Citation	Condition or Requirement

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of **Indiana** enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230).

This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries described in 42 CFR 438.50(d).

Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 438 et seq., the state shall place check mark to affirm such compliance.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)-(2)

B. Managed Care Delivery System.

The State will contract with the entity(ies) below and reimburse them as noted under each entity type.

1. X MCO
   a. X Capitation

2. ☐ PCCM (individual practitioners)
   a. ☐ Case management fee
   b. ☐ Bonus/incentive payments
   c. ☐ Other (please explain below)

3. ☐ PCCM (entity based)
   a. ☐ Case management fee
   b. ☐ Bonus/incentive payments
   c. ☐ Other (please explain below)

Citation	Condition or Requirement

For states that elect to pay a PCCM a bonus/incentive payment as indicated in B.2.b. or B.3.b, place a check mark to affirm the state has met ***all*** of the following conditions (which are representative of the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

☐ a. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.

☐ b. Incentives will be based upon a fixed period of time.

☐ c. Incentives will not be renewed automatically.

☐ d. Incentives will be made available to both public and private PCCMs.

☐ e. Incentives will not be conditioned on intergovernmental transfer agreements.

☐ f. Incentives will be based upon specific activities and targets.

CFR 438.50(b)(4) C. Public Process.

Describe the public process including tribal consultation, if applicable, utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)*

In early 1998, Indiana began outreach to Hoosiers seeking input on the new Children's Health Insurance Program (CHIP) option. Town halls were held throughout the state to seek public input, advisory groups were formed to assist in the design of the program and the state legislature passed necessary legislation to implement the new program. An extensive advertising campaign using television, radio and billboards was launched in 1998 to educate the public on the new program and encourage parents to enroll their children.

Many legislative study committee and advisory groups have formed since the implementation of CHIP in Indiana in 1998. These committee and groups provide a

Citation	Condition or Requirement

forum for the public and stakeholders to voice their opinions on CHIP and Hoosier Healthwise.

Presumptive Eligibility (PE) for pregnant women was legislatively mandated by the Indiana General Assembly during the 2007 legislative session. Public forums and presentations were held to gather feedback from providers and the public. Effective February 1, 2018, this population is no longer in managed care

D. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I)
1903(m)
42 CFR 438.50(c)(1)

1. X The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.

1932(a)(1)(A)(i)(I)
1905(t)
42 CFR 438.50(c)(2)
1902(a)(23)(A)

2. ☐The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.

1932(a)(1)(A)
42 CFR 438.50(c)(3)

3. X The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring Beneficiaries to receive their benefits through managed care entities will be met.

1932(a)(1)(A)
42 CFR 431.51
1905(a)(4)(C)

4. X The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.

1932(a)(1)(A)

5. X The state assures that it appropriately identifies individuals in the mandatory exempt groups identified in 1932(a)(1)(A)(i).

1932(a)(1)(A)
42 CFR 438

6. X The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.

Citation		Condition or Requirement
1903(m)		
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	7.	X The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.
1932(a)(1)(A) CFR 447.362 42 CFR 438.50(c)(6)	8.	☐ The state assures that all applicable requirements of 42 CFR 447.362 for 42 payments under any non-risk contracts will be met.
45 CFR 92.36	9.	X The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

Citation | Condition or Requirement

1932(a)(1)(A)
1932(a)(2)

E. Populations and Geographic Area

1. **Included Populations.** Please check which eligibility populations are included, if they are enrolled on a mandatory (M) or voluntary (V) basis, and the geographic scope of enrollment. Under the geography column, please indicate whether the nature of the population's enrollment is on a statewide basis, or if on less than a statewide basis, please list the applicable counties/regions.

Hoosier Healthwise

Population	M	Geographic Area	V	Geographic Area	Excluded
Section 1931 Children & Related Populations – 1905(a)(i)	X	**Statewide**			X
Section 1931 Adults & Related Populations1905(a)(ii)					X
Low-Income Adult Group					X
Former Foster Care Children under age 21					X
Former Foster Care Children age 21-25					X
Section 1925 Transitional Medicaid age 21 and older					X
SSI and SSI related Blind Adults, age 18 or older* - 1905(a)(iv)					X
Poverty Level Pregnant Women – 1905(a)(viii)	X	**Statewide**			
SSI and SSI related Blind Children, generally under age 18 – 1905(a)(iv)					X
SSI and SSI related Disabled children under age 18					X
SSI and SSI related Disabled adults age 18 and older – 1905(a)(v)					X
SSI and SSI Related Aged Populations age 65 or older- 1905(a)(iii)					X

Citation | Condition or Requirement

Population	M	Geographic Area	V	Geographic Area	Excluded
SSI Related Groups Exempt from Mandatory Managed Care under 1932(a)(2)(B)					X
Recipients Eligible for Medicare					X
American Indian/Alaskan Natives			X	**Statewide**	
Children under 19 who are eligible for SSI					X
Children under 19 who are eligible under Section 1902(e)(3)					X
Children under 19 in foster care or other in-home placement					X
Children under 19 receiving services funded under section 501(a)(1)(D) of title V and in accordance with 42 CFR 438.50(d)(v)					X
Other					Reasonable Classifications of Children

Healthy Indiana Plan

Population	M	Geographic Area	V	Geographic Area	Excluded
Section 1931 Children & Related Populations – 1905(a)(i)					X
Section 1931 Adults & Related Populations1905(a)(ii)	X	**Statewide**			
Low-Income Adult Group	X	**Statewide**			
Former Foster Care Children under age 21					X
Former Foster Care Children age 21-25					X
Section 1925 Transitional Medicaid age 21 and older	X	**Statewide**			

Citation | Condition or Requirement

Population	M	Geographic Area	V	Geographic Area	Excluded
SSI and SSI related Blind Adults, age 18 or older* - 1905(a)(iv)					X
Poverty Level Pregnant Women – 1905(a)(viii)					X
SSI and SSI related Blind Children, generally under age 18 – 1905(a)(iv)					X
SSI and SSI related Disabled children under age 18					X
SSI and SSI related Disabled adults age 18 and older -- 1905(a)(v)					X
SSI and SSI Related Aged Populations age 65 or older- 1905(a)(iii)					X
SSI Related Groups Exempt from Mandatory Managed Care under 1932(a)(2)(B)					X
Recipients Eligible for Medicare					X
American Indian/Alaskan Natives			X	**Statewide**	
Children under 19 who are eligible for SSI					X
Children under 19 who are eligible under Section 1902(e)(3)					X
Children under 19 in foster care or other in-home placement					X
Children under 19 receiving services funded under section 501(a)(1)(D) of title V and in accordance with 42 CFR 438.50(d)(v)					X
Other					

Citation | Condition or Requirement

2. **Excluded Groups.** Within the populations identified above as Mandatory or Voluntary, there may be certain groups of individuals who are excluded from the managed care program. Please indicate if any of the following groups are excluded from participating in the program:

☐ Other Insurance--Medicaid beneficiaries who have other health insurance.

X Reside in Nursing Facility or ICF/MR--Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

X Enrolled in Another Managed Care Program--Medicaid beneficiaries who are enrolled in another Medicaid managed care program

☐ Eligibility Less Than 3 Months--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

X Participate in HCBS Waiver--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).

X Retroactive Eligibility–Medicaid beneficiaries for the period of retroactive eligibility.

X Other (Please define): Residing in a State Operated Facility or Psychiatric Residential Facility (Hoosier Healthwise).

1932(a)(4) F. Enrollment Process.

1. Definitions.

   a. Auto Assignment- assignment of a beneficiary to a health plan when the beneficiary has not had an opportunity to select their health plan.

   b. Default Assignment- assignment of a beneficiary to a health plan when the beneficiary has had an opportunity to select their health plan.

2. Please describe how the state effectuates the enrollment process. Select an enrollment methodology from the following options and describe the elements listed beneath it:

   a. X The applicant is permitted to select a health plan at the time of application.

Citation	Condition or Requirement

i. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).

ii. What action the state takes if the applicant does not indicate a plan selection on the application.

iii. If action includes making a default assignment, describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).

iv. The state's process for notifying the beneficiary of the default assignment. (Example: *state generated correspondence.*)

Applicants have access to Enrollment Broker choice counseling. If an MCO is not selected on the application, default assignment to an MCO is based on the member's prior relationship with an MCO. If there is no prior relationship, the member is assigned based on equitable distribution. The MCO assigns a PMP based on past relationship if the member does not self-select one.

b. ☐ The beneficiary has an active choice period following the eligibility determination.

i. How the beneficiary is notified of their initial choice period, including its duration.

ii. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).

iii. Describe the algorithm used for default assignment and describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).

iv. The state's process for notifying the beneficiary of the default assignment.

c. ☐ The beneficiary is auto-assigned to a health plan immediately upon being determined eligible.

Citation	Condition or Requirement

i. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).

ii. The state's process for notifying the beneficiary of the auto-assignment. (*Example: state generated correspondence.*)

iii. Describe the algorithm used for auto-assignment and describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).

1932(a)(4)
42 CFR 438.50

3. State assurances on the enrollment process.

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

a. **X** The state assures it has an enrollment system that allows Beneficiaries who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

b. **X** The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid Beneficiaries enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

c. ☐ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs in accordance with 42 CFR 438.52(b). Please list the impacted rural counties:

X This provision is not applicable to this 1932 State Plan Amendment.

d. **X** The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

☐This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4)
42 CFR 438.56

G. Disenrollment.

1. The state will **X**/will not **X** limit disenrollment for managed care.

Citation	Condition or Requirement

1. The disenrollment limitation will apply for **9** months (up to 12 months).

2. **X** The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

3. Describe the state's process for notifying the Medicaid Beneficiaries of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*

   MCO Enrollment Packets

4. Describe any additional circumstances of "cause" for disenrollment (if any).

   The following are the just cause reasons for disenrollment from Hoosier Healthwise:
   - Receiving poor quality of care;
   - Failure of the MCO to provide covered services;
   - Failure of the MCO to comply with established standards of medical care administration;
   - Significant language or cultural barriers;
   - Corrective action levied against the MCO by FSSA;
   - Limited access to a primary care clinic or other health services within reasonable proximity to a member's residence;
   - A determination that another MCO's formulary is more consistent with a new member's existing health care needs;
   - Lack of access to medically necessary services covered under MCO's contract with the State;
   - A service is not covered by the MCO for moral or religious objections;
   - Related services are required to be performed at the same time and not all related services are available within the MCO's network, and the member's provider determines that receiving the services separately will subject the member to unnecessary risk;

Citation	Condition or Requirement
	• Lack of access to providers experienced in dealing with the member's healthcare needs; • The member's primary healthcare provider disenrolls from the member's current MCO and re-enrolls with another Hoosier Healthwise MCO; or • Other circumstances determined by FSSA or its designee to constitute poor quality of health care coverage.
	H. Information Requirements for Beneficiaries
1932(a)(5)(c) 42 CFR 438.50 42 CFR 438.10	X The state assures that its state plan program is in compliance with 42 CFR 438.10(e) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments.
1932(a)(5)(D)(b) 1903(m) 1905(t)(3)	I. List all benefits for which the MCO is responsible. Hoosier Healthwise: All State Plan except MRO, 1915(i), dental, Individualized Family Services Plan, Pharmacy, Individualized Education Plan. Disenrolled for: Long-Term Institutional, Hospice, HCBS waiver, psychiatric treatment in State hospital, PRTF. HIP: Benefits are defined in the HIP 1115 Demonstration Waiver.
1932(a)(5)(D)(b)(4) 42 CFR 438.228	J. X The state assures that each managed care organization has established an internal grievance procedure for enrollees.
1932(a)(5)(D)(b)(5) 42 CFR 438.206 42 CFR 438.207	K. Describe how the state has assured adequate capacity and services. The MCO contracts delineate a series of requirements related to network adequacy. For example, the MCOs must demonstrate compliance with: (i) primary medical provider availability within 30 miles of the member's residence; (ii) behavioral health providers within 30 miles (urban) or 45 miles (rural); and (iii) specialty providers within 60 or 90 miles (distance standard varies by provider type). The State monitors for compliance through geo-access reporting.
1932(a)(5)(D)(c)(1)(A) 42 CFR 438.240	L. X The state assures that a quality assessment and improvement strategy has been developed and implemented.
1932(a)(5)(D)(c)(2)(A) 42 CFR 438.350	M. X The state assures that an external independent review conducted by a qualified independent entity will be performed yearly.

Citation	Condition or Requirement

1932 (a)(1)(A)(ii) N. Selective Contracting Under a 1932 State Plan Option

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state will ☐/will not **X** intentionally limit the number of entities it contracts under a 1932 state plan option.

2. **X** The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*

4. **X** The selective contracting provision in not applicable to this state plan.

Citation	Condition or Requirement

RESERVED FOR FUTURE USE

CMS-10120 (exp. 01/31/2008)
1932(a)(J)(A) A. Section 1932(a)(l)(A) of the Social Security Act.

Citation	Condition or Requirement

The State of INDIANA enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii. - vii. below)

C. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)

1. The State will contract with an

____ i. MCO
__x__ ii. PCCM (including capitated PCCMs that qualify as PAHPs)
____ iii. Both

42 CFR 438.50(b)(2)
42 CFR 438.50(b)(3)

2. The payment method to the contracting entity will be:

____ i. fee for service;
____ ii. capitation;
__x__ iii. a case management fee;
__x__ iv. a bonus/incentive payment;
____ v. a supplemental payment, or
____ vi. other. (Please provide a description below).

A fee is paid to both the primary medical provider and disease management contractor for provision of case/disease management. During the 1st year of the contract (October 1, 2010 – September 30, 2011), no incentive payments will be available.

1905(t)
42 CFR 440.168

3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's

Citation	Condition or Requirement
42 CFR 438.6(c)(5)(iii)(iv)	case management fee, if certain conditions are met. If applicable to this state plan, place a check mark to affirm the state has met ***all*** of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)). _x_ i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered. _x_ ii. Incentives will be based upon specific activities and targets. _x_ iii. Incentives will be based upon a fixed period of time. _x_ iv. Incentives will not be renewed automatically. _x_ v. Incentives will be made available to both public and private PCCMs. _x_ vi. Incentives will not be conditioned on intergovernmental transfer agreements. ____ vii. Not applicable to this 1932 state plan amendment.
CFR 438.50(b)(4)	4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)* Care Select, an enhanced primary care case management (PCCM) program replacing Medicaid Select was phased in beginning October 1, 2007. Indiana Care Select Program is a care management program that provides comprehensive case management, care coordination and disease management services while ensuring that its members receive the appropriate care, at the appropriate time, in the appropriate setting. Beginning in 2006, the Office of Medicaid Policy and Planning (OMPP) began statewide public forums called community meetings. State staff first held a series of meetings in Central Indiana to gain public input. Prior to implementing the program, the OMPP held additional community meetings in each region of the state to provide detailed information on the new program.

Citation	Condition or Requirement

The State began the Care Select Advisory Group in 2006, which includes stakeholders from various state associations and advocacy groups. This group meets every other month. Additionally, many legislative study committees and Medicaid advisory groups exist and provide a forum for the public and stakeholders to voice their opinions on the Care Select and Traditional Medicaid programs.

In late summer of 2010, the State presented information on transitioning Care Select to a 1932 state plan amendment. Presentations were given during late summer and early fall to the state legislature and advisory groups. The Care Select Advisory Group, legislative study committees and other advisory groups continue to provide a forum for public comment on the Care Select and Traditional Medicaid programs.

1932(a)(1)(A)

5. The state plan program will_x_/will not___ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory_____/ voluntary_____ enrollment will be implemented in the following county/area(s):

Note from State: This program is being transitioned from a 1915(b) waiver effective October 1, 2010. Current (prior to October 1, 2010) and new enrollees will be automatically enrolled in the new program if disease management criteria are met. However, continued participation is voluntary and all members are allowed to opt out from the program at any time, including those that are automatically enrolled for transition (October 1, 2010). Members who meet the disease management criteria and are also eligible for Medicare or are also receiving services through an HCBS waiver will not be eligible for the Care Select Program.

ii. county/counties (mandatory) _____

v. county/counties (voluntary)_____

vi. area/areas (mandatory)_____

vii. area/areas (voluntary)_____

D. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

Citation		Condition or Requirement
1932(a)(1)(A)(i)(I) 1903(m) 42 CFR 438.50(c)(1)	1.	____The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.
1932(a)(1)(A)(i)(I) 1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)	2.	__x__The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.
1932(a)(1)(A) 42 CFR 438.50(c)(3)	3.	____The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.
1932(a)(1)(A 42 CFR 431.51 1905(a)(4)(C)	4.	__x__The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A) 42 CFR 438 42 CFR 438.50(c)(4) 1903(m)	5.	__x__The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	6.	____The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.
1932(a)(1)(A) for 42 CFR 447.362 42 CFR 438.50(c)(6)	7.	__x__The state assures that all applicable requirements of 42 CFR 447.362 payments under any nonrisk contracts will be met.
45 CFR 74.40	8.	__x__The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.
	E.	Eligible groups
1932(a)(1)(A)(i)	1.	List all eligible groups that will be enrolled on a voluntary basis.

Citation	Condition or Requirement

Aged, blind, disabled, foster children and wards of the State, and children receiving adoption assistance will be automatically enrolled in the Care Select Program if there is evidence (in claims) of one of the following conditions:

- Asthma
- Diabetes
- Chronic Heart Failure, Coronary Heart Disease, Hypertensive Heart Disease
- Chronic Kidney Disease
- Serious Mental Illness
- Severe Emotional Disturbance
- Depression

Individuals who are automatically enrolled may opt out by calling the enrollment broker and expressing that they are not interested in participating in the Care Select Program. Individuals that are in one of the above groups, but receiving coverage through Medicare or a Home and Community Based Services waiver will be excluded from automatic enrollment into the Care Select Program.

2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50.

Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.

1932(a)(2)(B)
42 CFR 438(d)(1)

i. ____Recipients who are also eligible for Medicare.

If enrollment is voluntary, describe the circumstances of enrollment. *(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)*

1932(a)(2)(C)
42 CFR 438(d)(2)

ii. ____Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

1932(a)(2)(A)(i)
42 CFR 438.50(d)(3)(i)

iii. ____Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.

Citation	Condition or Requirement
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv. __x__ Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
1932(a)(2)(A)(v) of- 42 CFR 438.50(3)(iii)	v. __x__ Children under the age of 19 years who are in foster care or other out- the-home placement.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi. __x__ Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vii. ____ Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.

E. Identification of Mandatory Exempt Groups

1932(a)(2)
42 CFR 438.50(d)

1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. *(Examples: children receiving services at a specific clinic or enrolled in a particular program.)*

1932(a)(2)
42 CFR 438.50(d)

2. Place a check mark to affirm if the state's definition of title V children is determined by:

____i. program participation,
____ii. special health care needs, or
____iii. both

1932(a)(2)
42 CFR 438.50(d)

3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system.

____i. yes
____ii. no

1932(a)(2)
42 CFR 438.50 (d)

4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: *(Examples: eligibility database, self- identification)*

Care Select is a voluntary program. All individuals automatically enrolled may opt out of the program at any time.

Citation	Condition or Requirement
	v. Children under 19 years of age who are eligible for SSI under title XVI;
	vi. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;
	vii. Children under 19 years of age who are in foster care or other out-of-home placement;
	viii. Children under 19 years of age who are receiving foster care or adoption assistance.
1932(a)(2) 42 CFR 438.50(d)	5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. *(Example: self-identification)* Care Select is a voluntary program. All individuals automatically enrolled may opt out of the program at any time.
1932(a)(2) 42 CFR 438.50(d)	6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: *(Examples: usage of aid codes in the eligibility system, self- identification)* iii. Recipients who are also eligible for Medicare. Recipients who are also eligible for Medicare are identified through the usage of aid codes in the State's MMIS system. iv. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act. There are no Federally recognized Tribes within the state of Indiana.
42 CFR 438.50	F. <u>List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment</u> Care Select is a voluntary program, no groups are mandatorily enrolled.

Citation	Condition or Requirement
42 CFR 438.50	G. List all other eligible groups who will be permitted to enroll on a voluntary basis None.
	I. Enrollment process.
1932(a)(4) 42 CFR 438.50	1. Definitions iii. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient. iv. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.
1932(a)(4) 42 CFR 438.50	2. State process for enrollment by default. Describe how the state's default enrollment process will preserve: iv. the existing provider-recipient relationship (as defined in H.1.i). A Care Select member, who had previously been assigned to a PMP that is currently enrolled in the program, is reassigned to that PMP if the appropriate scope of practice and restrictions apply. Members not enrolled in the Care Select program may choose to see any Indiana Medicaid provider. v. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii). If there is not a previous PMP relationship, the auto-assignment logic looks for a previous relationship with a CMO. The system then attempts to assign the member to an appropriate PMP in the CMO by geographical order at each hierarchical level for look back period of 365 days. Members not enrolled in the Care Select program may choose to see any Indiana Medicaid provider.

Citation	Condition or Requirement

vi. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)*

In the event previous PMP and CMO auto-assignment logic attempts fail to make an appropriate PMP assignment, the default level of the auto-assignment logic looks for the neediest CMO and compares the member's geographical coordinates to PMPs in the neediest CMO in order of proximity.

Members not enrolled in the Care Select program are not enrolled with a PCCM, and may choose to see any Indiana Medicaid provider.

1932(a)(4)
42 CFR 438.50

3. As part of the state's discussion on the default enrollment process, include the following information:

vii. The state will____/will not_x_ use a lock-in for managed care.

viii. The time frame for recipients to choose a health plan before being auto-assigned will be 60 days.

ix. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)*

The State's MMIS system will notify members of their selections or when a member is auto-assigned via a mailing.

x. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*

Care Select Program participants may opt-out (disenroll) from the program at any time.

xi. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)*

Citation	Condition or Requirement

If the member does not select a PMP, the auto-assignment logic will search for a previous PMP the member's previous CMO. If the member does not have a previous PMP with a previous CMO, the auto-assignment logic will search for a previous PMP with a different CMO. If a match is not found, the auto-assignment logic then looks for a previous relationship with a CMO. If there is not a previous CMO relationship, the auto-assignment logic searches for a family member's PMP. If a match is still not made, the auto-assignment logic will then assign the member to the neediest CMO and compares the member's geographical coordinates to PMPs in the neediest CMO in order of proximity.

xii. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)*

Auto-assignment rates will be reported to the State from the fiscal agent.

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

1. _x_ The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

6. _x_ The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

7. ____ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

_x_ This provision is not applicable to this 1932 State Plan Amendment.

8. ____ The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of

Citation	Condition or Requirement

the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)

_x_ This provision is not applicable to this 1932 State Plan Amendment.

9. _x_ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

_This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4)
42 CFR 438.50

J. Disenrollment

5. The state will___/will not_x_ use lock-in for managed care.

6. The lock-in will apply for ____ months (up to 12 months).

7. Place a check mark to affirm state compliance.

_x_ The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

8. Describe any additional circumstances of "cause" for disenrollment (if any).

No lock-in applies to the Care Select (PCCM) program.

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)
42 CFR 438.50
42 CFR 438.10

_x_ The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)

1932(a)(5)(D)
1905(t)

L. List all services that are excluded for each model (MCO & PCCM)

Medicaid Rehabilitation Option (MRO) services
Psychiatric Residential Treatment Facility (PRTF) services
Dental services
Individualized Family Services Plan (IFSP)

Citation	Condition or Requirement

Pharmacy
Individualized Education Plan (IEP)
Long-Term Institutional Care
Hospice
Home and Community Based Services (HCBS) Waiver
Psychiatric Treatment in a State Hospital

1932 (a)(1)(A)(ii) M. Selective contracting under a 1932 state plan option

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

5. The state will____/will not_x____ intentionally limit the number of entities it contracts under a 1932 state plan option.

6. _____ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

7. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*

8. __x__ The selective contracting provision in not applicable to this state plan.