input that would allow an interested party to learn about and comment on the proposal contents.
Next Steps:	SUD provisions: SUD monitoring protocol due by 7/1/18. SUD evaluation design due by 7/31/18. SUD mid-point assessment to be performed between DY 5 and 6. For the overall demonstration, a draft evaluation design is due by 7/31/18. The draft interim evaluation report is due at waiver renewal or 1 year prior to the demonstration's end. The summative evaluation report is due by 7/1/22 (18 months from STC end). The state also must submit 3 quarterly reports (due 60 days after the quarter ends) and 1 annual report (due 90 days after the DY ends) each year. The state must hold an annual public forum for comment on the demonstration's progress. There are no operational protocol requirements for implementation of the work requirement.
SOURCE: Healthy Indiana Plan, Special Terms and Conditions, #11-W-00296/5, effective Feb. 1, 2018-Dec. 31, 2020.	

NOTES: i- These include all services rated "A" or "B" by the U.S. Preventive Services Task Force, immunizations recommended by the CDC Advisory Committee on Immunization Practices, and services for infants, children, adolescents, and women supported by HRSA guidelines.

ii- Technically, these beneficiaries receive an ABP that is equivalent to the state plan benefit package.
iii- The debt is limited to the amount of the beneficiary's pro rata share of claims paid during the coverage period or amounts permissible under Medicaid cost-sharing rules for deductibles, whichever is less.
iv- Refunds are based on premium payments in excess of the beneficiary's pro rata share of claims at disenrollment.
v- Technically, these beneficiaries receive an ABP that is equivalent to the state plan benefit package.