

Attachment 3 – Services: General Provisions

3.1-C. Benchmark Benefit Package and Benchmark Equivalent Benefit Package (provided in accordance with 1937 of the Act and 42 CFR Part 440).

The State/Territory provides benchmark benefits:

- Provided
- Not Provided

States/Territories can have more than one alternative/benchmark benefit plan for different individuals in the new optional group. If the State/Territory has more than one alternative benefit plan, as in the example below, then a pre-print would need to appear for each additional Benchmark Plan title. (Ex: if the box signifying “Plan A” was checked then the remainder of the pre-print that would appear would be specific only to “Plan A”. If “Plan B” was checked then the following pre-print that would appear would be a completely new pre-print that would be filled out by the State/Territory and would correlate to “Plan B” only.)

Healthy Indiana Plan

1. Populations and geographic area covered

a) Individuals eligible under groups other than the early option group authorized under section 1902(a)(10)(A)(i)(VIII) and 1902(k)(2)

The State/Territory will provide the benefit package to the following populations:

- (i) Populations who are full benefit eligibility individuals in a category established on or before February 8, 2006, who will be required to enroll in an alternative benefit plan to obtain medical assistance.

Note: Populations listed below may not be required to enroll in a benchmark plan. The Benchmark-exempt individuals under 1937(a)(2)(B) are:

- A pregnant woman who is required to be covered under the State/Territory plan under section 1902(a)(10)(A)(i) of the Act.
- An individual who qualifies for medical assistance under the State/Territory plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for Supplemental Security Income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3) of the Act.
- An individual entitled to benefits under any part of Medicare.

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- An individual who is terminally ill and is receiving benefits for hospice care under title XIX.
- An individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and is required, as a condition of receiving services in that institution under the State/Territory plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.
- An individual who is medically frail or otherwise an individual with special medical needs. For these purposes, the State/Territory's definition of individuals who are medically frail or otherwise have special medical needs must at least include those individuals described in 42 CFR §438.50(d)(3), children with serious emotional disturbances, individuals with disabling mental disorders, individuals with serious and complex medical conditions, and individuals with physical and or mental disabilities that significantly impair their ability to perform one or more activities of daily living.
- An individual who qualifies based on medical condition for medical assistance for long-term care services described in section 1917(c)(1)(C) of the Act.
- An individual with respect to whom child welfare services are made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of title IV, without regard to age.
- A parent or caretaker relative whom the State/Territory is required to cover under section 1931 of the Act.
- A woman who is receiving medical assistance by virtue of the application of sections 1902(a)(10)(ii)(XVIII) and 1902(aa) of the Act.
- An individual who qualifies for medical assistance on the basis of section 1902(a)(10)(A)(ii)(XII) of the Act.
- An individual who is only covered by Medicaid for care and services necessary for the treatment of an emergency medical condition in accordance with section 1903(v) of the Act.
- An individual determined eligible as medically needy or eligible because of a reduction of countable income based on costs incurred for medical or other remedial care under section 1902(f) of the Act or otherwise based on incurred medical costs.

For full benefit Medicaid eligibility groups included in the alternative benefit plan, please indicate in the chart below:

- Each eligibility group the State/Territory will require to enroll in the alternative benefit plan;
- Each eligibility group the State/Territory will allow to voluntarily enroll in the alternative benefit plan;
- Specify any additional targeted criteria for each included group (e.g., income standard);
- Specify the geographic area in which each group will be covered.

Required Enrollment	Opt-In Enrollment	Full-Benefit Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
No	No	Mandatory categorically needy low-income families and children eligible	No	No

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		under section 1925 for Transitional Medical Assistance		
No	No	Mandatory categorically needy poverty level infants eligible under 1902(a)(10)(A)(i)(IV)	No	No
No	No	Mandatory categorically needy poverty level children aged 1 up to age 6 eligible under 1902(a)(10)(A)(i)(VI)	No	No
No	No	Mandatory categorically needy poverty level children aged 6 up to age 19 eligible under 1902(a)(10)(A)(i)(VII)	No	No
No	No	Other mandatory categorically needy groups eligible under 1902(a)(10)(A)(i) as listed below and include the citation from the Social Security Act for each eligibility group: <ul style="list-style-type: none"> • • • • 	No	No
No	No	Optional categorically needy poverty level pregnant women eligible under 1902(a)(10)(A)(ii)(IX)	No	No
No	No	Optional categorically needy poverty level infants eligible under 1902(a)(10)(A)(ii)(IX)	No	No
No	No	Optional categorically needy AFDC-related families and children eligible under 1902(a)(10)(A)(ii)(I)	No	No
No	No	Medicaid expansion/optional targeted low-income children eligible under 1902(a)(10)(A)(ii)(XIV)	No	No
No	No	Other optional categorically needy groups eligible under 1902(a)(10)(A)(ii) as listed below and include the citation from the Social Security Act for each eligibility group: <ul style="list-style-type: none"> • • • • 	No	No

(ii) The following populations will be given the option to voluntarily enroll in an alternative benefit plan. Please indicate in the chart below:

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- Each population the State/Territory will allow to voluntarily enroll in the alternative benefit plan,
- Specify any additional targeted criteria for each included population (e.g., income standard).
- Specify the geographic area in which each population will be covered.

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
No	Mandatory categorically needy low-income parents eligible under 1931 of the Act	No	No
No	Mandatory categorically needy pregnant women eligible under 1902(a)(10)(A)(i)(IV) or another section under 1902(a)(10)(A)(i):	No	No
No	Individuals qualifying for Medicaid on the basis of blindness	No	No
No	Individuals qualifying for Medicaid on the basis of disability	No	No
No	Individuals who are terminally ill and receiving Medicaid hospice benefits under 1902(a)(10)(A)(ii)(VII)	No	No
No	Institutionalized individuals assessed a patient contribution towards the cost of care	No	No
No	Individuals dually eligible for Medicare and Medicaid (42 CFR §440.315)	No	No
No	Disabled children eligible under the TEFRA option - section 1902(e)(3)	No	No
No	Medically frail and individuals with special medical needs	No	No
No	Children receiving foster care or adoption assistance under title IV-E of the Act	No	No
No	Women needing treatment for breast or cervical cancer who are eligible under 1902(a)(10)(A)(ii)(XVIII)	No	No
N/A	Individuals eligible as medically needy under section 1902(a)(10)(C) – NO medically needy program	N/A	N/A
No	Individuals who qualify based on medical condition for long term care services under 1917(c)(1)(C)	No	No

Limited Services Individuals

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
N/A	TB-infected individuals who are eligible under 1902(a)(10)(A)(ii)(XII) - Not covered	N/A	N/A

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No	Illegal or otherwise ineligible aliens who are only covered for emergency medical services under section 1903(v)	No	No
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(iii) When offering voluntary enrollment in a benchmark/benchmark-equivalent benefit plan to exempt populations, prior to enrollment the State/Territory assures it will:

- Effectively inform the individual that enrollment is voluntary, the individual may disenroll at any time and regain immediate access to full standard State/Territory plan coverage, and has described the process for disenrolling.
- Inform the individual of the benefits available under the benchmark/benchmark-equivalent benefit plan, the costs of the package and has provided a comparison of how the benchmark plan differs from the standard State/Territory plan benefits.
- Document in the exempt individual’s eligibility file that:
 - The individual was informed in accordance with this section prior to enrollment,
 - The individual was given ample time to arrive at an informed choice,
 - The individual voluntarily and affirmatively chose to enroll in the benchmark/benchmark-equivalent plan.
- For individuals the State/Territory determines have become exempt from enrollment in a benchmark/benchmark-equivalent 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. Please describe below the process the State/Territory will use to comply with this requirement.
- The State/Territory will promptly process all requests made by exempt individuals for disenrollment from the benchmark/benchmark-equivalent plan and has in place a process that ensures exempt individuals have access to all standard State/Territory plan services while the disenrollment request is being processed.
- The State/Territory will maintain data that tracks the total number of individuals that have voluntarily enrolled in a benchmark/benchmark-equivalent plan and the total number who have disenrolled.

For populations/individuals (checked above in 1a. & 1b.) who voluntarily enroll, describe in the below the manner in which the State/Territory will inform each individual that:

- Enrollment is voluntary;
- Each individual may choose at any time not to participate in an alternative benefit package and;
- Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State/Territory plan.

b) Individuals eligible under the early option group authorized under sections 1902(a)(10)(A)(i)(VIII) and 1902 (k)(2)

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Note: Individuals in the early option group who are exempt from mandatory enrollment in Benchmark coverage under 1937(a)(2)(B) CANNOT be mandated into a Benchmark plan. However, State/Territories may offer exempt individuals the opportunity to voluntarily enroll in the Benchmark plan.

Indiana is not offering the early option. This State Plan Amendment is intended to take effect January 1, 2014 for the newly eligible population.

- (i) The State/Territory has chosen to offer the populations/individuals in the early option group who are exempt from mandatory enrollment in the benchmark benefit plan the option to voluntarily enroll in the benchmark benefit plan. Please specify whether the benchmark will cover these individuals Statewide/Territory-wide or otherwise.
- (ii) When offering voluntary enrollment in a benchmark/benchmark-equivalent benefit plan to exempt populations, prior to enrollment the State/Territory assures it will:
- Effectively inform the individual that enrollment is voluntary, the individual may disenroll at any time and regain immediate access to full standard State/Territory plan coverage, and has described the process for disenrolling.
 - Inform the individual of the benefits available under the benchmark/benchmark-equivalent benefit plan, the costs of the package and has provided a comparison of how the benchmark plan differs from the standard State/Territory plan benefits.
 - Document in the exempt individual's eligibility file that:
 - The individual was informed in accordance with this section prior to enrollment,
 - The individual was given ample time to arrive at an informed choice,
 - The individual voluntarily and affirmatively chose to enroll in the benchmark/benchmark-equivalent plan.
 - For individuals the State/Territory determines have become exempt from enrollment in a benchmark/benchmark-equivalent 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. Please describe below the process the State/Territory will use to comply with this requirement.
 - The State/Territory will promptly process all requests made by exempt individuals for disenrollment from the benchmark/benchmark-equivalent plan and has in place a process that ensures exempt individuals have access to all standard State/Territory plan services while the disenrollment request is being processed.
 - The State/Territory will maintain data that tracks the total number of individuals that have voluntarily enrolled in a benchmark/benchmark-equivalent plan and the total number who have disenrolled.
 - For populations/individuals (checked above in 1a. & 1b.) who voluntarily enroll, describe below the manner in which the State/Territory will inform each individual that:
 - Enrollment is voluntary;
 - Each individual may choose at any time not to participate in an alternative benefit package and;

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- Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State/Territory plan.

2. Description of the Benefits

The State/Territory will provide the following alternative benefit package (check the one that applies).

a) Benchmark Benefits

- FEHBP-equivalent Health Insurance Coverage** – The standard Blue Cross/Blue Shield preferred provider option services benefit plan, described in and offered under section 8903(1) of Title 5, United States Code.
- State/Territory Employee Coverage** – A health benefits coverage plan that is offered and generally available to State/Territory employees within the State/Territory involved.

Please provide below either a World Wide Web URL (Uniform Resource Locator) link to the State/Territory's Employee Benefit Package or insert a copy of the entire State/Territory Employee Benefit Package.

- Coverage Offered Through a Commercial Health Maintenance Organization (HMO)** – The health insurance plan that is offered by an HMO (as defined in section 2791(b)(3) of the Public Health Service Act), and that has the largest insured commercial, non-Medicaid enrollment of such plans within the State/Territory involved.

The State/Territory assures that it complies with all Managed Care regulations at 43 CFR §438

Please provide below either a World Wide Web URL link to the HMO's benefit package or insert a copy of the entire HMO's benefit package.

- Secretary-approved Coverage** – Any other health benefits coverage that the Secretary determines provides appropriate coverage for the population served. Provide below a full description of the benefits in the plan, including any applicable limitations. Also include a benefit by benefit comparison to services in the State/Territory plan or to services in any of the three Benchmark plans above.

b) Benchmark-Equivalent Benefits.

Please specify below which benchmark plan or plans this benefit package is equivalent to:

- (i) **Inclusion of Required Services** – The State/Territory assures the alternative benefit plan includes coverage of the following categories of services: (Check all that apply).

Inpatient and outpatient hospital services;

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- Physicians’ surgical and medical services;
- Laboratory and x-ray services;
- Coverage of prescription drugs
- Mental health services
- Well-baby and well-child care services as defined by the State/Territory, including age-appropriate immunizations in accordance with the Advisory Committee on Immunization Practices;
- Emergency services
- Family planning services and supplies
- (ii) Additional services
Please list the additional services being provided.

Please insert below a full description of the benefits in the plan including any additional services and limitations.

HIP offers the following coverage:

- 1) *A basic commercial benefits package once annual medical costs exceed \$1,100*
- 2) *A Personal Wellness and Responsibility (POWER) Account valued at \$1,100 per adult to pay for initial medical costs. The POWER Accounts provide incentives for participants to utilize services in a cost-efficient manner. HIP members make monthly contributions to their POWER accounts depending on the their income level and the State funds the remainder of the account.*
- 3) *\$500 in “first dollar” preventive benefits, these benefits are at no cost to HIP members and will not deplete their POWER Account*

The Healthy Indiana Plan Covers:

Benefit	Limits
Inpatient Facility	
Medical/Surgical	
Mental Health/Substance Abuse	Covered same as any other service
Skilled Nursing Facilities	Subject to a 60-day maximum
Outpatient Facility	
Surgery	
Emergency Room	Co-payment for services determined to be non-emergency : \$6 for adults 100% FPL to 133% FPL, \$3 for adults up to 100% FPL
Urgent Care	
Physical/Occupational/Speech Therapy	25-visit annual maximum for each type of therapy

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<i>Radiology/Pathology</i>	
<i>Pharmacy and Blood</i>	<i>Generic preference, brands allowed when no generic is available</i>
Professional Services	
<i>Inpatient/Outpatient Surgery</i>	
<i>Inpatient/Outpatient ER Visits</i>	
<i>Office Visits/Consults</i>	
<i>Preventive Services</i>	<i>At least \$500 annual first dollar coverage</i>
<i>Physical/Occupational/Speech Therapy</i>	<i>25-visit annual maximum for each type of therapy</i>
<i>Radiology/Pathology</i>	
<i>Outpatient Mental Health/ Substance Abuse</i>	<i>Covered the same as any other illness</i>
Ancillary Services	
<i>Prescription Drug</i>	<i>Brand name drugs are not covered where a generic substitute is available</i>
<i>Home Health</i>	<i>Excludes long term care.</i>
<i>Hospice</i>	
<i>Emergency and Non-Emergency Transportation</i>	
<i>Durable Medical Equipment/Supplies/Prosthetics</i>	
<i>Family Planning Services</i>	<i>Excludes abortion or abortifacients. Includes contraceptives and sexually transmitted disease testing as described in Medicaid law (42 USC 1396).</i>
<i>Lead Screening Services</i>	<i>Under 21 Years of Age</i>
<i>Hearing Aids</i>	
<i>Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services</i>	<i>Subject to the HIP benefit coverage limits</i>
<i>Vision</i>	
<i>Disease Management Services</i>	
<i>Maternity Coverage</i>	

- X (iii) The State/Territory assures that the benefit package has been determined to have an aggregate actuarial value equivalent to the specified benchmark plan in an actuarial report that:
- Has been prepared by an individual who is a member of the American Academy of Actuaries;
 - Using generally accepted actuarial principles and methodologies;
 - Using a standardized set of utilization and price factors;
 - Using a standardized population that is representative of the population being served;
 - Applying the same principles and factors in comparing the value of different coverage (or

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categories of services) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and

- Takes into account the ability of a State/Territory to reduce benefits by taking into account the increase in actuarial value of benefits coverage without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used and taking into account the ability of the State/Territory to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State/Territory plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage.

Please insert a copy of the report.

The report from Milliman is attached to this submission.

- (iv) The State/Territory assures that if the benchmark plan used by the State/Territory for purposes of comparison in establishing the aggregate value of the benchmark-equivalent package includes any of the following two categories of services, the actuarial value of the coverage for each of these categories of services in the benchmark-equivalent coverage package is at least 75 % of the actuarial value of the coverage for that category of service in the benchmark plan used for comparison by the State/Territory:

- Vision services, and/or
- Hearing services

Please insert below a description of the categories of benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the category of services included in the benchmark benefit plan.

Benefit summary is attached.

- c) Additional Benefits

If checked please insert a full description of the additional benefits including any limitations.

3. Service Delivery System

Check all that apply.

- The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)
- The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements cited above, except that it will be operated with a primary care case management system consistent with section 1905(a)(25) and 1905(t). (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)

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The alternative benefit plan will be provided through a managed care organization consistent with applicable managed care requirements (42 CFR §438, 1903(m), and 1932).

The alternative benefit plan will be provided through PIHPs (Pre-paid Inpatient Health Plan) consistent with 42 CFR §438.

The alternative benefit plan will be provided through PAHPs (Pre-paid Ambulatory Health Plan).

The alternative benefit plan will be provided through a combination of the methods described above. Please describe how this will be accomplished. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology when applicable.)

HIP is provided through managed care organizations for all patients except those with specified high risk conditions. The HIP-Enhanced Services Plan (ESP) provides enhanced disease management services. ESP services are reimbursed on a fee for service basis per the attached reimbursement schedule.

4. Employer Sponsored Insurance

The alternative benefit plan is provided in full or in part through premiums paid for an employer sponsored health plan.

5. Assurances

The State/Territory assures EPSDT services will be provided to individuals under 21 years old who are covered under the State/Territory Plan under section 1902(a)(10)(A).

Through Benchmark only

As an Additional benefit under section 1937 of the Act

The State/Territory assures that individuals will have access to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) services as defined in subparagraphs (B) and (C) of section 1905(a)(2).

The State/Territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Act.

The State/Territory assures transportation (emergency and non-emergency) for individuals enrolled in an alternative benefit plan. Please describe how and under which authority(s) transportation is assured for these beneficiaries.

We understand that emergency and non-emergency transportation are a requirement of the benchmark plan and our intent is to comply with the benchmark requirements. Indiana's State Plan includes these services.

The State/Territory assures that family planning services and supplies are covered for individuals of child-bearing age.

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6. Economy and Efficiency of Plans

The State/Territory assures that alternative benefit coverage is provided in accordance with Federal upper payment limits procurement 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.

7. 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.

8. Implementation Date

The State/Territory will implement this State/Territory Plan amendment on January 1st, 2014 (date).

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