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State/Territory Name: Indiana

State Plan Amendment (SPA) #: IN-15-0025-HIP Plus ABP

This file contains the following documents in the order listed:

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

October 29, 2015

Joe Moser, Director of Medicaid
Indiana Office of Medicaid Policy and Planning
402 West Washington Street, Room W374
Indianapolis, Indiana 46204

ATTN: Kelly Flynn

RE: IN SPA TN# 15-0025 – Alternative Benefit Package for Healthy Indiana Plan Plus (ABP – HIP Plus)

Dear Mr. Moser,

Enclosed for your records is an approved copy of the following State Plan Amendment (SPA).

Transmittal #15-0025:

- This SPA updates ABP2a - the Voluntary Benefit Package Selection Assurances and updates the supporting medically frail population identification methodology.
- This SPA updates ABP2c - Enrollment Assurances for Mandatory Participants.
- Effective Date: October 1, 2015

All requirements pertaining to ABPs must be met including but not limited to: benefits, payment rates, reimbursement methodologies, cost-sharing state plan pages, and (if applicable) managed care service delivery systems (waivers and contracts). Amendments to the state's approved Medicaid program (SPAs, waivers, contracts) may require corresponding amendments to the ABP if the change to the benefit in the approved state plan will be mirrored in the ABP.

If you have any questions, please have a member of your staff contact Tannisse Joyce at (312) 886-5121 or by email at tannisse.joyce@cms.hhs.gov.

Sincerely,

/s/
Ruth A. Hughes
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosure

cc: Jason Frandson, CMCS
Kelly Flynn, OMPP
Amber Swartzell, OMPP

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name:
Indiana

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

IN-15-0025

Proposed Effective Date

10/01/0015 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

42 C.F.R. 435.119; 42 C.F.R. 440, Subpart C

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2015	$ 0.00
Second Year	2016	$ 0.00

Subject of Amendment

Outlines the ABP for HIP Plus.

The 10/1/15 amendment modifies ABP 2a and 2c as well as the medically frail supplemental information.

Governor's Office Review

- ○ **Governor's office reported no comment**
- ○ **Comments of Governor's office received**

  Describe:

- ○ **No reply received within 45 days of submittal**
- ◉ **Other, as specified**

  Describe:

  Indiana's State Plan does not require Governor's Office review. Please see section 7.4 of the State Plan.

Signature of State Agency Official

Submitted By:
Amber Swartzell
Last Revision Date:
Oct 21, 2015
Submit Date:
Oct 5, 2015

PLAN APPROVED – ONE COPY ATTACHED

DATE RECEIVED: October 5, 2015
EFFECTIVE DATE OF APPROVED MATERIAL: 10/1/15
TYPED NAME: Ruth A. Hughes

DATE APPROVED: 10/29/15
SIGNATURE OF REGIONAL OFFICIAL: /s/
TITLE: Associate Regional Administrator

Alternative Benefit Plan

State Name: Indiana

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0025

OMB Expiration date: 10/31/2014

Alternative Benefit Plan Populations ABP1

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name: Healthy Indiana Plan (HIP) 2.0 Plus

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Adult Group	Mandatory	X

Enrollment is available for all individuals in these eligibility group(s). No

Targeting Criteria (select all that apply):

☒ Income Standard.

Income Standard:

○ Income standard is used to target households with income at or below the standard.

○ Income standard is used to target households with income above the standard.

The income standard is as follows:

◉ A percentage:

○ A specific amount

○ Federal Poverty Level.

○ SSI Federal Benefit Amount.

◉ Other.

Enter the Other percentage 133

Describe:

HIP Plus is the benefit option for all eligible individuals with income up to and including 133% of the federal poverty level (FPL) as based on MAGI income standards who make a contribution to their Personal Wellness and Responsibility (POWER) account.

A woman who becomes pregnant while enrolled in the HIP Plus Plan may choose to transfer to the pregnancy Medicaid aid category. If she stays in HIP Plus, she may keep her HIP Plus benefits through the term of her pregnancy and postpartum period. Pregnant women receive additional benefits in Plus that are only available to pregnant women. For pregnant women, there is no material difference between the benefits covered under the pregnancy Medicaid aid category and the HIP Plus benefits. Women who are pregnant at their annual redetermination are not eligible to remain in HIP Plus and will be transfered to the pregnancy Medicaid aid category.

☐ Disease/Condition/Diagnosis/Disorder.

☒ Other.

Other Targeting Criteria (Describe):

New adult group members who are AI/AN and participate in the 1115 demonstration will be enrolled in the HIP Plus ABP with no POWER account contribution or cost-sharing requirements, regardless of FPL

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory. Yes

Any other information the state/territory wishes to provide about the population (optional)

Enrollment in the Alternative Benefit Plan (ABP) that is the HIP Plus Plan with Essential Health Benefits (EHBs) will include non-medically frail adults between the ages of 19 and 64 with income up to and including 133% of the Federal Poverty Level (FPL) as based on MAGI income standards.

Individuals with income at or below 100% FPL are eligible for HIP Plus. If they do not make the POWER account payment then they default to the HIP Basic Plan. Educational information about the differences in benefits and cost-sharing structure between HIP Basic and HIP Plus are provided in all member communications from both the state and the MCEs. This includes but is not limited to eligibility notices, welcome letters, invoices, and member handbooks. Members can also receive information about the difference in the Basic and Plus plans from all call center staff including the state call centers, the enrollment broker, and the MCE call centers. The state also makes educational information available to members online.

PRA Disclosure Statement

V.20140415

Alternative Benefit Plan

State Name: Indiana | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0025 | OMB Expiration date: 10/31/2014

Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act — ABP2a

The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan. [No]

These assurances must be made by the state/territory if the Adult eligibility group is included in the ABP Population.

☐ The state/territory shall enroll all participants in the "Individuals at or below 133% FPL Age 19 through 64" (section 1902(a)(10)(A)(i)(VIII)) eligibility group in the Alternative Benefit Plan specified in this state plan amendment, except as follows: A beneficiary in the eligibility group at section 1902(a)(10)(A)(i)(VIII) who is determined to meet one of the exemption criteria at 45 CFR 440.315 will receive a choice of a benefit package that is either an Alternative Benefit Plan that includes Essential Health Benefits and is subject to all 1937 requirements or an Alternative Benefit Plan that is the state/territory's approved Medicaid state plan not subject to 1937 requirements. The state/territory's approved Medicaid state plan includes all approved state plan programs based on any state plan authority, and approved 1915(c) waivers, if the state has amended them to include the eligibility group at section 1902(a)(10)(A)(i)(VIII).

☑ The state/territory must have a process in place to identify individuals that meet the exemption criteria and the state/territory must comply with requirements related to providing the option of enrollment in an Alternative Benefit Plan defined using section 1937 requirements, or an Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan that is not subject to section 1937 requirements.

☐ Once an individual is identified, the state/territory assures it will effectively inform the individual of the following:

a) Enrollment in the specified Alternative Benefit Plan is voluntary;

b) The individual may disenroll from the Alternative Benefit Plan defined subject to section 1937 requirements at any time and instead receive an Alternative Benefit Plan defined as the approved state/territory Medicaid state plan that is not subject to section 1937 requirements; and

c) What the process is for transferring to the state plan-based Alternative Benefit Plan.

☐ The state/territory assures it will inform the individual of:

a) The benefits available as Alternative Benefit Plan coverage defined using section 1937 requirements as compared to Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan and not subject to section 1937 requirements; and

b) The costs of the different benefit packages and a comparison of how the Alternative Benefit Plan subject to 1937 requirements differs from the Alternative Benefit Plan defined as the approved Medicaid state/territory plan benefits.

How will the state/territory inform individuals about their options for enrollment? (Check all that apply)

☒ Letter

☐ Email

☒ Other

Describe:

All eligibility notices to HIP members and any notices generated when a member reports changes will indicate how to report medically frail status to the managed care entity. The medically frail confirmation process will also be described in the member manual.

Provide a copy of the letter, email text or other communication text that will be used to inform individuals about their options for enrollment.

An attachment is submitted.

When did/will the state/territory inform the individuals?

Individuals will be informed of the medically frail self-report process in their initial eligibility notice and in all notices received when the member has reported a an eligibility change. The process will also be detailed the member manual. Individuals confirmed medically frail will be enrolled in the State Plan ABP.

Self-report of medically frail status is only one avenue for members to be confirmed frail. All individuals with an active disability determination by the Social Security Administration or a confirmed diagnoses of HIV/AIDS from the Indiana State Department of Health will be confirmed medically frail without having to self report their frail status. In addition, any member that has medical claims that confirm a medically frail condition throughout the year may be confirmed medically frail by their MCE without having to self-report their status.

Please describe the state/territory's process for allowing individuals in the Section 1902(a)(10)(A)(i)(VIII) eligibility group who meet exemption criteria to disenroll from the Alternative Benefit Plan defined using section 1937 requirements and enroll in the Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan.

Individuals that are confirmed to meet the medically frail criteria by their manged care entity will not receive the benefits described in the HIP Basic or HIP Plus ABPs and do not have the option to opt into these plans. They will receive the benefits on the State Plan ABP. These benefits will be provided through the same Managed Care Entities that provide the HIP Basic and HIP Plus ABPs . The benefits of the State Plan ABP offer additional benefits in excess of what is covered in HIP Basic and HIP Plus.

☐ The state/territory assures it will document in the exempt individual's eligibility file that the individual:

a) Was informed in accordance with this section prior to enrollment;

b) Was given ample time to arrive at an informed choice; and

c) Chose to enroll in Alternative Benefit Plan coverage subject to section 1937 requirements or defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

Where will the information be documented? (Check all that apply)

☐ In the eligibility system.

☐ In the hard copy of the case record.

☒ Other

Describe:

Confirmed medically frail individuals do not have the option to select the HIP Basic and Plus Plans, but will be automatically assigned to the State Plan ABP.

What documentation will be maintained in the eligibility file? (Check all that apply)

Alternative Benefit Plan

☐ Copy of correspondence sent to the individual.

☐ Signed documentation from the individual consenting to enrollment in the Alternative Benefit Plan.

☒ Other

Describe:

Confirmed medically frail individuals do not have the option to select the HIP Basic and Plus Plans that are the Alternative Benefit Plans (ABPs) with Essential Health Benefits, but will receive the benefits from the State Plan ABP.

☐ The state/territory assures that it will maintain data that tracks the total number of individuals who have voluntarily enrolled in either Alternative Benefit Plan coverage subject to section 1937 requirements or Alternative Benefit Plan coverage defined as the state/ territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

Other information related to benefit package selection assurances for exempt participants (optional):

Confirmed medically frail individuals will receive benefits that are in all ways equivalent to State Plan ABP benefits and offer benefits not covered through the HIP Basic and Plus ABPs. Therefore, medically frail individuals will not need to have the choice to opt into these two less generous plans.

PRA Disclosure Statement

V.20140415

Alternative Benefit Plan

State Name: Indiana | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0025 | OMB Expiration date: 10/31/2014

Enrollment Assurances - Mandatory Participants — ABP2c

These assurances must be made by the state/territory if enrollment is mandatory for any of the target populations or sub-populations.

When mandatorily enrolling eligibility groups in an Alternative Benefit Plan (Benchmark or Benchmark-Equivalent Plan) that could have exempt individuals, prior to enrollment:

☑ The state/territory assures it will appropriately identify any individuals in the eligibility groups that are exempt from mandatory enrollment in an Alternative Benefit Plan or individuals who meet the exemption criteria and are given a choice of Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan, not subject to section 1937 requirements.

How will the state/territory identify these individuals? (Check all that apply)

☒ Review of eligibility criteria (e.g., age, disorder/diagnosis/condition)

Describe:

Members with disability determination from the Social Security Administration or who have been confirmed as having HIV/AIDS by the Indiana State Department of Health will be confirmed medically frail on initial determination of eligibility.

All eligibility notices to members indicate that members can report changes in their medical condition and medically frail status to their MCE.

☒ Self-identification

Describe:

Self-identification is one of the ways frail status is identified. The primary medically frail identification method is via claims as detailed in the Other section. Members may self-identify by requesting a review of their medically frail status with their managed care entities after initial enrollment in HIP. Members that request a review of their medically frail status are subject to a verification process utilizing the Milliman underwriting guidelines as detailed below.

Once a member self-identifies as medically frail the Managed Care Entity (MCE) will validate applicant data to confirm medically frail status. The managed care entity will have 30 days as required by contract to confirm if the member is medically frail. Managed care entities may identify members as medically frail via claims received during the 30 day verification process, and members receiving health services and using pharmaceuticals to treat their medically frail conditions will likely be identified before the end of the 30 day verification period.

Confirmation may occur through applicant interview or follow-up, current treatment (claims) and/or physician medical attestation documented medical records. Members are confirmed medically frail by the managed care entity when they have a documented medically frail condition and meet the following point thresholds using the Milliman Underwriting Guidelines:

- 150 combined debit points for indicated medical, mental, or behavioral health conditions; or,
- 75 debit points for indicated behavioral health conditions; or,
- 75 debit points for indicated substance abuse conditions; or,
- Needs assistance with one of the activities of daily living.

The debit point system above provides the minimal points a member would meet to be identified as medically frail. For example, individuals who are infected with the hepatitis C virus, but have no signs of the virus, receive no medications and have normal liver functions, will be assigned 50 debit points and not qualify as medically frail. However, an individual that has abnormal liver function will be assigned 150 debit points or higher for conditions such as cirrhosis of the liver at 650 debit

points. From these examples, an individual must meet 150 debit points or higher and have a condition listed on the medically frail condition listing to be considered as having a medical condition identified as medically frail. A person that has a medical condition that falls below the 150 threshold and/or is not a condition listed on the medically frail condition listing would not be considered medically frail. A medically frail determination would be effective for 12 months and after this time is required to be reverified and updated by the MCE. The debit point system, threshold range, and extensive tables of medical conditions each assigned debit points was developed from the Millliman Underwriting Guidelines and is the methodology that will be utilized to determine a medically frail identification.

To develop the debit point system, a code list and software tool from the medical ICD-9 codes and pharmacy NDC codes was used. The use of medical and pharmacy codes in assessing claims data allows for an automated process when screening individuals for medically frail conditions on an ongoing basis.

Members identified as medically frail will receive the State Plan ABP effective the first of the month following the confirmation of their medically frail status by the managed care entity.

Individuals have the right to appeal all medically frail determinations through the state, but must first exhaust the grievance process with their managed care entity.

☒ Other

Describe:

On an ongoing basis, health and pharmacy claims data and data from medical professionals including lab results will be used in the identification and conformation of medically frail status using an automated process. Similar to verification that occurs with the member request to review frail status, members that have pharmacy or medical claims that demonstrate conditions that may qualify them for medically frail status will have their claims checked against the Milliman Underwriting Guidelines. Those that have claims over the point threshold will automatically be designated as medically frail and receive the State Plan ABP. For individuals that do not meet the medically frail threshold based on claims alone, medical records, risk assessments and lab results may be utilized to verify medically frail status.

☐ The state/territory must inform the individual they are exempt or meet the exemption criteria and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the “Individuals at or below 133% FPL Age 19 through 64” eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

☐ The state/territory assures that for individuals who have become exempt from enrollment in an Alternative Benefit Plan, the state/territory must inform the individual they are now exempt and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the “Individuals at or below 133% FPL Age 19 through 64” eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

How will the state/territory identify if an individual becomes exempt? (Check all that apply)

☒ Review of claims data

☒ Self-identification

☒ Review at the time of eligibility redetermination

☒ Provider identification

☐ Change in eligibility group

☐ Other

How frequently will the state/territory review the Alternative Benefit Plan population to determine if individuals are exempt from mandatory enrollment or meet the exemption criteria?

- ○ Monthly
- ○ Quarterly
- ○ Annually
- ○ Ad hoc basis
- ◉ Other

Describe:

Managed Care entities may continually assess their enrolled population to determine if an individual has claims that qualify them for medically frail status. The Managed Care Entities will alert the state when an individual qualifies for medically frail status to initiate the activation of benefits of the State Plan ABP. On an annual basis all individuals marked medically frail must be reconfirmed as medically frail by their Managed Care Entity.

Managed care entities determination of frail status is subject to review and audit by the state.

☑ The state/territory assures that it will promptly process all requests made by exempt individuals for disenrollment from the Alternative Benefit Plan and has in place a process that ensures exempt individuals have access to all standard state/territory plan services or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

Describe the process for processing requests made by exempt individuals to be disenrolled from the Alternative Benefit Plan:

Individuals that meet the medically frail criteria will not receive the HIP Basic and HIP Plus benefits described in the Alternative Benefit Plans (ABPs) and do not have the option to opt into these plans, because they do not contain enhanced benefits. Individuals that are confirmed as medically frail will be enrolled in the State Plan ABP. The benefits of the State Plan ABP as provided to HIP eligible individuals through managed care are at least as generous as the HIP Basic and Plus benefits in each benefit offered and offer additional benefits in excess of what is covered in these plans.

Other Information Related to Enrollment Assurance for Mandatory Participants (optional):

To ensure accurate and fair identification methods are in place when determining a member's medical condition, such as medically frail, the state will establish an oversight process. The State utilizes external quality control measures to ensure proper identification for medically frail individuals. The type of quality control measures utilized depends on the frail identification method used by the MCE. When the MCE identifies a member as medically frail, they must document and notify the State. The notification must include (1) the medically frail designation; (2) the date of the determination; and (3) the method used to make the medically frail determination. The following outlines the State audit procedures based on the identification method used.

• MCE identifies member as medically frail based on the Milliman Underwriting Guidelines by using the Milliman tool that conducts analysis of claims data. This can be done at any time. The tool analyzes claims to determine if the member has accrued sufficient debit points to meet the debit point thresholds that designate a member as frail. The State will review the determination and claims data on an ongoing basis throughout the enrollment period, however, determinations made by the MCEs through the use of the Milliman tool based on member claims are considered to be non-partial.

• MCE identifies member as medically frail based on supplemental data. All supplemental data used to support a frail designation must be indexed to the Milliman Underwriting Guidelines. The Milliman tool provides an automated way to analyze claims for indications of frail status, however if claims have not yet been filed, the Milliman Underwriting Guidelines may also be met through a manual process. When meeting the Milliman Underwriting Guidelines points thresholds through a manual process, the MCE must complete a generic

description of the information utilized by the MCE to support the medically frail designation. This information will be reviewed by the State or its designated vendor to independently confirm these medically frail designations. The State will also conduct audits of the MCE's medically frail determinations to ensure the Milliman Underwriting Guidelines are appropriately applied.

Medically frail audits will include review of non-claim data to form a complete picture of the health of the member. This data review could include, but not be limited to: output files from the Milliman Renewal MUGs tool indicating the number of debit points the member accumulated; completed Health Risk Assessments; documentation of attempts to make contact with their member and/or physician(s); recorded responses and supporting information indicating member impairment in Activities of Daily Living (ADLs); and supplemental information gathered by the MCE in order to make a complete decision (such as lab results, physician notes or lifestyle factors). To ensure accurate and timely review of members, the State will also monitor the average time and determination completion rate for each MCE as well as complete in depth reviews surrounding member state appeals (e.g. rate of appeals, appeals outcome statistics, number of State Fair Hearings requested) and Internet Queries (IQs).

In addition, to the specific methods described, the State's MCE audit procedures are ongoing. The State will conduct regular audits of the MCE's Medically Frail Supplemental File to determine and verify appropriate placement of medically frail members including the use of Milliman Underwriting Guidelines. If the member does not meet the medically frail criteria based upon the State's review, the State will request additional information from the MCE. The State anticipates that approximately ten percent (10%) of the total HIP population will be designated as medically frail. If at any time the State finds that a significant amount more or less than ten percent (10%) of an MCE's total HIP population is designated as medically frail, the State will initiate a random audit of the MCE population to ensure that the Milliman Underwriting Guidelines are being applied appropriately or supporting data was used properly. If any MCE is found to have a consistent issue applying the Milliman Underwriting Guidelines in a uniform fashion, the State's will take the appropriate corrective actions.

The State's oversight processes, as explained, focus on ensuring the member receives the proper health services needed which include the appropriate health designation.

PRA Disclosure Statement

V.20140415

Alternative Benefit Plan

State Name: Indiana | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0025 | OMB Expiration date: 10/31/2014

Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package — ABP3

Select one of the following:

- ○ The state/territory is amending one existing benefit package for the population defined in Section 1.
- ◉ The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package: HIP Plus Plan

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

- ◉ Benchmark Benefit Package.
- ○ Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

- ○ The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).
- ○ State employee coverage that is offered and generally available to state employees (State Employee Coverage):
- ○ A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):
- ◉ Secretary-Approved Coverage.
  - ○ The state/territory offers benefits based on the approved state plan.
  - ◉ The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.

Please briefly identify the benefits, the source of benefits and any limitations:

Indiana will use benefits from the largest commercial HMO by enrollment that was a plan option for the State's commercial EHB benchmark. The commercial HMO selected as the base benchmark plan for the HIP Plus ABP complies with the regulations set forth for alternative health benefit plans under §440.347 as related to the essential health benefits (EHBs). The state's methodology in selecting the plan design was to ensure the benefits of the ABP that is the State Plan are at least as generous as the HIP Basic and Plus benefits. The HIP Plus Plan provides comprehensive coverage that includes dental and vision services, TMJ and bariatric surgery. The prescription drug benefit will include all of the drugs in the HIP Basic formulary, which contains the coverage and non-coverage requirements for legend drugs by Indiana Medicaid, found in 405 IAC 5-24-3. The HIP Plus ABP offers additional benefits beyond the base benchmark for pregnant women. If a woman becomes pregnant, she will have the option to maintain her current HIP Plus Plan benefits with extended services for pregnant women.

Selection of Base Benchmark Plan

The state/territory must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

Alternative Benefit Plan

The Base Benchmark Plan is the same as the Section 1937 Coverage option. No

Indicate which Benchmark Plan described at 45 CFR 156.100(a) the state/territory will use as its Base Benchmark Plan:

- ○ Largest plan by enrollment of the three largest small group insurance products in the state's small group market.
- ○ Any of the largest three state employee health benefit plans by enrollment.
- ○ Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- ◉ Largest insured commercial non-Medicaid HMO.

Plan name: Advantage 1001

Other Information Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional):

The state assures that all services in the base benchmark have been accounted for throughout the benefit chart in ABP5. The state assures the accuracy of all information in ABP5 depicting amount, duration and scope parameters of services authorized in the current approved Medicaid state plan and covered on the selected base benchmark plan.

PRA Disclosure Statement

V.20140415

Alternative Benefit Plan

State Name: Indiana

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0025

OMB Expiration date: 10/31/2014

Alternative Benefit Plan Cost-Sharing ABP4

☐ Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A. Yes

☐ The state/territory has completed and attached to this submission Attachment 4.18-F to indicate the Alternative Benefit Plan's cost-sharing provisions that are different from those otherwise approved in the state plan.

An attachment is submitted.

Other Information Related to Cost Sharing Requirements (optional):

Authorization for the cost sharing provisions for the HIP Plus Plan are contained in Indiana's HIP 2.0 1115 Demonstration.

V.20140415

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L-

Benefits Description ABP5

The state/territory proposes a "Benchmark-Equivalent" benefit package. No

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

Base Benchmark Commercial HMO
Advantage HMO
Plus Plan

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary-Approved

Alternative Benefit Plan

■ 1. Essential Health Benefit: Ambulatory patient services Collapse All ☐

Benefit Provided: Primary Care Physician (PCP) Services Office Visit

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Office visit services include supplies for treatment of the illness or injury, medical consultations, procedures performed in the physician's office, second opinion consultations and specialist treatment services provided by a PCP.
For second opinion consultations, the Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Specialty Physician Visits

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Referral Physician Office Visit included.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Home Health Services

Source: Secretary-Approved Other

Authorization: Other

Provider Qualifications: Medicaid State Plan

Alternative Benefit Plan

Amount Limit:
100 visits per year.

Duration Limit:
None

Remove

Scope Limit:
Services covered only if not considered custodial care and are prescribed in writing by a participating physician as medically necessary, in place of inpatient hospital care or convalescent nursing home and services provided under physician's care.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Services include skilled medical services; nursing care given or supervised by RN; nutritional counseling furnished or supervised by RD; home hospice services; home health aides; laboratory services, drugs, and medicines prescribed by a physician in connection with home health care; and medical social services.
Home hospice services are considered a separate service.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Outpatient Surgery

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Outpatient medical and surgical hospital services are covered when medically necessary. Includes diagnostic invasive procedures that may or may not require anesthesia.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Allergy Testing

Source:
Base Benchmark Commercial HMO

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:

None

Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes allergy procedures-administration of serum.

Benefit Provided:

Chemotherapy-Outpatient

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes outpatient therapeutic injections which are medically necessary and may not be self-administered.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

IV Infusion Services

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes coverage for outpatient infusion therapy.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Alternative Benefit Plan

Benefit Provided: Radiation Therapy- Outpatient

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes coverage for outpatient services.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Dialysis

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage provided for outpatient (including home) dialysis services provided by a participating provider.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Outpatient Services

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

None

Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes colonoscopy and pacemaker. Benefits provided are PCP, specialty and referral for all physician services in an outpatient facility.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Clinical Trials for Cancer Treatment

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Items and services that are not routine care costs or unrelated to the care method will not be covered.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

The clinical trial must be approved or funded by one of the following: National Institute of Health; cooperative group of research facilities that have an established peer review program that is approved by a National Institute of Health or center; FDA; United States Department of Veterans Affairs; United States Department of Defense; institutional review board of an institution located in Indiana that has a multiple project assurance contract approved by the National Institute of Health Office for Protection from Research Risks; and research entity that meets eligibility criteria for a support grant from a National Institutes of Health center.
Coverage provided for routine care costs that are incurred in the course of a clinical trial.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, review of clinical trial to ensure qualified, review of routine costs related to clinical trial and a justification of services rendered for the medical needs of the member.

Benefit Provided:

Dental- Limited Covered Services- Accident/Injury

Source:

Base Benchmark Commercial HMO

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Treatment complete within 1 year from initiation.

Duration Limit:

None

Scope Limit:

Coverage not provided for orthodontia, dental procedures, repair of injury caused by an intrinsic force,

such as the force of the upper and lower jaw in chewing, repair of artificial teeth, dentures or bridges.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Injury to sound and natural teeth including teeth that have been filled, capped or crowned.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, to report injury to insurer and receive follow-up care within specified time-frame, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Urgent Care- Walk-ins

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage includes after hours care.

Benefit Provided: Routine Foot Care

Source: Secretary-Approved Other

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: 6 visits per year.

Duration Limit: None

Scope Limit:

Coverage not provided for supportive devices of the feet, including but not limited to foot orthotics, corrective shoes, arch supports for the treatment of plantar fasciitis, flat feet, fallen arches, weak feet, chronic foot strain, corns, bunions

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Scope limit continued- and calluses.
Covered when medically necessary for the treatment of diabetes and lower extremity circulatory diseases. For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Alternative Benefit Plan

Benefit Provided:

Voluntary Sterilization for Males

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Add

Alternative Benefit Plan

■ 2. Essential Health Benefit: Emergency services Collapse All ☐

Benefit Provided:
Emergency Department Services

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Medical care provided outside of the U.S. is not covered.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Emergency room included.

Benefit Provided:
Emergency Transportation: Ambulance/Air Ambulance

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Other medically necessary ambulance transport (ambulance, medi-van or similar medical ground, air or water transport to or from the hospital or both ways and transfer from a hospital to a lower level of care) is covered.
For other medically necessary transportation, authorization may be required in which the Managed Care Entities (MCEs) may require other details, such as general member information, to contact PCP for other types of transportation related services and a justification of services rendered for the medical needs of the member.

Add

Alternative Benefit Plan

■ 3. Essential Health Benefit: Hospitalization Collapse All ☐

Benefit Provided:
General Inpatient Hospital Care

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Benefit does not include personal comfort items, including those services and supplies not directly related to care, such as guest meals, accommodations or personal hygiene products, and room and board when temporary leave permitted.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Services include semi-private room and board (private room provided when medically necessary); intensive care unit/coronary care unit; inpatient cardiac rehabilitation and rehabilitation therapy; general nursing care; use of operating room or delivery suite; surgical and anesthesia services and supplies; ordinary casts; splints and dressings; drugs and oxygen used in hospital; laboratory and x-ray examinations; electrocardiograms; special duty nursing (when requested by a physician and certified as medically necessary); and inpatient specialty pharmaceuticals.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, review of medical necessity, authorization by acting physician, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Inpatient Physician Services

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Benefit includes PCP, specialty and may require a referral for physician services in the hospital.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Alternative Benefit Plan

Benefit Provided:
Inpatient Surgical Services

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Benefit does not include bariatric surgery, surgical and nonsurgical treatment of TMJ, personal comfort items, including those services and supplies not directly related to care, such as guest meals, accommodations or personal hygiene products,

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Scope Limit continued- and room and board when temporary leave permitted.
Surgical hospital services are covered when medically necessary. Services include semi-private room and board (private room provided when medically necessary); intensive care unit/coronary care unit; general nursing care; use of operating room or delivery suite; surgical and anesthesia services and supplies; ordinary casts; splints and dressings; drugs and oxygen used in hospital; laboratory and x-ray examinations; electrocardiograms; special duty nursing (when requested by a physician and certified as medically necessary); and inpatient specialty pharmaceuticals.
Surgical operations may include replacement of diseased tissue removed while a member.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Non-Cosmetic Reconstructive Surgery

Source:
Base Benchmark Commercial HMO

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Services begin within 1 year of the accident.

Duration Limit:
None

Scope Limit:
Benefit does not include personal comfort items, including those services and supplies not directly related to care, such as guest meals, accommodations or personal hygiene products, and room and board when temporary leave permitted.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Surgical hospital services are covered when medically necessary and approved by physician.
Reconstructive procedures performed to restore or improve impaired physical function or defects resulting from an accident.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a

planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided: Mastectomy- Reconstructive Surgery

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Benefit does not include personal comfort items, including those services and supplies not directly related to care, such as guest meals, accommodations or personal hygiene products, and room and board when temporary leave permitted.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Surgical hospital services are covered when medically necessary and approved by physician. Covered services include reconstruction of the breast upon which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications at all stages of mastectomy, including lymphedemas.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Transplants

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Human organ and tissue transplant services for both the recipient and the donor, when the recipient is a member. No coverage is provided for the donor or the recipient when the recipient is not a member. Specialty Care Physician (SCP) provides pre-transplant evaluation. Non-experimental, non-investigational organ and other transplants are covered. Donor's medical expenses covered if the person receiving the transplant is a member, and donor's expenses are not covered by another issuer.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a

planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided: Congenital Abnormalities

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Benefit does not include personal comfort items, including those services and supplies not directly related to care, such as guest meals, accommodations or personal hygiene products, and room and board when temporary leave permitted.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Surgical hospital services are covered when medically necessary and approved by physician.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Anesthesia

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage includes anesthesia services and supplies.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Hospice Care

Source: Base Benchmark Commercial HMO

Alternative Benefit Plan

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Remove

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Room and board services are not covered when temporary leave permitted.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

This benefit may be provided in hospitals, skilled nursing facilities, and freestanding hospice centers. Covered services include semi-private room (private room provided when medically necessary). Hospice care provided if terminal illness, in accordance with a treatment plan before admission to the program. Treatment plan must provide statement from physician that life expectancy is 6 months or less. Concurrent care is provided to children (19 & 20 year olds).
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Medical Social Services

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Hospital services to assist member and family in understanding and coping with the emotional and social problems affecting health status.

Benefit Provided:
Dialysis

Source:
Base Benchmark Commercial HMO

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:

None

Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Inpatient dialysis services provided by a participating provider.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Chemotherapy

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes coverage for inpatient services.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Radiation Therapy

Source:

Base Benchmark Commercial HMO

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes coverage for inpatient services.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a

planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Add

Alternative Benefit Plan

☑ 4. Essential Health Benefit: Maternity and newborn care — Collapse All ☐

Benefit Provided:
Obstetric Care

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Limits equivalent to State Plan.

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage is provided from the State Plan under the physician benefit and includes various obstetrical services such as antepartum and postpartum visits, laboratory and x-ray (ultrasound) services and other services as medically necessary and appropriate. The benefit provides for antepartum services up to 14 visits for normal pregnancies. High-risk pregnancies may allow for additional visits. Postpartum services includes 2 visits within 60 days of delivery.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Add

Alternative Benefit Plan

Collapse All ☐

☑ 5. Essential Health Benefit: Mental health and substance use disorder services including behavioral health treatment

Benefit Provided: Mental/Behavioral Health Inpatient

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Benefit does not include hypnotherapy, behavioral modification, or milieu therapy when used to treat conditions that are not recognized as mental disorders; personal comfort items; and room and board when temporary leave available.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefits include evaluation and treatment in a psychiatric day facility and electroconvulsive therapy.
Coverage may also include partial hospitalization depending on the type of services provided.
These services are not provided through institutions of mental disease (IMDs).
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Mental/Behavioral Health Outpatient

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Coverage does not include self-help training or other related forms of non-medical self care; marriage counseling; hypnotherapy, behavioral modification, or milieu therapy when used to treat conditions that are not recognized as mental disorders.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage applies to individual therapy and group therapy sessions. Benefit may also include partial hospitalization depending on the type of services provided.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Alternative Benefit Plan

Benefit Provided:
Substance Abuse Inpatient Treatment

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Benefit does not include services and supplies for the treatment of co-dependency or caffeine addiction; personal comfort items; and room and board when temporary leave permitted.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Benefit includes detoxification for alcohol or other drug addiction. Coverage may also include partial hospitalization depending on the type of services provided.
These services are not provided through institutions of mental disease (IMDs).
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Substance Abuse Outpatient Treatment

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Benefit does not include services and supplies unrelated to mental health for the treatment of co-dependency or caffeine addiction.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Coverage includes detoxification for alcohol or other drug addiction. Benefit may also include partial hospitalization depending on the type of services provided.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Add

■ 6. Essential Health Benefit: Prescription drugs

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):	Authorization:	Provider Qualifications:
☒ Limit on days supply	Yes	State licensed
☒ Limit on number of prescriptions		
☒ Limit on brand drugs		
☒ Other coverage limits		
☒ Preferred drug list		

Coverage that exceeds the minimum requirements or other:

The prescription drug benefit will cover at least one drug in every category and class or the number of drugs covered in each category and class as the base benchmark, whichever is greater. The Plus Plan will have a formulary that will include coverage for all of the drugs in the HIP Basic formulary, which contains the coverage and non-coverage requirements for legend drugs by Indiana Medicaid, found in 405 IAC 5-24-3. The Plus Plan pharmacy benefit provides additional enhanced benefits that include the following:

- Access to many brand name drugs without prior authorization requirements;
- 90 day prescription supplies;
- Mail order pharmacy benefit;
- Medication Therapy Management (MTM) Services; and
- No copayment for any filled prescription.

These additional pharmacy services are only available to individuals enrolled in the HIP Plus Plan. In addition, the exact drugs covered under the formulary may vary by the Managed Care Entities (MCEs).

For authorization, Managed Care Entities may require prior authorization requirements, such as general member information, a justification of need for Rx related to the medical needs of the member and a planned course of treatment, if applicable, as related to the number Rx provided and duration of treatment. Prior authorization requirements for prescription drugs may vary by MCE, but will comply with Mental Health Parity requirements. MCEs will be required to have a process in place to allow drugs that are medically necessary, but not included on the formulary to be accessed by members.

Alternative Benefit Plan

■ 7. Essential Health Benefit: Rehabilitative and habilitative services and devices Collapse All ☐

Benefit Provided:
Physical Therapy, Occupational Therapy, Speech The

Source:
Secretary-Approved Other

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
75 combined visits annually.

Duration Limit:
None

Scope Limit:
Rehabilitative and habilitative services are offered at parity and share the same, comparable benefit limits. Coverage does not include nonsurgical treatment of TMJ.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Amount limit continued- As an outpatient benefit, coverage is limited to 75 combined visits annually for PT, OT, ST, cardiac and pulmonary rehabilitation.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Durable Medical Equipment (DME)

Source:
Secretary-Approved Other

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
15 mo rental cap;1 every 5 yr per member- replace

Duration Limit:
None

Scope Limit:
DME does not include corrective shoes, arch supports, dental prostheses, deluxe equipment, common first aid supplies and non-durable supplies. Other non-covered services include but not limited to equipment not suitable for home use.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Benefit includes but not limited to wheel chairs, crutches, respirators, traction equipment, hospital beds, monitoring devices, oxygen-breathing apparatus and insulin pumps. Training for use of DME is also covered and applicable rental fees. Covered services are only for the basic type of DME necessary to provide for medical needs and does not include non-durable supplies that are not an integral part of the DME set-up.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Alternative Benefit Plan

Benefit Provided:
Prosthetics

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Benefit does not include foot orthotics, devices solely for comfort or convenience and devices from a non-accredited provider.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

A prosthetic device means an artificial arm or leg or any portion thereof. Orthotic devices are also covered under this benefit as custom fabricated braces or supports designed as a component of an artificial arm or leg. Covered services include the purchase, replacement or adjustment of artificial limbs when required due to a change in your physical condition or body size due to normal growth.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Corrective Appliances

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Benefit does not include but not limited to artificial or prosthetic limbs, cochlear implants, dental appliances, dentures, foot orthotics, corrective shoes, arch supports for plantar fasciitis, flat feet, fallen arches and corns.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit must be medically necessary and used to restore function or to replace body parts. Benefit includes but not limited to hemodialysis equipment, breast prostheses, back braces, artificial eyes, one pair eyeglasses due to cataract surgery, ostomy supplies and prosthetics (all prosthetics except prosthetic limbs). Coverage not intended for non-durable appliances.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Alternative Benefit Plan

Benefit Provided: Cardiac Rehabilitation

Source: Secretary-Approved Other

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: 75 combined visits annually.

Duration Limit: None

Scope Limit: Rehabilitative services are offered at parity and share the same, comparable benefit limits.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Amount limit continued- As an outpatient benefit, coverage is limited to 75 combined visits annually for PT, OT, ST and pulmonary rehabilitation.
Benefit includes services for the improvement of cardiac disease or dysfunction.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Medical Supplies

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Benefit does not include non-durable supplies and/or convenience items.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit includes casts, dressings, splints and other devices used for reduction of fractures and dislocations.

Benefit Provided: Pulmonary Rehabilitation

Source: Secretary-Approved Other

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: 75 combined visits annually.

Duration Limit: None

Scope Limit:

Benefit does not include formalized and pre-designed rehabilitation programs for pulmonary conditions. Rehabilitative services are offered at parity and share the same, comparable benefit limits.

Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Amount limit continued- As an outpatient benefit, coverage is limited to 75 combined visits annually for PT, OT, ST and cardiac rehabilitation.
Benefit consists of services that are for the improvement of pulmonary disease or dysfunction that has a poor response to treatment. Examples of poor response include but are not limited to patients with respiratory failure, frequent emergency room visits, progressive dyspnea, hypoxemia or hypercapnia.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Skilled Nursing Facility (SNF)

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

100 days per benefit period.

Duration Limit:

None

Scope Limit:

A SNF does not include any institution or portion of any institution that is primarily for rest, the aged, non-skilled care, or care of mental diseases or substance abuse. Room and board services are not covered when temporary leave permitted.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Covered services include semi-private room (private room provided when medically necessary), drugs, specialty pharmaceuticals, medical social services, short term physical, speech, occupational therapies (subject to limits) and other services generally provided.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Autism Spectrum Disorder Services

Source:

Secretary-Approved Other

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

75 combined visits annually.

Duration Limit:

None

Alternative Benefit Plan

Scope Limit:

None

Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Amount limit continued- As an outpatient benefit, coverage is limited to 75 combined visits annually for PT, OT, ST, cardiac and pulmonary rehabilitation.
Benefit, formerly known as Pervasive Development Disorder (PDD), is a state mandate that must be covered as outlined in the Indiana insurance code.
Benefit provides coverage for Asperger's syndrome and autism. Coverage for services are provided as prescribed by the treating physician in accordance with the treatment plan.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Hearing Aids

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

1 per member every 5 years.

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Medically frail populations will receive State Plan benefits. For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Home Health:Medical Supplies, Equipment and Applia

Source:

Base Benchmark Commercial HMO

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Benefit does not include non-durable supplies and/or convenience items.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefits include medical supplies in connection with home health care.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided: Inpatient Cardiac Rehabilitation

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: 90 days annual maximum.

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit includes services for the improvement of cardiac disease or dysfunction.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Inpatient Rehabilitation Therapy

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: 90 days annual maximum.

Duration Limit: None

Scope Limit: Rehabilitative and habilitative services are offered at parity and share the same, comparable benefit limits.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage includes physical, occupational, speech and pulmonary therapy of acute illness or injury to the extent that significant potential exists for progress toward a previous level of functioning.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Alternative Benefit Plan

Add

Alternative Benefit Plan

■ 8. Essential Health Benefit: Laboratory services Collapse All ☐

Benefit Provided:
Lab Tests

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Coverage does not include lab expenses related to physical exams when provided for employment, school, sports' programs, travel, immigration, administrative purposes or insurance purposes.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Benefit provided as outpatient services when medically necessary.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
X-Rays

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Coverage does not include x-ray expenses related to physical exams when provided for employment, school, sports' programs, travel, immigration, administrative purposes or insurance purposes.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Benefit provided as outpatient services when medically necessary.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Imaging- MRI, CT, and PET

Source:
Base Benchmark Commercial HMO

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Remove

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit provided as outpatient services when medically necessary. Coverage also includes MRA and SPECT scan.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Pathology

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit provided as outpatient services when medically necessary.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Radiology

Source:
Base Benchmark Commercial HMO

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit provided as outpatient services when medically necessary.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided:

EKG and EEG

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit provided as outpatient services when medically necessary.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Add

Alternative Benefit Plan

■ 9. Essential Health Benefit: Preventive and wellness services and chronic disease management Collapse All ☐

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided: Preventive Care Services

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Physician services for wellness and preventive services include but are not limited to routine physical exam, routine total blood cholesterol screening, routine gynecological services and routine immunizations. Includes (1) all preventive items or services that have a rating of 'A' or 'B' by the United States Preventive Task Force (USPSTF); (2) Immunizations recommended for the individuals age and health status by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC); (3) for infants, children, adolescents and adults, preventive care and screenings included in the Health Resources and Services Administration's (HRSA) Bright Futures comprehensive guidelines; and (4) preventive screenings for women as as recommended by the Institute of Medicine (IOM).

Benefit Provided: Routine Prostate Specific Antigen (PSA) Test

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: One test annually for an individual who is at least 50 years old or less than 50 if at high risk for prostate cancer.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: None

Benefit Provided: Diabetes Self Management Training

Source: Base Benchmark Commercial HMO

Alternative Benefit Plan

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Remove

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Covered services are limited to physician authorized visits after receiving a diagnosis of diabetes; after receiving a diagnosis that represents a significant change in symptoms or condition and there is a medically necessary change in self-management; and for re-education or refresher training.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Health Education

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
3 visits.

Duration Limit:
None

Scope Limit:
Classes in nutrition or smoking cessation will be approved up to 3 visits when referred by your physician.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit provided by the PCP as part of preventive health care and other health education classes approved by the insurer.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Add

Alternative Benefit Plan

■ 10. Essential Health Benefit: Pediatric services including oral and vision care Collapse All ☐

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
EPSDT is required in the ABP for 19 and 20 year olds.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services provided under EPSDT may include preventive and diagnostic services that are medically necessary and may need continued treatment.
In accordance with CMS regulation, individuals covered under EPSDT are not subject to the IMD exclusion.

Add

☐ 11. Other Covered Benefits from Base Benchmark Collapse All ☐

Alternative Benefit Plan

☒ 12. Base Benchmark Benefits Not Covered due to Substitution or Duplication Collapse All ☐

Base Benchmark Benefit that was Substituted:
Infertility Diagnoses: substitution

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Infertility Diagnoses benefit offered in the base benchmark was removed and replaced in EHB 1 by substitution with part of the actuarial value of Male Sterilization procedures which are not covered on the base benchmark. Coverage for Male Sterilization procedures comes from the coverage provided on the State Plan.

Base Benchmark Benefit that was Substituted:
Routine Foot Care: substitution

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

The benefit is covered. A more restrictive limit of 6 visits per year was added. In EHB 1, this has been substituted with the remaining actuarial value from the male sterilization benefit. There is no limit on Routine Foot Care in the base benchmark.

Base Benchmark Benefit that was Substituted:
Home Health Services: substitution

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

The benefit is covered. Within the benefit, training of family members to provide home health services is a non-covered benefit. In EHB 1, this sub-benefit was substituted with the actuarial value remaining from the male sterilization benefit.

Base Benchmark Benefit that was Substituted:
Urgent Care- Walk-ins: substitution

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

The benefit is covered. Within the benefit, physician home visits is a non-covered benefit. In EHB 1, this sub-benefit was substituted with the actuarial value remaining from the male sterilization benefit.

Base Benchmark Benefit that was Substituted:
Maternity Services: duplication

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was duplicated with the Medicaid State Plan Obstetric benefit in EHB 4.

Base Benchmark Benefit that was Substituted:
Maternity - Delivery: duplication

Source:
Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was duplicated with the Medicaid State Plan Obstetric benefit in EHB 4.

Remove

Base Benchmark Benefit that was Substituted:

Durable Medical Equipment (DME): substitution

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

The benefit is covered. The limits for a 15 month rental cap and 5 year replacement for equipment were added. In EHB 7, this has been substituted with the actuarial value remaining from adding hearing aids as a benefit from the State Plan. There is no limit on Durable Medical Equipment in the base benchmark.

Base Benchmark Benefit that was Substituted:

PT, OT, ST: substitution

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

The benefit is covered. Within the benefit, the service limits are covered as an annual limit combined for therapies. In EHB 7, service limits for limits per condition have been substituted with the actuarial value remaining from adding hearing aids as a benefit from the State Plan. The base benchmark allows for 75 combined visits per distinct condition or episode.

Base Benchmark Benefit that was Substituted:

Cardiac Rehabilitation: substitution

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

The benefit is covered. Within the benefit, the service limits are covered as an annual limit combined for therapies. In EHB 7, the service limits for limits per condition have been substituted with the actuarial value remaining from adding hearing aids as a benefit from the State Plan. The base benchmark allows for 75 combined visits per distinct condition or episode.

Base Benchmark Benefit that was Substituted:

Pulmonary Rehabilitation: substitution

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

The benefit is covered. Within the benefit, the service limits are covered as an annual limit combined for therapies. In EHB 7, the service limits for limits per condition have been substituted with hearing aids. In addition, formalized and pre-designed rehabilitation programs for pulmonary conditions have also been substituted with hearing aids. Both substitutions were completed with the actuarial value remaining from adding hearing aids as a benefit from the State Plan. The base benchmark allows for 75 combined visits per distinct condition or episode.

Base Benchmark Benefit that was Substituted:

Autism Spectrum Disorder Services: substitution

Source:
Base Benchmark

Alternative Benefit Plan

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

The benefit is covered. Within the benefit, the service limits are covered as an annual limit combined for therapies. In EHB 7, the service limits for limits per condition have been substituted with the actuarial value remaining from adding hearing aids as a benefit from the State Plan. The base benchmark allows for 75 combined visits per distinct condition or episode.

Remove

Base Benchmark Benefit that was Substituted:

Applied Behavior Analysis: substitution

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

In EHB 7, ABA has been substituted with the actuarial value remaining from adding hearing aids as a benefit from the State Plan.

Base Benchmark Benefit that was Substituted:

Non Surgical Treatment Option Morbid Obesity: dupl

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

In EHB 9, the benefit is covered under preventive and wellness services. The ACA preventive services provides coverage beyond the benefit limits.

Add

Alternative Benefit Plan

☒ 13. Other Base Benchmark Benefits Not Covered Collapse All ☐

Base Benchmark Benefit not Included in the Alternative Benefit Plan:

Adult Vision

Source: Base Benchmark

Remove

Explain why the state/territory chose not to include this benefit:

Adult vision is covered in the base benchmark plan, but it is an excepted benefit and therefore not an Essential Health Benefit.

Base Benchmark Benefit not Included in the Alternative Benefit Plan:

Newborn Child Coverage

Source: Base Benchmark

Remove

Explain why the state/territory chose not to include this benefit:

Benefit is excluded since the ABP is for ages 19-64. Newborns born to members will be covered through Medicaid for children. The newborn coverage includes the initial newborn examinations.

Base Benchmark Benefit not Included in the Alternative Benefit Plan:

Emergency Services Outside the U.S.

Source: Base Benchmark

Remove

Explain why the state/territory chose not to include this benefit:

Emergency care provided outside the U.S. is covered in the base benchmark plan. Non-emergency services are not covered. To conform with Medicaid standards, the benefit will not be covered in the ABP.

Base Benchmark Benefit not Included in the Alternative Benefit Plan:

Lodging and Transportation for Transplants (Donor)

Source: Base Benchmark

Remove

Explain why the state/territory chose not to include this benefit:

Transportation and lodging services for the donor are covered under the base benchmark plan subject to a dollar limit, these services are not considered an EHB and are considered a non-covered benefit for the ABP.

Add

Alternative Benefit Plan

☒ 14. Other 1937 Covered Benefits that are not Essential Health Benefits Collapse All ☐

Other 1937 Benefit Provided:

Dental: Adult

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Services limits provided in other box.

Duration Limit:

None

Scope Limit:

Limited to basic commercial package.

Other:

The dental benefits include evaluations and cleanings (2 per person per benefit year); bitewing x-rays (4 x-rays per person per benefit year); comprehensive x-rays (1 complete set every 5 years); minor restorative or corrective services, such as fillings or extractions (4 combined per person per benefit year); and major restorative services, such as crowns (1 per person per benefit year).
For authorization, the dental insurer may require prior authorization requirements, such as general member information and a justification for the type of dental services rendered based on the medical needs of the member.

Other 1937 Benefit Provided:

Adult Vision

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Service limits provided in other box.

Duration Limit:

None

Scope Limit:

None

Other:

The vision benefits include routine exam (1 every 2 years); eyeglasses, including frames and lenses (1 pair every 5 years if there is not a sufficient change in prescription (vision), loss, irreparable damage, or theft); frames include but not limited to plastic or metal; replacement eyeglasses (covered when medical necessity guidelines met or due to loss, theft or damage beyond repair); contact lenses (covered for medical necessity, such as facial deformity or allergy to frame prevents wearing eyeglasses); vision surgeries (covered for medical necessity); and vision training therapies (covered for medical necessity).
Not all frames and lenses are covered, unless medically necessary. Members may choose to upgrade frames and lenses and pay the difference.
For authorization, vision insurer may require prior authorization requirements, such as general member information and a justification for the type of vision services rendered based on the medical needs of the member or the dollar amount of the service.

Other 1937 Benefit Provided:
TMJ

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
State Plan benefit. Coverage includes treatment of temporomandibular joint (TMJ) disorder.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, documentation of non-surgical treatment and duration prior to surgery and a justification of services rendered for the medical needs and circumstances of the member.

Other 1937 Benefit Provided:
Bariatric Surgery

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Benefit does not include personal comfort items, including those services and supplies not directly related to care, such as guest meals, accommodations or personal hygiene products, and room and board when temporary leave permitted.

Other:
State Plan Benefit. To be eligible for this benefit the member must meet the following criteria:
1) Have morbid obesity that has persisted for at least five years duration, and physician-supervised non-surgical medical treatment has been unsuccessful for at least 6 consecutive months; or
2) Member has successfully achieved weight loss after participating in physician-supervised non-surgical medical treatment, but has been unsuccessful at maintaining weight loss for two years [> 3 kg (6.6 lb.) weight gain].
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, physician documentation and documentation of attempt to follow non-surgical treatment and duration prior to surgery, documentation of pre- and post-operative expectations, behavioral health evaluation, consultation reports from other specialists and a justification of services rendered for the medical needs and circumstances of the member.

Other 1937 Benefit Provided:
Chiropractic Care - Pregnancy Benefit

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Alternative Benefit Plan

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Remove

Amount Limit:
Limits equivalent to State Plan.

Duration Limit:
None

Scope Limit:
None

Other:
Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. Coverage provided is subject to program restrictions.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Other 1937 Benefit Provided:
Non-emergency Transportation - Pregnancy Benefit

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. Coverage provided is subject to program restrictions.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Other 1937 Benefit Provided:
Medicaid Rehabilitation Option (MRO)- Pregnancy Be

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Remove

Scope Limit:
None

Other:
Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. MRO services are designed to assist in the rehabilitation of the consumer‘s optimum functional ability in daily living activities.

Other 1937 Benefit Provided:
Dental Services- Pregnancy Benefit

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Limits equivalent to State Plan.

Duration Limit:
None

Scope Limit:
None

Other:
Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. The dental benefits include State Plan equivalent benefits.
For authorization, the dental insurer may require prior authorization requirements, such as general member information and a justification for the type of dental services rendered based on the medical needs of the member.

Other 1937 Benefit Provided:
Health Education - Smoking Cess -Pregnancy Benefit

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
12 week course.

Duration Limit:
None

Scope Limit:
None

Other:
Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. The benefit includes up to 12 weeks in a smoking cessation course providing treatment and counseling.

Alternative Benefit Plan

For authorization, the Manged Care Entity (MCE) may require prior authorization requirements, such as general member information and a justification for the type of services rendered based on the medical needs of the member.

Remove

Other 1937 Benefit Provided:

Osteopathic Manipulative Treatment (OMT)

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

State Plan benefit.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Add

Alternative Benefit Plan

☐ 15. Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)

Collapse All ☐

PRA Disclosure Statement

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V.20131219

Alternative Benefit Plan

State Name: Indiana | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0025 | OMB Expiration date: 10/31/2014

Benefits Assurances — ABP7

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age. Yes

☑ The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).

☑ The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act.

Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

- (●) Through an Alternative Benefit Plan.
- ( ) Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Other Information regarding how ESPDT benefits will be provided to participants under 21 years of age (optional):

Prescription Drug Coverage Assurances

☑ The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

☑ The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.

☑ The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.

☑ The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

Other Benefit Assurances

☑ The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.

☑ The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.

Alternative Benefit Plan

- [x] The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.

- [x] The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.

- [x] The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

- [x] The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.

- [ ] The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.

- [x] The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: “A” and “B” services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

PRA Disclosure Statement

V.20140415

Alternative Benefit Plan

State Name: Indiana | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0025 | OMB Expiration date: 10/31/2014

Service Delivery Systems — ABP8

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

- ☒ Managed care.
  - ☒ Managed Care Organizations (MCO).
  - ☐ Prepaid Inpatient Health Plans (PIHP).
  - ☐ Prepaid Ambulatory Health Plans (PAHP).
  - ☐ Primary Care Case Management (PCCM).
- ☒ Fee-for-service.
- ☐ Other service delivery system.

Managed Care Options

Managed Care Assurance

☑ The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

HIP 2.0 is being implemented as a replacement of the original HIP program. HIP has been offering benefits through a managed care delivery system since 2008, and HIP 2.0 will build upon the established HIP structure. During implementation, HIP 2.0 MCEs will be the same MCEs that currently offer HIP benefits. The state is engaging with these current HIP MCEs to assure that current HIP members are smoothly transitioned to HIP 2.0.

MCO: Managed Care Organization

The managed care delivery system is the same as an already approved managed care program. Yes

The managed care program is operating under (select one):

- ○ Section 1915(a) voluntary managed care program.
- ○ Section 1915(b) managed care waiver.
- ◉ Section 1932(a) mandatory managed care state plan amendment.
- ○ Section 1115 demonstration.
- ○ Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Alternative Benefit Plan

Identify the date the managed care program was approved by CMS: Dec., 14, 2007

Describe program below:

The HIP 2.0 program was developed from expanding the existing HIP program to reach more individuals and provide better access to benefits including more coverage options. This program will replace traditional Medicaid for all non-disabled adults ages 19-64 with income below 133% of FPL as based on MAGI income standards. The key feature of the HIP program is the high-deductible design and the Personal Wellness and Responsibility (POWER) account where members make contributions based on their income and use the funds in the account to cover their deductible expenses. Under HIP 2.0, members who consistently make required contributions to their POWER account will maintain access to the HIP Plus plan that includes enhanced benefits, such as dental and vision coverage. Members up to and including 100% FPL who do not make monthly POWER account contributions will be placed in the HIP Basic plan, a more limited benefit plan, which will also require co-payments for all services in lieu of the monthly POWER account contributions. Those with income over this amount who do not make required contributions are disenrolled and subject to a six month lock-out period. Lock-out will not apply if you are medically frail, residing in a domestic violence shelter or in a state declared disaster area.

All HIP medical benefits are currently provided through three managed care entities ("MCE"), Anthem, MDwise, and Managed Health Services. These same MCE's will provide HIP 2.0 services. HIP members have access to enrollment brokers, who provide counseling on the available MCE choices. For HIP members, once an MCE has been selected and the member has paid their POWER account contribution, the member must remain in the MCE for 12 months, as applicable. Members who do not select an MCE will be auto-assigned to an MCE, but will have the opportunity to change the assigned MCE before the first POWER account contribution is made.

Additional Information: MCO (Optional)

Provide any additional details regarding this service delivery system (optional):

As selected above, the state's managed care program currently operates under Section 1932(a) mandatory managed care state plan amendment. This is concurrent with the 1115 authority in order to authorize the enrollment processes.

Fee-For-Service Options

Indicate whether the state/territory offers traditional fee-for-service and/or services managed under an administrative services organization:

- (●) Traditional state-managed fee-for-service
- ( ) Services managed under an administrative services organization (ASO) arrangement

Please describe this fee-for-service delivery system, including any bundled payment arrangements, pay for performance, fee-for-service care management models/non-risk, contractual incentives as well as the population served via this delivery system.

Additional Information: Fee-For-Service (Optional)

Provide any additional details regarding this service delivery system (optional):

Under HIP 2.0, all services are carved into the Managed Care System except for Medicaid Rehabilitation Option (MRO) services which will be provided to qualifying individuals receiving the ABP that is the State Plan. Individuals eligible for MRO under HIP 2.0 would also be eligible for the State's 1915(i) Behavioral and Primary Health Care Coordination program. It is anticipated that there will be minimal use of MRO for individuals enrolled in HIP 2.0.

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V.20140417

Alternative Benefit Plan

State Name: Indiana

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0025

OMB Expiration date: 10/31/2014

Employer Sponsored Insurance and Payment of Premiums	ABP9
The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package.	No
The state/territory otherwise provides for payment of premiums.	No

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

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V.20140415

Alternative Benefit Plan

State Name: Indiana

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0025

OMB Expiration date: 10/31/2014

General Assurances — ABP10

Economy and Efficiency of Plans

☑ The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services. Yes

Compliance with the Law

☑ The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.

☑ The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).

☑ The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

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V.20140415

Alternative Benefit Plan

State Name: Indiana

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0025

OMB Expiration date: 10/31/2014

Payment Methodology ABP11

Alternative Benefit Plans - Payment Methodologies

☑ The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.

An attachment is submitted.

V.20140415