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State/Territory Name: IN

State Plan Amendment (SPA) #: 18-0051

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

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

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) 18-0051

Dear Mr. Hatchett:

Enclosed for your records is an approved copy of the following state plan amendment TN 18-0051:

- This state plan amendment adds chiropractic and enhanced substance use disorder benefits to Healthy Indiana Plan Plus.
- 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: Angela Todd, FSSA
Kelly Flynn, 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-18-051

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 add chiropractic and enhanced substance use disorder benefits.

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:
Typed Name: Ruth A. Hughes
Title: Associate Regional Administrator

Date Approved:
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-18-051**

General Information:

Submission Title:

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

IN ABP 15-0025 - HIP Plus ABP

Description:

This submission outlines the ABPs for HIP Plus. The fiscal impact of the expansion is reflected in the related eligibility group SPAs, and per CMS guidance, the fiscal impact submitted with this transaction is $0.

☑ 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 <u>only</u>** 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 **<u>benchmark</u>** 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 **<u>benchmark-equivalent</u>** 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-18-051**

Form Code	Form Name	Uploaded Form Count
ABP1	**Alternative Benefit Plan Populations**	**1**
ABP2a		**1**

Form Code	Form Name	Uploaded Form Count
	Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act	
ABP2b	**Voluntary Enrollment Assurances for Eligibility Groups other than the Adult Group under Section 1902(a)(10)(A)(i)(VIII) of the Act**	**0**
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 Plus ABP 1 **Uploaded Form Name:** **Date Uploaded:** ABP1 HIP Plus-3.28.28.pdf

Support Documents

Document
Please provide a short description of this support document: Public notice for HIP 2.0 ABPs and cost sharing. **Uploaded Document Name:** **Date Uploaded:** HIPSPAPublicNotice.pdf

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:

Form
HIP Plus ABP 2a **Uploaded Form Name:** **Date Uploaded:** 6.1.15 ABP2a HIP Plus.pdf

Support Documents

Document
Please provide a short description of this support document: Medically Frail Methodology Examples **Uploaded Document Name:** **Date Uploaded:** 6.2.15 Medically Frail Methodology Examples.pdf
Please provide a short description of this support document: Medically Frail Population Identification **Uploaded Document Name:** **Date Uploaded:** 6.2.15 Medically Frail Population Identification Update.pdf

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

Support Documents

Document

Form ABP2c: Enrollment Assurances - Mandatory Participants

ABP2c Forms List

Form
Please provide a short description of this ABP2c form: HIP Plus ABP 2c **Uploaded Form Name:** **Date Uploaded:** ABP2c HIP Basic-Update 3.28.18.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: HIP Plus ABP 3 **Uploaded Form Name:** **Date Uploaded:** 3.24.15 ABP3 HIPPlus.pdf

Support Documents

Document

Form ABP4: Alternative Benefit Plan Cost-Sharing

ABP4 Forms List

Form
Please provide a short description of this ABP4 form: ABP4 HIP Plus **Uploaded Form Name:** **Date Uploaded:** ABP4 HIP Plus-3.28.18.pdf

Support Documents

Document

Form ABP5: Benefits Description

ABP5 Forms List

Form
Please provide a short description of this ABP5 form: HIP Plus ABP 5 **Uploaded Form Name:** **Date Uploaded:** ABP5 HIP Plus-3.28.18.pdf

Support Documents

Document

Form ABP6: Benchmark-Equivalent Benefit Package

ABP6 Forms List

Form

Support Documents

Document

Form ABP7: Benefits Assurances

ABP7 Forms List

Form
Please provide a short description of this ABP7 form: HIP Plus ABP 7 **Uploaded Form Name:** **Date Uploaded:** 12.2.14 ABP7 HIPPlus.pdf

Support Documents

Document

Form ABP8: Service Delivery Systems

ABP8 Forms List

Form
Please provide a short description of this ABP8 form: HIP Plus ABP 8 **Uploaded Form Name:** **Date Uploaded:** ABP8 HIP Plus-3.28.18.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 Plus ABP 9 **Uploaded Form Name:** **Date Uploaded:** 12.11.14 ABP9 HIP Plus.pdf

Support Documents

Document

Form ABP10: General Assurances

ABP10 Forms List

Form
Please provide a short description of this ABP10 form: HIP Plus ABP 10 **Uploaded Form Name:** **Date Uploaded:** 12.2.14 ABP10 HIPPlus.pdf

Support Documents

Document

Form ABP11: Payment Methodology

ABP11 Forms List

Form
Please provide a short description of this ABP11 form: HIP Plus ABP 11 **Uploaded Form Name:** **Date Uploaded:** 12.2.14 ABP11 HIPPlus.pdf

Support Documents

Document

Medicaid Alternative Benefit Plan: Tribal Input

State/Territory name: **Indiana**

Transmittal Number: **IN-18-051**

☐ **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**

Summarize Comments

Summarize Response

☐ **Payment methodology**

Summarize Comments

Summarize Response

☐ **Eligibility**

Summarize Comments

Summarize Response

☐ **Benefits**

Summarize Comments

Summarize Response

☐ **Service delivery**

Summarize Comments

Summarize Response

☐ **Other Issue**

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name: **Indiana**

Transmittal Number:

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Federal Statute/Regulation Citation

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Federal Budget Impact

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

Subject of Amendment

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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**