

Table of Contents

State/Territory Name: IN

State Plan Amendment (SPA) #: 18-0050

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages



June 20, 2018

Shane Hatchett, Acting Medicaid Director
Family and Social Services Administration
402 West Washington, Room W461
Indianapolis, IN 46204

ATTN: Angela Todd

RE: Transmittal Number (TN) 18-0050

Dear Mr. Hatchett:

Enclosed for your records is an approved copy of the following state plan amendment TN 18-0050:

- This state plan amendment will permanently discontinue the Healthy Indiana Plan Link alternative benefit plan.
- Effective Date: February 1, 2018
- Approval Date: June 20, 2018

If you have any questions, please have a member of your staff contact Jennifer Maslowski at (217) 492-4120 or by email at jennifer.maslowski@cms.hhs.gov.

Sincerely,

/s/

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

Enclosure

cc: Kelly Flynn, FSSA
Angela Todd, FSSA

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-18-050

Proposed Effective Date

02/01/2018 (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	2018	\$ 0.00
Second Year	2019	\$ 0.00

Subject of Amendment

This amendment is to permanently discontinue the HIP Link ABP.

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: Kelly Flynn
Last Revision Date: Jun 15, 2018
Submit Date: Mar 28, 2018

Date Received: February 13, 2018
Signature of Regional Official: /s/
Typed Name: Ruth A. Hughes
Title: Associate Regional Administrator

Date Approved: June 20, 2018
Effective Date of Approved Material: February 1, 2018

Medicaid Alternative Benefit Plan

Medicaid Alternative Benefit Plan: General Information

State/Territory name: **Indiana**
Transmittal Number: **IN-18-050**

General Information:

Submission Title:

short (under 100 characters) label used to identify this submission in the web application

IN ABP 15-026 - HIP Link ABP

Description:

This submission is to permanently discontinue the HIP Link ABP.

Public notice has been conducted prior to SPA submission pursuant to 42 CFR 440.386.

ABP Screening Statements to Indicate Required Forms

Select one of the following options for eligibility group coverage:

- The population group for this Alternative Benefit Plan includes only the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.** *If the state selects this option, the state must complete form ABP2a to indicate agreement to voluntary benefit package selection assurances for the adult group.*
- The population group for this Alternative Benefit Plan includes the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act, and also includes other groups.** *If the state selects this option, the state must complete forms ABP2a and ABP2b to indicate agreement to voluntary benefit package selection assurances for the adult group and voluntary enrollment assurances for other eligibility groups.*
- The population for this Alternative Benefit Plan does not include the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.** *If the state selects this option, the state must complete form ABP2b to indicate agreement to voluntary enrollment assurances for these eligibility groups.*

Enrollment is mandatory for some or all participants. *If selected, the state must complete form ABP2c to indicate agreement to mandatory enrollment assurances.*

Specify the number of **benchmark** benefit packages that will be created or amended with this submission. *The state must submit one version of forms ABP3, ABP4, ABP5, and ABP8 for each benchmark benefit package.*

1

Specify the number of **benchmark-equivalent** benefit packages that will be created or amended with this submission. *The state must submit one version of forms ABP3, ABP4, ABP6, and ABP8 for each benchmark-equivalent benefit package.*

0

Medicaid Alternative Benefit Plan: File Management Summary

State/Territory name: **Indiana**
Transmittal Number: **IN-18-050**

Form Code	Form Name	Uploaded Form Count
ABP1	Alternative Benefit Plan Populations	1
ABP2a	Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act	1

TN: 18-0050

Approval Date: 6/20/2018

Indiana

Effective Date: 2/1/2018

Form Code	Form Name	Uploaded Form Count
ABP2b	Voluntary Enrollment Assurances for Eligibility Groups other than the Adult Group under Section 1902(a)(10)(A)(i)(VIII) of the Act	1
ABP2c	Enrollment Assurances - Mandatory Participants	1
ABP3	Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package	1
ABP4	Alternative Benefit Plan Cost-Sharing	1
ABP5	Benefits Description	1
ABP6	Benchmark-Equivalent Benefit Package	0
ABP7	Benefits Assurances	1
ABP8	Service Delivery Systems	1
ABP9	Employer Sponsored Insurance and Payment of Premiums	1
ABP10	General Assurances	1
ABP11	Payment Methodology	1

Medicaid Alternative Benefit Plan: File Management Detail

Form ABP1: Alternative Benefit Plan Populations

ABP1 Forms List

Form
Please provide a short description of this ABP1 form: HIP Link ABP 1 Uploaded Form Name: 7.31.15 ABP1 HIPLink.pdf Date Uploaded:

Support Documents

Document
Please provide a short description of this support document: Public Notice Uploaded Document Name: 8.19.15 Published public notice.pdf Date Uploaded:

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

ABP2a Forms List

Form
Please provide a short description of this ABP2a form: HIP Link ABP 2a Uploaded Form Name:

TN: 18-0050

Approval Date: 6/20/2018

Indiana

Effective Date: 2/1/2018

Form	
	Date Uploaded:
9.21.15 ABP2a HIPLink.pdf	

Support Documents

Document

Form ABP2b: Voluntary Enrollment Assurances for Eligibility Groups other than the Adult Group under Section 1902(a)(10)(A)(i)(VIII) of the Act

ABP2b Forms List

Form	
Please provide a short description of this ABP2b form: HIP Link ABP 2b	
Uploaded Form Name:	Date Uploaded:
7.31.15 ABP2b HIPLink.pdf	

Support Documents

Document

Form ABP2c: Enrollment Assurances - Mandatory Participants

ABP2c Forms List

Form	
Please provide a short description of this ABP2c form: HIP Link ABP 2c	
Uploaded Form Name:	Date Uploaded:
9.1.15 ABP2c HIPLink.pdf	

Support Documents

Document

Form ABP3: Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package

ABP3 Forms List

Form	
Please provide a short description of this ABP3 form: ABP 3 HIP Link	
Uploaded Form Name:	

Form	
	Date Uploaded:
9.25.15 ABP3 HIPLink.pdf	

Support Documents

Document

Form ABP4: Alternative Benefit Plan Cost-Sharing

ABP4 Forms List

Form	
Please provide a short description of this ABP4 form: HIP Link ABP 4	
Uploaded Form Name:	Date Uploaded:
8.10.15 ABP4 HIPLink.pdf	

Support Documents

Document

Form ABP5: Benefits Description

ABP5 Forms List

Form	
Please provide a short description of this ABP5 form: HIP Link ABP 5	
Uploaded Form Name:	Date Uploaded:
8.31.15 ABP5 HIPLink.pdf	

Support Documents

Document	
Please provide a short description of this support document: Supplemental Info	
Uploaded Document Name:	Date Uploaded:
9.25.15 Supplemental Information ABP 5.pdf	

Form ABP6: Benchmark-Equivalent Benefit Package

ABP6 Forms List

TN: 18-0050

Indiana

Approval Date: 6/20/2018

Effective Date: 2/1/2018

Form

Support Documents

Document

Form ABP7: Benefits Assurances

ABP7 Forms List

Form	
Please provide a short description of this ABP7 form: HIP Link ABP 7	
Uploaded Form Name:	Date Uploaded:
8.31.15 ABP7 HIPLink.pdf	

Support Documents

Document	
Please provide a short description of this support document: Supplemental info - ABP 7	
Uploaded Document Name:	Date Uploaded:
8.31.15 Supplemental Information ABP 7.pdf	

Form ABP8: Service Delivery Systems

ABP8 Forms List

Form	
Please provide a short description of this ABP8 form: HIP Link ABP8	
Uploaded Form Name:	Date Uploaded:
7.31.15 ABP8 HIPLink.pdf	

Support Documents

Document

Form ABP9: Employer Sponsored Insurance and Payment of Premiums

ABP9 Forms List

Form
Please provide a short description of this ABP9 form: HIP Link ABP 9

Form	
Uploaded Form Name:	Date Uploaded:
8.20.15 ABP9 HIPLink.pdf	

Support Documents

Document	
Please provide a short description of this support document:	
<input type="text"/>	
Uploaded Document Name:	Date Uploaded:

Form ABP10: General Assurances

ABP10 Forms List

Form	
Please provide a short description of this ABP10 form: HIP Link ABP 10	
Uploaded Form Name:	Date Uploaded:
8.14.15 ABP 10 HipLink.pdf	

Support Documents

Document	
Please provide a short description of this support document: Supplemental info	
Uploaded Document Name:	Date Uploaded:
10.1.15 Supplemental Information ABP 10.pdf	

Form ABP11: Payment Methodology

ABP11 Forms List

Form	
Please provide a short description of this ABP11 form: HIP Link ABP 11	
Uploaded Form Name:	Date Uploaded:
8.12.15 ABP11 HIPLink.pdf	

Support Documents

Document	
Please provide a short description of this support document: Supplemental Info	
Uploaded Document Name:	Date Uploaded:
10.1.15 Supplemental Information ABP 11.pdf	

Medicaid Alternative Benefit Plan: Tribal Input

State/Territory name: **Indiana**
 Transmittal Number: **IN-18-050**

One or more Indian Health Programs or Urban Indian Organizations furnish health care services in this State.

- This State Plan Amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations.
- The State has solicited advice from Indian Health Programs, Urban Indian Organizations, and/or Tribal governments prior to submission of this State Plan Amendment.

Complete the following information regarding any tribal consultation conducted with respect to this submission:

Tribal consultation was conducted in the following manner. States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation below:

- Indian Tribes
- Indian Health Programs
- Urban Indian Organization

The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.

Indicate the key issues raised in Indian consultative activities:

- Access
 - Summarize Comments
 - Summarize Response
- Quality
 - Summarize Comments
 - Summarize Response
- Cost

TN: 18-0050

Approval Date: 6/20/2018

Indiana

Effective Date: 2/1/2018

	Summarize Comments	<input type="text"/>
	Summarize Response	<input type="text"/>
<input type="checkbox"/>	Payment methodology	
	Summarize Comments	<input type="text"/>
	Summarize Response	<input type="text"/>
<input type="checkbox"/>	Eligibility	
	Summarize Comments	<input type="text"/>
	Summarize Response	<input type="text"/>
<input type="checkbox"/>	Benefits	
	Summarize Comments	<input type="text"/>
	Summarize Response	<input type="text"/>
<input type="checkbox"/>	Service delivery	
	Summarize Comments	<input type="text"/>
	Summarize Response	<input type="text"/>
<input type="checkbox"/>	Other Issue	

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name: Indiana

Transmittal Number:

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Proposed Effective Date

(mm/dd/yyyy)

Federal Statute/Regulation Citation

Federal Budget Impact

TN: 18-0050

Approval Date: 6/20/2018

Indiana

Effective Date: 2/1/2018

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

Subject of Amendment

This amendment is to permanently discontinue the HIP Link ABP.

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:	Kelly Flynn
Last Revision Date:	Jun 8, 2018
Submit Date:	Mar 28, 2018