Alternative Benefit Plan

State Name: Indiana

Attachment 3.1-L-

OMB Control Number: 0938-1148

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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:

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

Managed Care Options

Managed Care Assurance

- [x] 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 new HIP 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, members who consistently make required contributions to their POWER account will maintain access to the HIP Plus plan that includes enhanced benefits, such as chiropractic, 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 four managed care entities ("MCE"), Anthem, CareSource, MDwise, and Managed Health Services. These same MCE's will provide HIP 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, 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 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.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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