STATE PLAN UNDER TITLE XIX
OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

HCFA-AT-80-38 (BPP)
MAY 22, 1980

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: Indiana

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*Forms Provided

Revision: HCFA-PM-91- 4 (BPD) OMB No. 0938-
AUGUST 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: INDIANA

Citation

42 CFR
430.10

As a condition for receipt of Federal funds under title XIX of the Social Security Act, the

Office of Medicaid Policy and Planning
(Single State Agency)

submits the following State plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this State plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

TN No. 91-16
Supersedes TN No. 76-12
Approval Date 3-13-92
Effective Date 1-1-92
HCFA ID: 7982E

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Indiana

SECTION 1 SINGLE STATE AGENCY ORGANIZATION

Citation
42 CFR 431.10
AT-79-29

1.1 Designation and Authority

(a) The Indiana Office of Medicaid Policy and Planning is the single State agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named in this paragraph.)

ATTACHMENT 1.1-A is a certification signed by the State Attorney General identifying the single State agency and citing the legal authority under which it adminsters or supervises administration of the program.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State INDIANA

Citation
Sec. 1902(a)
of the Act

1.1(b) The State agency that administered or supervised the administration of the plan approved under title X of the Act as of January 1, 1965, has been separately designated to administer or supervise the administration of that part of this plan which relates to blind individuals.

☐ Yes. The State agency so designated is

_____

_____.

This agency has a separate plan covering that portion of the State plan under title XIX for which it is responsible.

☒ Not applicable. The entire plan under title XIX is administered or supervised by the State agency named in paragraph 1.1(a).

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State INDIANA

Citation
Intergovernmental Cooporation Act of 1968

1.1(c) Waivers of the single State agency requirement which are currently operative have been granted under authority of the Intergovernmental Cooperation Act of 1968.

☐ Yes. ATTACHMENT 1.1-B describes these waivers and the approved alternative organizational arrangements.

☐ Not applicable. Waivers are no longer in effect.

☒ Not applicable. No waivers have ever been granted.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State INDIANA

Citation			
42 CFR 431.10 AT-79-29	1.1(d)	☐	The agency named in paragraph 1.1(a) has responsibility for all determinations of eligibility for Medicaid under this plan.
		☒	Determinations of eligibility for Medicaid under this plan are made by the agency(ies) specified in ATTACHMENT 2.2-A. There is a written agreement between the agency named in paragraph 1.1(a) and other agency(ies) making such determinations for specific groups covered under this plan. The agreement defines the relationships and respective responsibilities of the agencies.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State INDIANA

Citation		
42 CFR 431.10 AT-79-29	1.1(e)	All other provisions of this plan are administered by the Medicaid agency except for those functions for which final authority has been granted to a Professional Standards Review Organization under title XI of the Act.
	(f)	All other requirements of 42 CFR 431.10 are met.

State Indiana

Citation
42 CFR 431.11
AT-79-29

1.2 Organization for Administration

(a) ATTACHMENT 1.2-A contains a description of the organization and functions of the Medicaid agency and an organization chart of the agency.

(b) Within the State agency, the Office of Medicaid Policy and Planning has been designated as the medical assistance unit. ATTACHMENT 1.2-B contains a description of the organization and functions of the medical assistance unit and an organization chart of the unit.

(c) ATTACHMENT 1.2-C contains a description of the kinds and numbers of professional medical personnel and supporting staff used in the administration of the plan and their responsibilities.

(d) Eligibility determinations are made by State or local staff of an agency other than the agency named in paragraph 1.1(a). ATTACHMENT 1.2-D contains a description of the staff designated to make such determinations and the functions they will perform.

☐ Not applicable. Only staff of the agency named in paragraph 1.1(a) make such determinations.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State INDIANA

Citation
42 CFR
431.50(b)
AT-79-29

1.3 Statewide Operation

The plan is in operation on a Statewide basis in accordance with all requirements of 42 CFR 431.50.

☒ The plan is State administered.

☐ The plan is administered by the political subdivisions of the State and is mandatory on them.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: Indiana

Citation 42 CFR 431.12(b) AT-78-90	1.4	State Medical Care Advisory Committee There is an advisory committee to the Medicaid agency director on health and medical care Services established in accordance with and Meeting all the requirements of 42 CFR 431.12.	
42 CFR 438.104		_X_	The State enrolls recipients in MCO, PIHP, PAHP, and/or PCCM programs. The State assures that it complies with 42 CFR 438.104(c) to consult with the Medical Care Advisory Committee in the review of marketing materials.

Revision: HCFA-PM-94-3 (MB)
APRIL 1994
State/Territory: Indiana

Citation

1.5 Pediatric Immunization Program

1928 of the Act

1. The State has implemented a program for the distribution of pediatric vaccines to program-registered providers for the immunization of federally vaccine-eligible children in accordance with section 1928 as indicated below.

   a. The State program will provide each vaccine-eligible child with medically appropriate vaccines according to the schedule developed by the Advisory Committee on Immunization Practices and without charge for the vaccines.

   b. The State will outreach and encourage a variety of providers to participate in the program and to administer vaccines in multiple settings, e.g., private health care providers, providers that receive funds under Title V of the Indian Health Care Improvement Act, health programs or facilities operated by Indian tribes, and maintain a list of program-registered providers.

   c. With respect to any population of vaccine-eligible children a substantial portion of whose parents have limited ability to speak the English language, the State will identify program-registered providers who are able to communicate with this vaccine-eligible population in the language and cultural context which is most appropriate.

   d. The State will instruct program-registered providers to determine eligibility in accordance with section 1928(b) and (h) of the Social Security Act.

   e. The State will assure that no program-registered provider will charge more for the administration of the vaccine than the regional maximum established by the Secretary. The State will inform program-registered providers of the maximum fee for the administration of vaccines.

   f. The State will assure that no vaccine-eligible child is denied vaccines because of an inability to pay an administration fee.

   g. Except as authorized under section 1915(b) of the Social Security Act or as permitted by the Secretary to prevent fraud or abuse, the State will not impose any additional qualifications or conditions, in addition to those indicated above, in order for a provider to qualify as a program-registered provider.

Revision: HCFA-PM-94-3 (MB)
APRIL 1994
State/Territory: Indiana

Citation

1928 of the Act

2. The State has not modified or repealed any Immunization Law in effect as of May 1, 1993 to reduce the amount of health insurance coverage of pediatric vaccines.

3. The State Medicaid Agency has coordinated with the State Public Health Agency in the completion of this preprint page.

4. The State agency with overall responsibility for the implementation and enforcement of the provisions of section 1928 is:

___ State Medicaid Agency

X State Public Health Agency

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State: INDIANA

SECTION 2 - COVERAGE AND ELIGIBILITY

Citation
42 CFR
435.10 and
Subpart J

2.1 Application, Determination of Eligibility and Furnishing Medicaid

(a) The Medicaid agency meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility, and furnishing Medicaid.

Revision: HCFA-PM- (MB)

State/Territory: Indiana

Citation		
42 CFR 435.914 1902(a)(34) of the Act	2.1(b) (1)	Except as provided in items 2.1(b)(2) and (3) below, individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if they were, or on application would have been, eligible. The effective date of prospective and retroactive eligibility is specified in Attachment 2.6-A.
1902(e)(8) and 1905(a) of the Act	(2)	For individuals who are eligible for Medicare cost-sharing expenses as qualified Medicare beneficiaries under section 1902(a)(10)(E)(i) of the Act, coverage is available for services furnished after The end of the month which the individual is first Determined to be a qualified Medicare beneficiary. Attachment 2.6-A specifies the requirements for Determination of eligibility for this group.
1902(a)(47) and 1920 of The Act	X (3)	Pregnant women are entitled to ambulatory prenatal care under the plan during a presumptive eligibility period in accordance with section 1920 of the Act. Attachment 2.6-A specifies the requirements for Determination of eligibility for this group.

Revision: HCFA-PM-91-8 (MB) OMB No.
October 1991

State/Territory: INDIANA

Citation

1902(a)(55) of the Act	2.1(d)	The Medicaid agency has procedures to take applications, assist applicants, and perform initial processing of applications from those low income pregnant women, infants, and children under age 19, described in §1902(a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), and (a)(10)(A)(ii)(IX) at locations other than those used by the title IV-A program including FQHCs and disproportionate share hospitals. Such application forms do not include the ADFC form except as permitted by HCFA instructions.

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State: INDIANA

Citation
42 CFR
435.10

2.2 Coverage and Conditions of Eligibility

Medicaid is available to the groups specified in ATTACHMENT 2.2-A.

/_/ Mandatory categorically needy and other required special groups only.

/_/ Mandatory categorically needy, other required special groups, and the medically needy, but no other optional groups.

/XX/ Mandatory categorically needy, other required special groups, and specified optional groups.

/_/ Mandatory categorically needy, other required special groups, specified optional groups, and the medically needy.

The conditions of eligibility that must be met are specified in ATTACHMENT 2.6-A.

All applicable requirements of 42 CFR Part 435 and sections 1902(a)(10)(A)(i)(IV), (V), and (VI), 1902(a)(10)(A)(ii)(XI), 1902(a)(10)(E), 1902(l) and (m), 1905(p), (q) and (s), 1920, and 1925 of the Act are met.

Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

State: Indiana

Citation
435.10 and 435.403, and 1902(b) of the Act, P.L. 99-272 (Section 9529) and P.L. 99-509 (Section 9405)

2.3 Residence

Medicaid is furnished to eligible individuals who are residents of the State under 42 CFR 435.403, regardless of whether or not the individuals maintain the residence permanently or maintain it at a fixed address.

Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

State: Indiana

Citation	2.4 Blindness
42 CFR 435.530(b) 42 CFR 435.531 AT-78-90 AT-79-29	All of the requirements of 42 CFR 435.530 and 42 CFR 435.531 are met. The more restrictive definition of blindness in terms of ophthalmic measurement used in this plan is specified in ATTACHMENT 2.2-A.

State of Indiana

Citation(s)	
42 CFR 435.121 435.540(b) 435.541	2.5 Disability All of the requirements of 435.540 and 435.541 are met. The State uses the same definition of disability used under the SSI program.

*Agency that determines eligibility for coverage

Revision: HCFA-PM-92-1 (MB)
FEBRUARY 1992

State: INDIANA

Citation(s)

42 CFR
435.10 and
Subparts G & H
1902(a)(10)(A)(i)
(III), (IV), (V),
(VI), and (VII),
1902(a)(10)(A)(ii)
(IX), 1902(a)(10)
(A)(ii)(X), 1902
(a)(10)(C),
1902(f), 1902(l)
and (m),
1905(p) and (s),
1902(r)(2),
and 1920

2.6 Financial Eligibility

(a) The financial eligibility conditions for Medicaid-only eligibility groups and for persons deemed to be cash assistance recipients are described in ATTACHMENT 2.6-A.

Revision: HCFA-PM-86-20 (BERC) OMB-No. 0938-0193
SEPTEMBER 1986

State/Territory: Indiana

Citation	2.7	Medicaid Furnished Out of State
431.52 and 1902(b) of the Act, P.L. 99-272 (Section 9529)		Medicaid is furnished under the conditions specified in 42 CFR 431.52 to an eligible individual who is a resident of the State while the individual is in another State, to the same extent that Medicaid is furnished to residents in the State.

Revision: HCFA-PM-94-5 (MB)
APRIL 1994

State/Territory: Indiana

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation

3.1 Amount, Duration, and Scope of Services

42 CFR Part 440, Subpart B 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act

(a) Medicaid is provided in accordance with the requirements of 42 CFR Part 440, Subpart B and sections 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act.

(1) Categorically needy.

Services for the categorically needy are described below and in ATTACHMENT 3.1-A. These services include:

1902(a)(10)(A) and 1905(a) of the Act

(i) Each item or service listed in section 1905(a)(1) through (5) and (21) of the Act, is provided as defined in 42 CFR Part 440, Subpart A, or, for EPSDT services, section 1905(r) and 42 CFR Part 441, Subpart B.

(ii) Nurse-midwife services listed in section 1905(a)(17) of the Act, are provided to the extent that nurse-midwives are authorized to practice under State law or regulation and without regard to whether the services are furnished in the area of management of the care of mothers and babies throughout the maternity cycle. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.

___ Not applicable. Nurse-midwives are not authorized to practice in this State.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: Indiana

Citation 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1902(e)(5) of the Act

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

/XX (iv) Services for medical conditions that may complicate the pregnancy (other than pregnancy-related or postpartum services) are provided to pregnant women.

1902(a)(10), clause (VII) of the matter following (E) of the Act

(v) Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy are the same services provided to poverty level pregnant women eligible under the provision of sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.

Revision: HCFA-PM-92-7 (MB)
October 1992

State/Territory: Indiana

Citation			Amount, Duration, and Scope of Services: Categorically Needy (Continued)
		(vi)	Home health services are provided to individuals entitled to nursing facility services as indicated in item 3.1(b) of this plan.
1902(e)(7) of the Act		(vii)	Inpatient services that are being furnished to infants and children described in section 1902(l)(1)(B) through (D), or section 1905(n)(2) of the Act on the date the infant or child attains the maximum age for coverage under the approved State plan will continue until the end of the stay for which the inpatient services are furnished.
1902(e)(9) of the Act	X	(viii)	Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.
1902(a)(52) and 1925 of the Act		(ix)	Services are provided to families eligible under section 1925 of the Act as indicated in item 3.5 of this plan.
1905(a)(23) and 1929	____	(x)	Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy, specifies all limitations on the amount, duration and scope of those services, and lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

State of: Indiana

Citation (Continued) 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy

1905(a)(26) and 1934

X Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy. (Note: Other programs to be offered to Categorically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Categorically Needy beneficiaries would also list the additional coverage that is in excess of established service limits for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: Indiana

Citation 3.1 Amount, Duration, and Scope of Services (continued)

42 CFR Part 440, Subpart B (a)(2) Medically needy.

/ / This State plan covers the medically needy. The services described below and in ATTACHMENT 3.1-B are provided.

Services for the medically needy include:

1902(a)(10)(C)(iv) of the Act (i) If services in an institution for mental diseases or an intermediate care facility for the mentally retarded (or both) are provided to any medically needy group, then each medically needy group is provided either the services listed in section 1905(a)(1) through (5) and (17) of the Act, or seven of the services listed in section 1905(a)(1)through (20). The services are provided as defined in 42 CFR Part 440, Subpart A and in sections 1902, 1905, and 1915 of the Act.

/ / Not applicable with respect to nurse-midwife services under section 1902(a)(17). Nurse-midwives are not authorized to practice in this State.

1902(e)(5) of the Act (ii) Prenatal care and delivery services for pregnant women.

Revision: HCFA-PM-91-4 (BPD) AUGUST 1991 OMB No.: 0938-

State/Territory: Indiana

Citation 3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day the pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

/ (iv) Services for any other medical condition that may complicate the pregnancy (other than pregnancy-related and postpartum services) are provided to pregnant women.

(v) Ambulatory services, as defined in ATTACHMENT 3.1-B, for recipients under age 18 and recipients entitled to institutional services.

/ Not applicable with respect to recipients entitled to institutional services; the plan does not cover those services for the medically needy.

(vi) Home health services to recipients entitled to nursing facility services as indicated in item 3.1(b) of this plan.

42 CFR 440.140, 440.150, Subpart B, 442.441, Subpart C 1902(a)(20) and (21) of the Act

/ (vii) Services in an institution for mental diseases for individuals over age 65..

/ (viii) Services in an intermediate care facility for the mentally retarded.

Revision: HCFA-PM-93- 5 (MB)
MAY 1993

State: INDIANA

Citation

3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)

1902(e)(9) of Act

___ (x) Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.

1905(a)(23) and 1929 of the Act

___ (xi) Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.

ATTACHMENT 3.1-B identifies the services provided to each covered group of the medically needy; specifies all limitations on the amount, duration, and scope of those items; and specifies the ambulatory services provided under this plan and any limitations on them. It also lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

State of: Indiana

Program of All-Inclusive Care for the Elderly State Plan Amendment

Citation 3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)
1905(a)(26) and 1934

____ Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

ATTACHMENT 3.1-B identifies services provided to each covered group of the medically needy. (Note: Other programs to be offered to Medically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Medically Needy beneficiaries would also list the additional coverage that is in excess of established service limits for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

Citation	3.1	Amount, Duration, and Scope of Services (continued)
	(a)(3)	Other Required Special Groups: Qualified Medicare Beneficiaries
1902(a)(10)(E)(i) and clause (VIII) of the matter following (F), and 1905(p)(3) of the Act		Medicare cost sharing for qualified Medicare beneficiaries described in section 1905(p) of the Act is provided only as indicated in item 3.2 of this plan.
1902(a)(10)(E)(ii) and 1905(s) of the Act	(a)(4)(i)	Other Required Special Groups: Qualified Disabled and Working Individuals Medicare Part A premiums for qualified disabled and working individuals described in section 1902(a)(10)(E)(ii) of the Act are provided as indicated in item 3.2 of this plan.
1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii) of the Act	(ii)	Other Required Special Groups: Specified Low-Income Medicare Beneficiaries Medicare Part B premiums for specified low-income Medicare beneficiaries described in section 1902(a)(10)(E)(iii) of the Act are provided as indicated in item 3.2 of this plan.
1902(a)(10)(E)(iv)(I)1905(p)(3)(A)(ii), and 1933 of the Act	(iii)	Other Required Special Groups: Qualifying Individuals - 1 Medicare Part B premiums for qualifying individuals described in 1902(a)(10)(E)(iv)(I) and subject to 1933 of the Act are provided as indicated in item 3.2 of this plan.

Revision: HCFA-PM-98-1 (CMSO)
APRIL 1998

State: Indiana

Citation

1902(a)(10)(E)(iv)(II), 1905(p)(3)(A)(iv)(II), 1905(p)(3) the Act	(iv)	Other Required Special Groups: Qualifying Individuals - 2 The portion of the amount of increase to the Medicare Part B premium attributable to the Home Health provisions for qualifying individuals described in 1902(A)(10)(E)(iv)(II) and subject to 1933 of the Act are provided as indicated in item 3.2 of this plan.
1925 of the Act	(a)(5)	Other Required Special Groups: Families Receiving Extended Medicaid Benefits Extended Medicaid benefits for families described in section 1925 of the Act are provided as indicated in item 3.5 of this plan.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: Indiana

Citation 3.1 Amount, Duration, and Scope of Services (Continued)

Sec. 245A(h) of the Immigration and Nationality Act

(a)(6) Limited Coverage for Certain Aliens

(i) Aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who meet the financial and categorical eligibility requirements under the approved State Medicaid plan are provided the services covered under the plan if they--

(A) Are aged, blind, or disabled individuals as defined in section 1614(a)(1) of the Act;

(B) Are children under 18 years of age; or

(C) Are Cuban or Haitian entrants as defined in section 501(e)(1) and (2)(A) of P.L. 96-422 in effect on April 1, 1983.

(ii) Except for emergency services and pregnancy-related services, as defined in 42 CFR 447.53(b) aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who are not identified in items 3.1(a)(6)(i)(A) through (C) above, and who meet the financial and categorical eligibility requirements under the approved State plan are provided services under the plan no earlier than five years from the date the alien is granted lawful temporary resident status.

Revision: HCFFA-PM-91-4 March 2008 (BPD) OMB No.: 0938

State/Territory: Indiana

Citation		Amount, Duration, and Scope of Services: Limited Coverage for Certain Aliens (continued)
1902 (a) and 1903 (v) of the Act		(iii) Aliens who are not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law who meet the eligibility conditions under this plan, except for the requirement for receipt of AFDC, SSI, or a State supplementary payment, are provided Medicaid only for care and services necessary for the treatment of an emergency medical condition (including emergency labor and delivery) as defined in section 1903 (v) (3) of the Act.
1905 (a) (9) of the Act	(a) (7)	Homeless Individuals. Clinic services furnished to eligible individuals who do not reside in a permanent dwelling or do not have a fixed home or mailing address are provided without restrictions regarding the site at which the services are furnished.
1902 (a) (47) and 1920 of the Act	☒ (a) (8)	Ambulatory prenatal care for pregnant women is provided during a presumptive eligibility period if the care is furnished by a provider that is eligible for payment under the State plan.
42 CFR 441.55 50 FR 43654 1902 (a) (43), 1905 (a) (4) (B), and 1905 (r) of the Act	(a) (9)	EPSDT SERVICES. The Medicaid agency meets the requirements of sections 1902(a) (43), 1905 (a) (4) (B), and 1905 (r) of the Act with respect to early and periodic screening, diagnostic, and treatment (EPSDT) services.

Revision: HCFA-PM-91-1991 (BPD) OMB No.: 0938-

State: Indiana

Citation 3.1(a)(9) Amount, Duration, and Scope of Services: EPSDT Services (continued)

42 CFR 441.60 /_/ The Medicaid agency has in effect agreements with continuing care providers. Described below are the methods employed to assure the providers' compliance with their agreements.**

42 CFR 440.240 and 440.250 (a)(10) Comparability of Services

1902(a) and 1902 (a)(10), 1902(a)(52), 1903(v), 1915(g), 1925(b)(4), and 1932 of the Act

Except for those items or services for which sections 1902(a), 1902(a)(10), 1903(v), 1915, 1925, and 1932 of the Act, 42 CFR 440.250, and section 245A of the Immigration and Nationality Act, permit exceptions:

(i) Services made available to the categorically needy are equal in amount, duration, and scope for each categorically needy person.

(ii) The amount, duration, and scope of services made available to the categorically needy are equal to or greater than those made available to the medically needy.

(iii) Services made available to the medically needy are equal in amount, duration, and scope for each person in a medically needy coverage group.

/_/ (iv) Additional coverage for pregnancy-related service and services for conditions that may complicate the pregnancy are equal for categorically and medically needy.

** Describe here.

The continuing care provider submits monthly encounter data reflecting the number of examinations completed, the number of examinations where a referable condition was identified, and the number of follow-up treatment encounters. Medicaid staff make periodic on-site reviews to monitor the provider's record of case management.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State INDIANA

Citation
42 CFR Part 440, Subpart B
42 CFR 441.15
AT-78-90
AT-80-34

3.1(b) Home health services are provided in accordance with the requirements of 42 CFR 441.15.

(1) Home health services are provided to all categorically needy individuals 21 years of age or over.

(2) Home health services are provided to all categorically needy individuals under 21 years of age.

☒ Yes

☐ Not applicable. The State plan does not provide for skilled nursing facility services for such individuals.

(3) Home health services are provided to the medically needy:

☐ Yes, to all

☐ Yes, to individuals age 21 or over; SNF services are provided

☐ Yes, to individuals under age 21; SNF services are provided

☐ No; SNF services are not provided

☒ Not applicable; the medically needy are not included under this plan

Revision: HCFA-PM-93-8 (BPD)

State/Territory: Indiana

Citation 3.1 Amount, Duration, and Scope of Services (continued)

42 CFR 431.53 (c)(1) Assurance of Transportation

Provision is made for assuring necessary transportation of recipients to and from providers. Methods used to assure such transportation are described in ATTACHMENT 3.1-D.

42 CFR 483.10 (c)(2) Payment for Nursing Facility Services

The State includes in nursing facility services at least the items and services specified in 42 CFR 483.10 (c) (8) (i).

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State INDIANA

Citation
42 CFR 440.260
AT-78-90

3.1(d) Methods and Standards to Assure Quality of Services

The standards established and the methods used to assure high quality care are described in ATTACHMENT 3.1-C.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State INDIANA

Citation		
42 CFR 441.20 AT-78-90	3.1(e)	Family Planning Services The requirements of 42 CFR 441.20 are met regarding freedom from coercion or pressure of mind and conscience, and freedom of choice of method to be used for family planning.

Revision: HCFA-PM-87-5 (BERC) OMB No.: 0938-0193
APRIL 1987

State/Territory: Indiana

Citation
42 CFR 441.30
AT-78-90

3.1 (f) (1) Optometric Services

Optometric services (other than those provided under §§435.531 and 436.531) are not now but were previously provided under the plan. Services of the type an optometrist is legally authorized to perform are specifically included in the term "physicians' services" under this plan and are reimbursed whether furnished by a physician or an optometrist.

/ / Yes.

/ / No. The conditions described in the first sentence apply but the term "physicians' services" does not specifically include services of the type an optometrist is legally authorized to perform.

/X/ Not applicable. The conditions in the first sentence do not apply.

1903(i)(1)
of the Act,
P.L. 99-272
(Section 9507)

(2) Organ Transplant Procedures

Organ transplant procedures are provided.

/ / No.

/X/ Yes. Similarly situated individuals are treated alike and any restriction on the facilities that may, or practitioners who may, provide those procedures is consistent with the accessibility of high quality care to individuals eligible for the procedures under this plan. Standards for the coverage of organ transplant procedures are described at ATTACHMENT 3.1-E.

Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

State/Territory: Indiana

Citation
42 CFR 431.110(b)
AT-78-90

3.1 (g) Participation by Indian Health Service Facilities

Indian Health Service facilities are accepted as providers, in accordance with 42 CFR 431.110(b), on the same basis as other qualified providers.

1902(e)(9) of the Act, P.L. 99-509 (Section 9408)

(h) Respiratory Care Services for Ventilator-Dependent Individuals

Respiratory care services, as defined in section 1902(e)(9)(C) of the Act, are provided under the plan to individuals who--

(1) Are medically dependent on a ventilator for life support at least six hours per day;

(2) Have been so dependent as inpatients during a single stay or a continuous stay in one or more hospitals, SNFs or ICFs for the lesser of--

/X/ 30 consecutive days;

/ / ___ days (the maximum number of inpatient days allowed under the State plan);

(3) Except for home respiratory care, would require respiratory care on an inpatient basis in a hospital, SNF, or ICF for which Medicaid payments would be made;

(4) Have adequate social support services to be cared for at home; and

(5) Wish to be cared for at home.

/X/ Yes. The requirements of section 1902(e)(9) of the Act are met.

/ / Not applicable. These services are not included in the plan.

Revision: HCFA-PM-93- 5 (MB)
MAY 1993

State: INDIANA

Citation

3.2 Coordination of Medicaid with Medicare and Other Insurance

(a) Premiums

(1) Medicare Part A and Part B

1902(a)(10)(E)(i) and 1905(p)(1) of the Act

(i) Qualified Medicare Beneficiary (QMB)

The Medicaid agency pays Medicare Part A premiums (if applicable) and Part B premiums for individuals in the QMB group defined in Item A.25 of ATTACHMENT 2.2-A, through the group premium payment arrangement, unless the agency has a Buy-in agreement for such payment, as indicated below.

Buy-In agreement for:

X Part A X Part B

___ The Medicaid agency pays premiums, for which the beneficiary would be liable, for enrollment in an HMO participating in Medicare.

Revision: HCFA-PM-97-3 (CMSO)
December 1997

State: Indiana

Citation

1902(a)(10)(E)(ii) and 1905(s) of the Act

(ii) Qualified Disabled and Working Individual (QDWI)

The Medicaid agency pays Medicare Part A premiums under a group premium payment arrangement, subject to any contribution required as described in ATTACHMENT 4.18-E, for individuals in the QDWI group defined in item A.26 of ATTACHMENT 2.2-A of this plan.

1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii) of the Act

(iii) Specified Low-Income Medicare Beneficiary (SLMB)

The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals in the SLMB group defined in item A.27 of ATTACHMENT 2.2-A of this plan.

1902(a)(10)(E)(iv)(I), 1905(p)(3)(A)(ii), and 1933 of the Act

(iv) Qualifying Individual-1 (QI-1)

The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals described in 1902(a)(10)(E)(iv)(I) and subject to 1933 of the Act.

1902(a)(10)(E)(iv)(II), 1905(p)(3)(A)(ii), and 1933 of the Act

(v) Qualifying Individual-2 (QI-2)

The Medicaid agency pays the portion of the amount of increase to the Medicare Part B premium attributable to the Home Health Provision to the individuals described in 1902(a)(10)(E)(iv)(II) and subject to 1933 of the Act.

Revision: HCFA-PM-97-3 (CMSO)
December 1997

State: Indiana

Citation

1843(b) and 1905(a) of the Act and 42 CFR 431.625

(vi) Other Medicaid Recipients

The Medicaid agency pays Medicare Part B premiums to make Medicare Part B coverage available to the following individuals:

X All individuals who are: (a) receiving benefits under titles I, IV-A, X, XIV, or XVI (AABD or SSI); b) receiving State supplements under title XVI; or c) withing a group listed at 42 CFR 431.625(d)(2).

X Individuals receiving title II or Railroad Retirement benefits. *

_ Medically needy individuals (FFP is not available for this group).

1902(a)(30) and 1905(a) of the Act

(2) Other Health Insurance

X The Medicaid agency pays insurance premiums for medical or any other type of remedial care to maintain a third party resource for Medicaid covered services provided to eligible individuals (except individuals 65 years of age or older and disabled individuals. entitled to Medicare Part A but not enrolled in Medicare Part B).

*Except individuals who do not meet the State's Medicaid eligibility criteria.

Revision: HCFA-PM-93-2 (MB)
MARCH 1993

State: INDIANA

Citation

(b) Deductibles/Coinsurance

(1) Medicare Part A and B

1902(a)(30), 1902(n), 1905(a),and 1916 of the Act

Supplement 1 to ATTACHMENT 4.19-B describes the methods and standards for establishing payment rates for services covered under Medicare, and/or the methodology for payment of Medicare deductible and coinsurance amounts, to the extent available for each of the following groups.

Sections 1902 (a)(10)(E)(i) and 1905(p)(3) of the Act

(i) Qualified Medicare Beneficiaries (QMBS)

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for QMBs (subject to any nominal Medicaid copayment) for all services available under Medicare.

1902(a)(10), 1902(a)(30), and 1905(a) of the Act

(ii) Other Medicaid Recipients

The Medicaid agency pays for Medicaid services also covered under Medicare and furnished to recipients entitled to Medicare (subject to any nominal Medicaid copayment). For services furnished to individuals who are described in section 3.2(a)(1)(iv), payment is made as follows:

42 CFR 431.625

X For the entire range of services available under Medicare Part B.

___ Only for the amount, duration, and scope of services otherwise available under this plan.

1902(a)(10), 1902(a)(30), 1905(a), and 1905(p) of the Act

(iii) Dual Eligible--QMB plus

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for all services available under Medicare and pays for all Medicaid services furnished to individuals eligible both as QMBs and categorically or medically needy (subject to any nominal Medicaid copayment).

Revision: HCFA-PM-91-8 (MB) OMB No.:
October 1991

State/Territory: Indiana

Citation		Condition or Requirement
1906 of the Act	(c)	Premiums, Deductibles, Coinsurance and Other Cost Sharing Obligations The Medicaid agency pays all premiums, deductibles, coinsurance and other cost sharing obligations for items and services covered under the State plan (subject to any nominal Medicaid copayment) for eligible individuals in employer-based cost-effective group health plans. When coverage for eligible family members is not possible unless ineligible family members enroll, the Medicaid agency pays premiums for enrollment of other family members when cost-effective. In addition, the eligible individual is entitled to services covered by the State plan which are not included in the group health plan. Guidelines for determining cost effectiveness are described in section 4.22(h).
1902(a)(10)(F) of the Act	(d)	/__/ The Medicaid agency pays premiums for individuals described in item 19 of Attachment 2.2-A.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State INDIANA

Citation
42 CFR 441.101,
42 CFR 431.620(c)
and (d)
AT-79-29

3.3 Medicaid for Individuals Age 65 or Over in Institutions for Mental Diseases

Medicaid is provided for individuals 65 years of age or older who are patients in institutions for mental diseases.

☒ Yes. The requirements of 42 CFR Part 441, Subpart C, and 42 CFR 431.620(c) and (d) are met.

☐ Not applicable. Medicaid is not provided to aged individuals in such institutions under this plan.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State INDIANA

Citation		
42 CFR 441.252 AT-78-99	3.4	Special Requirements Applicable to Sterilization Procedures All requirements of 42 CFR Part 441, Subpart F are met.

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State: Indiana

Citation
1902(a)(52) and 1925 of the Act

3.5 Families Receiving Extended Medicaid Benefits

(a) Services provided to families during the first 6-month period of extended Medicaid benefits under Section 1925 of the Act are equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

(b) Services provided to families during the second 6-month period of extended Medicaid benefits under section 1925 of the Act are--

☒ Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

☐ Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients, (or may be greater if provided through a caretaker relative employer's health insurance plan) minus any one or more of the following acute services:

☐ Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

☐ Medical or remedial care provided by licensed practitioners.

☐ Home health services.

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State: Indiana

Citation 3.5 Families Receiving Extended Medicaid Benefits (Continued)

- ☐ Private duty nursing services.
- ☐ Physical therapy and related services.
- ☐ Other diagnostic, screening, preventive, and rehabilitation services.
- ☐ Inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases.
- ☐ Intermediate care facility services for the mentally retarded.
- ☐ Inpatient psychiatric services for individuals under age 21.
- ☐ Hospice services.
- ☐ Respiratory care services.
- ☐ Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary.

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State: Indiana

Citation 3.5 Families Receiving Extended Medicaid Benefits
(Continued)

(c)/ / The agency pays the family's premiums, enrollment fees, deductibles, coinsurance, and similar costs for health plans offered by the caretaker's employer as payments for medical assistance--

/ / 1st 6 months / / 2nd 6 months

/ / The agency requires caretakers to enroll in employers' health plans as a condition of eligibility.

/ / 1st 6 mos. / / 2nd 6 mos.

(d)/ / (1) The Medicaid agency provides assistance to families during the second 6-month period of extended Medicaid benefits through the following alternative methods:

/ / Enrollment in the family option of an employer's health plan.

/ / Enrollment in the family option of a State employee health plan.

/ / Enrollment in the State health plan for the uninsured.

/ / Enrollment in an eligible health maintenance organization (HMO) with a prepaid enrollment of less than 50 percent Medicaid recipients (except recipients of extended Medicaid).

Revision: HCFA-PM-91- 4 (BPD) AUGUST 1991 OMB No.: 0938-

State: Indiana

Citation 3.5 Families Receiving Extended Medicaid Benefits (Continued)

Supplement 2 to ATTACHMENT 3.1-A specifies and describes the alternative health care plan(s) offered, including requirements for assuring that recipients have access to services of adequate quality.

(2) The agency--

(i) Pays all premiums and enrollment fees imposed on the family for such plan(s).

/ / (ii) Pays all deductibles and coinsurance imposed on the family for such plan(s).

Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

State/Territory: Indiana

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation
42 CFR 431.15
AT-79-29

4.1 Methods of Administration

The Medicaid agency employs methods of administration found by the Secretary of Health and Human Services to be necessary for the proper and efficient operation of the plan.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State INDIANA

Citation	4.2 Hearings for Applicants and Recipients
42 CFR 431.202 AT-79-29 AT-80-34	The Medicaid agency has a system of hearings that meets all the requirements of 42 CFR Part 431, Subpart E.

Revision: HCFA-AT-87-9 (BERC) OMB No.: 0938-0193
AUGUST1987

State/Territory: Indiana

Citation	4.3 Safeguarding Information on Applicants and Recipients
42 CFR 431.301 AT-79-29	Under State statute which imposes legal sanctions, safeguards are provided that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.
52 FR 5967	All other requirements of 42 CFR Part 431, Subpart F are met.

Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

State/Territory: Indiana

Citation	4.4 Medicaid Quality Control
42 CFR 431.800(c) 50 FR 21839 1903(u)(1)(D) of the Act, P.L. 99-509 (Section 9407)	(a) A system of quality control is implemented in accordance with 42 CFR Part 431, Subpart P. (b) The State operates a claims processing assessment system that meets the requirements of 431.800(e), (g), (h) and (k). (j) / / Yes. /x/ Not applicable. The State has an approved Medicaid Management Information System (MMIS).

Revision: HCFA-PM-88-10 (BERC)
SEPTEMBER 1988

OMB No.: 0938-0193

State/Territory: Indiana

Citation
42 CFR 455.12
AT-78-90
48 FR 3742
52 FR 48817

4.5 Medicaid Agency Fraud Detection and Investigation Program

The Medicaid agency has established and will maintain methods, criteria, and procedures that meet all requirements of 42 CFR 455.13 through 455.21 and 455.23 for prevention and control of program fraud and abuse.

New: HCFA-PM-9 (CMSO)
199

State: Indiana

Citation		
Section 1902(a)(64) of the Social Security Act P.L. 105-33	4.5a	Medicaid Agency Fraud Detection and Investigation Program The Medicaid agency has established a mechanism to receive reports from beneficiaries and others and compile data concerning alleged instances of waste, fraud, and abuse relating to the operation of this title.

PROPOSED SECTION 4 - GENERAL PROGRAM ADMINISTRATION

4.5 Medicaid Recovery Audit Contractor Program

Citation Section 1902(a)(42)(B)(i) of the Social Security Act	___ The State has established a program under which it will contract with one or more recovery audit contractors (RACs) for the purpose of identifying underpayments and overpayments of Medicaid claims under the State plan and under any waiver of the State plan. _X__ The State is seeking an exception to establishing such program for the following reasons: FSSA-OMPP utilizes the Fraud and Abuse Detection System (FADS) contract under FSSA Program Integrity to monitor the Indiana Health Coverage Programs for fraud, waste, and abuse, as well as identify underpayments and overpayments of Medicaid claims under the State plan and under any waiver of the State Plan. Indiana has adequate appeal processes in place for entities to appeal any adverse determinations made by FSSA Program Integrity. Indiana assures that the recovered amounts will be subject to the State's quarterly expenditure estimates and funding of the State's share. FSSA Program Integrity coordinates with all other State audit entities, as well as State and Federal law enforcement entities and the CMS Medicaid Integrity Program. The State of Indiana was previously granted an exception from CMS and now seeks an exception from October 1, 2023, through October 1, 2025.
Section 1902(a)(42)(B)(ii)(I) of the Act	___ The State/Medicaid agency has contracts of the type(s) listed in section 1902(a)(42)(B)(ii)(I) of the Act. All contracts meet the requirements of the statute. RACs are consistent with the statute. Place a check mark to provide assurance of the following: ___ The State will make payments to the RAC(s) only from amounts recovered. ___ The State will make payments to the RAC(s) on a contingent Basis for collecting overpayments.
Section 1902 (a)(42)(B)(ii)(II)(aa) of the Act	The following payment methodology shall be used to determine State payments to Medicaid RACs for identification and recovery of overpayments (e.g., the percentage of the contingency fee):

	___ The State attests that the contingency fee rate paid to the Medicaid RAC will not exceed the highest rate paid to Medicare RACs, as published in the Federal Register. _____ The State attests that the contingency fee rate paid to the Medicaid RAC will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will only submit for FFP up to the amount equivalent to that published rate. _____The contingency fee rate paid to the Medicaid RAC that will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will submit a justification for that rate and will submit for FFP for the full amount of the contingency fee.
Section 1902 (a)(42)(B)(ii)(II)(bb) of the Act	___ The following payment methodology shall be used to determine State payments to Medicaid RACs for the identification of underpayments (e.g., amount of flat fee, the percentage of the contingency fee): Flat fee-underpayments
Section 1902 (a)(42)(B)(ii)(III) of the Act	___ The State has an adequate appeal process in place for entities to appeal any adverse determination made by the Medicaid RAC(s).
Section 1902 (a)(42)(B)(ii)(IV) (aa) of the Act	___ The State assures that the amounts expended by the State to carry out the program will be amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan.
Section 1902(a)(42)(B)(ii)(IV) (bb) of the Act	___ The State assures that the recovered amounts will be subject to a State's quarterly expenditure estimates and funding of the State's share.
Section 1902 (a)(42)(B)(ii)(IV) (cc) Of the Act	___ Efforts of the Medicaid RAC(s) will be coordinated with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, and/or State and Federal law enforcement entities and the CMS Medicaid Integrity Program.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State INDIANA

Citation
42 CFR 431.16
AT-79-29

4.6 Reports

The Medicaid agency will submit all reports in the form and with the content required by the Secretary, and will comply with any provisions that the Secretary finds necessary to verify and assure the correctness of the reports. All requirements of 42 CFR 431.16 are met.

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State INDIANA

Citation
42 CFR 431.17
AT-79-29

4.7 Maintenance of Records

The Medicaid agency maintains or supervises the maintenance of records necessary for the proper and efficient operation of the plan, including records regarding applications, determination of eligibility, the provision of medical assistance, and administrative costs, and statistical, fiscal and other records necessary for reporting and accountability, and retains these records in accordance with Federal requirements. All requirements of 42 CFR 431.17 are met.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State INDIANA

Citation
42 CFR 431.18(b)
AT-79-29

4.8 Availability of Agency Program Manuals

Program manuals and other policy issuances that affect the public, including the Medicaid agency's rules and regulations governing eligibility, need and amount of assistance, recipient rights and responsibilities, and services offered by the agency are maintained in the State office and in each local and district office for examination, upon request, by individuals for review, study, or reproduction. All requirements of 42 CFR 431.18 are met.

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State INDIANA

Citation
42 CFR 433.37
AT-78-90

4.9 Reporting Provider Payments to Internal Revenue Service

There are procedures implemented in accordance with 42 CFR 433.37 for identification of providers of services by social security number or by employer identification number and for reporting the information required by the Internal Revenue Code (26 U.S.C. 6041) with respect to payment for services under the plan.

New: HCFA-PM-99-3
JUNE 1999

State: Indiana

Citation	
42 CFR 431.51 AT 78-90 46 FR 48524 48 FR 23212 1902(a)(23)	4.10 Free Choice of Providers (a) Except as provided in paragraph (b), the Medicaid agency assures that an individual eligible under the plan may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is qualified to perform the services, including an organization that provides these services or arranges for their availability on a prepayment basis. Providers who elect not to provide services based on a history of bad debt, including unpaid copayments, shall give recipients advance notice and a reasonable opportunity for payment. Recipients retain the ability to seek services from other enrolled providers.
P.L. 100-93 (section 8(f)) P.L. 100-203 (Section 4113)	(b) Paragraph (a) does not apply to services furnished to an individual - (1) Under an exception allowed under 42 CFR 431.54, subject to the the limitations in paragraph (c), or (2) Under a waiver approved under 42 CFR 431.55, subject to the limitations in paragraph (c), or (3) By an individual or entity excluded from participation in accordance with section 1902(p) of the Act, (4) By individuals or entities who have been convicted of a felony under Federal or State law and for which the State determines that the offense is inconsistent with the best interests of the individual eligible to obtain Medicaid services, or (5) Under an exception allowed under 42 CFR 438.50 or 42 CFR 440.168, subject to the limitations in paragraph (c). (c) Enrollment of an individual eligible for medical assistance in a primary care case management system described in section 1905(t), 1915(a), 1915(b)(1), or 1932(a); or managed care organization, prepaid inpatient health plan, a prepaid ambulatory health plan, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive emergency services or services under section 1905(a)(4)(c).

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State INDIANA

Citation
42 CFR 431.610
AT-78-90
AT-80-34

4.11 Relations with Standard-Setting and Survey Agencies

(a) The State agency utilized by the Secretary to determine qualifications of institutions and suppliers of services to participate in Medicare is responsible for establishing and maintaining health standards for private or public institutions (exclusive of Christian Science sanatoria) that provide services to Medicaid recipients. This agency is STATE BOARD OF HEALTH

(b) The State authority(ies) responsible for establishing and maintaining standards, other than those relating to health, for public or private institutions that provide services to Medicaid recipients is (are) STATE BOARD OF HEALTH,

STATE FIRE MARSHALL DEPARTMENT,

ADMINISTRATIVE BUILDING COUNCIL

(c) ATTACHMENT 4.11-A describes the standards specified in paragraphs (a) and (b) above, that are kept on file and made available to the Health Care Financing Administration on request.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State INDIANA

Citation		
42 CFR 431.610 AT-78-90 AT-89-34	4.11(d)	The STATE BOARD OF HEALTH (agency) which is the State agency responsible for licensing health institutions, determines if institutions and agencies meet the requirements for participation in the Medicaid program. The requirements in 42 CFR 431.610(e), (f) and (g) are met.

TN # _____
Supersedes
TN # 74-5

Approval Date 2/12/75 Effective Date 4/1/74

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State INDIANA

Citation
42 CFR 431.105(b)
AT-78-90

4.12 Consultation to Medical Facilities

(a) Consultative services are provided by health and other appropriate State agencies to hospitals, nursing facilities, home health agencies, clinics and laboratories in accordance with 42 CFR 431.105(b).

(b) Similar services are provided to other types of facilities providing medical care to individuals receiving services under the programs specified in 42 CFR 431.105(b).

☒ Yes, ~~as listed below:~~
to all providers who request services as provided in paragraph (a) above.

☐ Not applicable. Similar services are not provided to other types of medical facilities.

Revision: HCFA-PM-91-4 (BPD) AUGUST 1991 OMB No.: 0938-

State/Territory Indiana

Citation 4.13 Required Provider Agreement

With respect to agreements between the Medicaid agency and each provider furnishing services under the plan:

42 CFR 431.107 (a) For all providers, the requirements of 42 CFR 431.107 and 42 CFR Part 442, Subparts A and B (if applicable) are met.

In accordance with 42 CFR 442, Subpart B, the agency may refuse to execute an agreement with a certified nursing facility for additional beds when:

(1) An existing nursing facility undergoes a change in ownership that results in an increase in the number of Medicaid certified beds eligible for reimbursement.
(2) The overall occupancy rate for all facilities in the geographic region is less than 95%.

In accordance with 42 CFR 442, Subpart B, the agency may not refuse to execute an agreement with a certified nursing facility when:

(3) The nursing facility closes a building and replaces it with a new building with no more Medicaid certified beds than were contained in the previous building.
(4) The nursing facility is owned by the State of Indiana.
(5) The nursing facility is under development on December 15, 2005 to add, construct or convert certified beds. In determining whether the facility is under development on December 15, 2005, the office shall consider
(A) whether:
(i) architectural plans have been completed;
(ii) funding has been received;
(iii) zoning requirements have been met;
(iv) construction plans for the project have been approved by the state department of health and department of fire and building safety; and
(B) any other evidence that the office determines is an indication that the nursing facility is under development.
(6) The nursing facility is part of a continuing care retirement community that is required to file a disclosure statement under IC 23-2-4.

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

OMB No.: 0938-

State/Territory Indiana

42 CFR Part 483 1919 of the Act	(b)	For providers of NF services, requirements of 42 CFR Part 483, Subpart B, and section 1919 of the Act are also met.
42 CFR Part 483, Subpart D	(c)	For provider of ICF/MR services, the requirements of participation in 42 CFR Part 483, Subpart D are also met.
1902 of the Act	(d)	For each provider that is eligible under the plan to furnish ambulatory prenatal care to pregnant women during a presumptive eligibility period, all the requirements of section 1920(b)(2) and (c) are met.

☒ Not applicable. Ambulatory prenatal care is not provided to pregnant women during a presumptive eligibility period.

Revision: HCFA-PM-91-9 (MB) OMB No.:
October 1991

State/Territory: Indiana

Citation
1902 (a)(58)
1902(w) 4.13 (e) For each provider receiving funds under the plan, all the requirements for advance directives of section 1902(w) are met:

(1) Hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans (unless the PAHP excludes providers in 42 CFR 489.102), and health insuring organizations are required to do the following:

(a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.

(b) Provide written information to all adult individuals on their policies concerning implementation of such rights;

(c) Document in the individual's medical records whether or not the individual has executed an advance directive;

(d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(e) Ensure compliance with requirements of State Law (whether

Revision: HCFA-PM-91-9 (MB) OMB No.:
October 1991

State/Territory: Indiana

statutory or recognized by the courts) concerning advance directives; and

(f) Provide (individually or with others) for education for staff and the community on issues concerning advance directives.

(2) Providers will furnish the written information described in paragraph (1)(a) to all adult individuals at the time specified below:

(a) Hospitals at the time an individual is admitted as an inpatient.

(b) Nursing facilities when the individual is admitted as a resident.

(c) Providers of home health care or personal care services before the individual comes under the care of the provider;

(d) Hospice program at the time of initial receipt of hospice care by the individual from the program; and

(e) Managed care organizations, health insuring organizations, prepaid inpatient health plans, and prepaid ambulatory health plans (as applicable) at the time of enrollment of the individual with the organization.

(3) Attachment 4.34A describes law of the State (whether statutory or as Recognized by the courts of the State) concerning advance directives.

_____ Not applicable. No State law Or court decision exist regarding advance directives.

Revision: HCFA-PM-91-10 (MB)
DECEMBER 1991

State/Territory: Indiana

Citation
42 CFR 431.60
42 CFR 456.2
50 FR 15312
1902(a)(30)(C) and
1902(d) of the
Act, P.L. 99-509
(Section 9431)

4.14 Utilization/Quality Control

(a) A Statewide program of surveillance and utilization control has been implemented that safeguards against unnecessary or inappropriate use of Medicaid services available under this plan and against excess payments, and that assesses the quality of services. The requirements of 42 CFR Part 456 are met:

X Directly

_____ By undertaking medical and utilization review requirements through a contract with a Utilization and Quality Control Peer Review Organization (PRO) designated under 42 CFR Part 462. The contract with the PRO —

(1) Meets the requirements of §434.6(a):

(2) Includes a monitoring and evaluation plan to ensure satisfactory performance;

(3) Identifies the services and providers subject to PRO review;

(4) Ensures that PRO review activities are not inconsistent with the PRO review of Medicare services; and

(5) Includes a description of the extent to which PRO determinations are considered conclusive for payment purposes.

1932(c)(2)
and 1902(d) of the
ACT, P.L. 99-509
(section 9431)

X A qualified External Quality Review Organization performs an annual External Quality Review that meets the requirements of 42 CFR 438 Subpart E each managed care organization, prepaid inpatient health plan, and health insuring organizations under contract, except where exempted by the regulation

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

State: Indiana

OMB NO. 0938-0193

Citation
42 CFR 456.2
50 FR 15312

4.14 (b) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart C, for control of the utilization of inpatient hospital services.

/ / Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

/ / Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart C for:

/ / All hospitals (other than mental hospitals).

/ / Those specified in the waiver.

/X/ No waivers have been granted.

Revision: HCFA-PM-85-7 (BERC) OMB NO.: 0938-0193
JULY 1985

State/Territory: Indiana

Citation
42 CFR 456.2
50 FR 15312

4.14 (c) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart D, for control of utilization of inpatient services in mental hospitals.

☐ Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

/ / Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart D for:

/ / All mental hospitals.

/ / Those specified in the waiver.

[X] No waivers have been granted.

/ / Not applicable. Inpatient services in mental hospitals are not provided under this plan.

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

State: Indiana

OMB NO. 0938-0193

Citation
42 CFR 456.2
50 FR 15312

4.14 (d) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart E, for the control of utilization of skilled nursing facility services.

/ / Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

/ / Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart E for:

/ / All skilled nursing facilities.

/ / Those specified in the waiver.

/X/ No waivers have been granted.

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

State: Indiana

OMB NO. 0938-0193

Citation
42 CFR 456.2
50 FR 15312

4.14 /_/(e) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart F, for control of the utilization of intermediate care facility services. Utilization review in facilities is provided through:

/_/ Facility-based review.

/_/ Direct review by personnel of the medical assistance unit of the State agency.

/X/ Fiscal Agent Personnel under contract to the medical assistance unit of the State agency.

/_/ Utilization and Quality Control Peer Review Organizations.

/_/ Another method as described in ATTACHMENT 4.14-A.

/_/ Two or more of the above methods. ATTACHMENT 4.14-B describes the circumstances under which each method is used.

/_/ Not applicable. Intermediate care facility services are not provided under this plan.

Adequate per phone conv Ron Benjamin 6/10/86 since actual contract is with ACS

Revision: HCFA-PM-91-10 (MB)
December 1991

State/Territory: Indiana

Citation 4.14 Utilization/Quality Control (Continued)

42 CFR 438.356(e)

For each contract, the State must follow an open, competitive procurement process that is in accordance with State law and regulations and consistent with 45 CFR part 74 as it applies to State procurement of Medicaid services.

42 CFR 438.354
42 CFR 438.356(b) and (d)

The State must ensure that an External Quality Review Organization and its subcontractors performing the External Quality Review or External Quality Review-related activities meets the competence and independence requirements.

___ Not applicable.

Revision: HCFA-PM-92-2 (HSQB)
MARCH 1992

State/Territory: Indiana

Citation 4.15 Inspection of Care in Intermediate Care Facilities for the Mentally Retarded, Facilities Providing Inpatient Psychiatric Services for Individuals Under 21, and Mental Hospitals

42 CFR Part 456 Subpart I, and 1902(a)(31) and 1903(g) of the Act

____ The State has contracted with a Peer Review Organization (PRO) to perform inspection of care for:

____ ICFs/MR;

____ Inpatient psychiatric facilities for recipients under age 21; and

____ Mental Hospitals.

42 CFR Part 456 Subpart A and 1902(a)(30) of the Act

_X_ All applicable requirements of 42 CFR Part 456, Subpart I, are met with respect to periodic inspections of care and services.

____ Not applicable with respect to intermediate care facilities for the mentally retarded services; such services are not provided under this plan.

____ Not applicable with respect to services for individuals age 65 or over in institutions for mental disease; such services are not provided under this plan.

____ Not applicable with respect to inpatient psychiatric services for individuals under age 21; such services are not provided under this plan.

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State INDIANA

Citation
42 CFR 431.615(c)
AT-78-90

4.16 Relations with State Health and Vocational Rehabilitation Agencies and Title V Grantees

The Medicaid agency has cooperative arrangements with State health and vocational rehabilitation agencies and with title V grantees, that meet the requirements of 42 CFR 431.615.

ATTACHMENT 4.16-A describes the cooperative arrangements with the health and vocational rehabilitation agencies.

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Indiana

Citation
42 CFR 433.36(c)
1902(a)(18) and
1917(a) and (b) of
the Act

4.17 Liens and Adjustments or Recoveries

(a) Liens

____ The State imposes liens against an individual's real property on account of medical assistance paid or to be paid.

The State complies with the requirements of section 1917(a) of the Act and regulations at 42 CFR 433.36(c)-(g) with respect to any lien imposed against the property of any individual prior to his or her death on account of medical assistance paid or to be paid on his or her behalf.

____ The State imposes liens on real property on account of benefits incorrectly paid.

__X__ The State imposes TEFRA liens 1917(a)(1)(B) on real property of an individual who is an inpatient of a nursing facility, ICF/MR, or other medical institution, where the individual is required to contribute toward the cost of institutional care all but a minimal amount of income required for personal needs.

The procedures by the State for determining that an institutionalized individual cannot reasonably be expected to be discharged are specified in Attachment 4.17-A. (NOTE: If the State indicates in its State plan that it is imposing TEFRA liens, then the State is required to determine whether an institutionalized individual is permanently institutionalized and afford these individuals notice, hearing procedures, and due process requirements.)

____ The State imposes liens on both real and personal property of an individual after the individual's death.

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Indiana

(b) Adjustments or Recoveries

The State complies with the requirements of Section 1917(b) of the Act and regulations at 42 CFR 433.36(h)-(i).

Adjustments or recoveries for Medicaid claims correctly paid are as follows:

(1) For permanently institutionalized individuals, adjustments or recoveries are made from the individual's estate or upon sale of the property subject to a lien imposed because of medical assistance paid on behalf of the individual for services provided in a nursing facility, ICF/MR, or other medical institution.

___ Adjustments or recoveries are made for all other medical assistance paid on behalf of the individual.

(2) ___ The State determines "permanent institutional status" of individuals under the age of 55 other than those with respect to whom it imposes liens on real property under Section 1917(a)(1)(B) (even if it does not impose those liens).

(3) For any individual who received medical assistance at age 55 or older, adjustments or recoveries of payments are made from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services.

_X_ In addition to adjustment or recovery of payments for services listed above, payments are adjusted or recovered for other services under the State Plan as listed below:

All medical assistance paid on behalf of the recipient after the recipient became fifty-five years of age or older except for Medicare cost sharing identified at 4.17(b)(3) Continued.

Recovery shall be made for benefits provided prior to October 1, 1993, only if the recipient was sixty-five years of age or older at the time the benefits were provided.

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Indiana

4.17 (b) Adjustments or Recoveries

(3) Continued Limitations on Estate Recovery--Medicare Cost Sharing

(i) Medical assistance for Medicare cost sharing is protected from estate recovery for the following categories of dual eligibles QMB, SLMB, QI, QDWI, QMB+, SLMB+. This protection extends to medical assistance for four Medicare cost sharing benefits: (Part A and B premiums, deductibles, coinsurance, co-payments). with dates of service on or after January 1, 2010. The date of service for deductibles, coinsurance, and copayments is the date the request for payment is received by the State Medicaid Agency. The date of services for premiums is the date the State Medicaid Agency paid the premium.

(ii) In addition to being a qualified dual eligible the individual must also be age 55 of over. The above protection from estate recovery applies to approved mandatory (i. e., nursing facility, home and community-based services, and related prescription drugs and hospital services) as well as optional Medicaid services identified in the State Plan, which are applicable to the categories of duals referenced above.

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Indiana

(4) X

The State disregards assets or resources for individuals who receive or are entitled to receive benefits under a long term care insurance policy as provided for in Attachment 2.6-A, Supplement 8b.

The State adjusts or recovers from the individual's estate on account of all medical assistance paid for nursing facility and other long term care services provided on behalf of the individual. (States other than California, Connecticut, Indiana, Iowa, and New York which provide long term care insurance policy-based asset or resource disregard must select this entry. These five States may either check this entry or one of the following entries.)

The State does not adjust or recover from the individual's estate on account of any medical assistance paid for nursing facility or other long term care services provided on behalf of the individual.

X

The State adjusts or recovers from the assets or resources on account of medical assistance paid for nursing facility or other long term care services provided on behalf of the individual to the extent described below:

The State seeks recovery for medical assistance paid on behalf of the recipient after the recipient became 55 years of age or older. If the recipient is survived by a spouse, recovery shall be made after the death of the surviving spouse. Only those assets included in the recipient's "estate" (all real and personal property and other assets included within the recipient's estate as defined for purposes of state probate law) are subject to recovery. If the recipient is survived by a child, no recovery shall be made while the child is either: (1) under 21 years of age; or (2) blind or disabled as defined in 42 USC 1382c. A claim may not be enforced against the following assets: (1) personal effects, ornaments, or keepsakes of the deceased; (2) assets of an individual who purchases a long term care insurance policy that are disregarded pursuant to IC 12-15-3-6. The Medicaid agency may waive recovery, in whole or in part, in cases of undue hardship.

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Indiana

(c) Adjustments or Recoveries: Limitations

The State complies with the requirements of section 1917(b)(2) of the Act and regulations at 42 CFR §433.36(h)-(i).

(1) Adjustment or recovery of medical assistance correctly paid will be made only after the death of the individual's surviving spouse, and only when the individual has no surviving child who is either under age 21, blind, or disabled.

(2) With respect to liens on the home of any individual who the State determines is permanently institutionalized and who must as a condition of receiving services in the institution apply their income to the cost of care, the State will not seek adjustment or recovery of medical assistance correctly paid on behalf of the individual until such time as none of the following individuals are residing in the individual's home:

(a) a sibling of the individual (who was residing in the individual's home for at least one year immediately before the date that the individual was institutionalized), or

(b) a child of the individual (who was residing in the individual's home for at least two years immediately before the date that the individual was institutionalized) who establishes to the satisfaction of the State that the care the child provided permitted the individual to reside at home rather than become institutionalized.

(3) No money payments under another program are reduced as a means of adjusting or recovering Medicaid claims incorrectly paid.

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Indiana

(d) ATTACHMENT 4.17-A

(1) Specifies the procedures for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home. The description of the procedure meets the requirements of 42 CFR 433.36(d).

(2) Specifies the criteria by which a son or a daughter can establish that he or she has been providing care, as specified under 42 CFR 433.36(f).

(3) Defines the following terms:

- estate (at a minimum, estate as defined under State probate law). Except for the grandfathered States listed in section 4.17(b)(3), if the State provides a disregard for assets or resources for any individual who received or is entitled to receive benefits under a long term care insurance policy, the definition of estate must include all real, personal property, and assets of an individual (including any property or assets in which the individual had any legal title or interest at the time of death to the extent of the interest and also including the assets conveyed through devices such as joint tenancy, life estate, living trust, or other arrangement),
- individual's home,
- equity interest in the home,
- residing in the home for at least 1 or 2 years,
- on a continuous basis,
- discharge from the medical institution and return home, and
- lawfully residing.

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Indiana

(4) Describes the standards and procedures for waiving estate recovery when it would cause undue hardship.

(5) Defines when adjustment or recovery is not cost-effective. Defines cost-effective and includes methodology or thresholds used to determine cost-effectiveness.

(6) Describes collection procedures. Includes advance notice requirements, specifies the method for applying for a waiver, hearing and appeals procedures, and the time frames involved.

Revision: HCFA-AT-91-4(BPD) AUGUST 1991 OMB No.: 0938-

State/Territory: Indiana

Citation		4.18 Recipient Cost Sharing and Similar Charges
42 CFR 447.51 through 447.58	(a)	Unless a waiver under 42 CFR 431.55(g) applies, deductibles, coinsurance rates, and copayments do not exceed the maximum allowable charges under 42 CFR 447.54.
1916(a) and (b) of the Act	(b)	Except as specified in items 4.18(b)(4), (5), and (6) below, with respect to individuals covered as categorically needy or as qualified Medicare beneficiaries (as defined in section 1905(p)(1) of the Act) under the plan:

(1) No enrollment fee, premium, or similar charge is imposed under the plan.

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under--

[ ] Age 19

[ ] Age 20

[ ] Age 21

Reasonable categories of individuals who are age 18 or older, but under age 21, to whom charges apply are listed below, if applicable.

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: Indiana

Citation 4.18(b)(2) (Continued)

42 CFR 447.51 through 447.58

(iii) All services furnished to pregnant women.

[ ] Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution to spend for medical care costs all but a minimal amount of his or her income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

(vii) Services furnished by a managed care organization, health insuring organization, prepaid inpatient health plan, or prepaid ambulatory health plan in which the individual is enrolled, unless they meet the requirements of 42 CFR 447.60.

42 CFR 438.108
42 CFR 447.60

[ ] Managed care enrollees are charged deductibles, coinsurance rates, and copayments in an amount equal to the State Plan service cost-sharing.

[X] Managed care enrollees are not charged deductibles, coinsurance rates, and copayments.

1916 of the Act, P.L. 99-272, (Section 9505)

(viii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: Indiana

Citation 4.18(b) (Continued)

42 CFR 447.51 through 447.48

(3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed for services that are not excluded from such charges under item (b)(2) above.

☐ Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age groups:

☒ 18 or older

☐ 19 or older

☐ 20 or older

☐ 21 or older

☐ Charges apply to services furnished to the following reasonable categories of individuals listed below who are 18 years of age or older but under age 21.

Revision: HCFA-PM-91-4 (BPD) AUGUST 1991 OMB No.: 0938-

State/Territory: Indiana

Citation 42 CFR 447.51 through 447.58

4.18(b)(3) (Continued)

(iii) For the categorically needy and qualified Medicare beneficiaries, ATTACHMENT 4.18-A specifies the:

(A) Service(s) for which a charge(s) is applied;

(B) Nature of the charge imposed on each service;

(C) Amount(s) of and basis for determining the charge(s);

(D) Method used to collect the charge(s);

(E) Basis for determining whether an individual is unable to pay the charge and the means by which such an individual is identified to providers;

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and

(G) Cumulative maximum that applies to all deductible, coinsurance or copayment charges imposed on a specified time period.

/X/ Not applicable. There is no maximum.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: Indiana

Citation			
1916(c) of the Act	4.18(b)(4)	☐	A monthly premium is imposed on pregnant women and infants who are covered under section 1902(a)(10)(A)(ii)(IX) of the Act and whose income equals or exceeds 150 percent of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(c) of the Act are met. ATTACHMENT 4.18-D specifies the method the State uses for determining the premium and the criteria for determining what constitutes undue hardship for waiving payment of premiums by recipients.
1902(a)(52) and 1925(b) of the Act	4.18(b)(5)	☐	For families receiving extended benefits during a second 6-month period under section 1925 of the Act, a monthly premium is imposed in accordance with sections 1925(b)(4) and (5) of the Act.
1916(d) of the Act	4.18(b)(6)	☐	A monthly premium, set on a sliding scale, imposed on qualified disabled and working individuals who are covered under section 1902(a)(10)(E)(ii) of the Act and whose income exceeds 150 percent (but does not exceed 200 percent) of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(d) of the Act are met. ATTACHMENT 4.18-E specifies the method and standards the State uses for determining the premium.

Revision: HCFA-PM-91- 4 (BPD)
AUGUST 1991

OMB No.: 0938-

State/Territory: Indiana

Citation

42 CFR 447.51 through 447.58

4.18(c) ☐ Individuals are covered as medically needy under the plan.

(1) ☐ An enrollment fee, premium or similar charge is imposed. ATTACHMENT 4.18-B specifies the amount of and liability period for such charges subject to the maximum allowable charges in 42 CFR 447.52(b) and defines the State's policy regarding the effect on recipients of non-payment of the enrollment fee, premium, or similar charge.

447.51 through 447.58

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under--

☐ Age 19

☐ Age 20

☐ Age 21

Reasonable categories of individuals who are age 18, but under age 21, to whom charges apply are listed below, if applicable:

Revision: HCFA-PM-91- 4 (BPD) AUGUST 1991 OMB No.: 0938-

State/Territory: Indiana

Citation 4.18 (c)(2) (Continued)

42 CFR 447.51 through 447.58

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

(iii) All services furnished to pregnant women.

/ / Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

1916 of the Act, P.L. 99-272 (Section 9505)

(vii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

447.51 through 447.58

(viii) Services provided by a health maintenance organization (HMO) to enrolled individuals.

/ / Not applicable. No such charges are imposed.

Revision: HCFA-PM-91-4 (BPD) AUGUST 1991 OMB No.: 0938-

State/Territory: Indiana

Citation 4.18(c)(3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed on services that are not excluded from such charges under item (b)(2) above.

/X/ Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age group:

/ / 18 or older

/ / 19 or older

/ / 20 or older

/ / 21 or older

Reasonable categories of individuals who are 18 years of age, but under 21, to whom charges apply are listed below, if applicable.

Revision: HCFA-PM-91- 4 (BPD)
AUGUST 1991

OMB No.: 0938-

State/Territory: Indiana

Citation 4.18(c)(3) (Continued)

447.51 through

447.58

(iii) For the medically needy, and other optional groups, ATTACHMENT 4.18-C specifies the:

(A) Service(s) for which charge(s) is applied;

(B) Nature of the charge imposed on each service;

(C) Amount(s) of and basis for determining the charge(s);

(D) Method used to collect the charge(s);

(E) Basis for determining whether an individual is unable to pay the charge(s) and the means by which such an individual is identified to providers;

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and

(G) Cumulative maximum that applies to all deductible, coinsurance, or copayment charges imposed on a family during a specified time period.

☐ Not applicable. There is no maximum.

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: Indiana

Citation 4.19 Payment for Services

42 CFR 447.252
1902(a)(13)
and 1923 of
the Act

(a) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, and sections 1902(a)(13) and 1923 of the Act with respect to payment for inpatient hospital services.

ATTACHMENT 4.19-A describes the methods and standards used to determine rates for payment for inpatient hospital services.

/ / Inappropriate level of care days are covered and are paid under the State plan at lower rates than other inpatient hospital services, reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G) of the Act.

/X/ Inappropriate level of care days are not covered.

Revision: HCFA-PM-93- 6 (MB) OMB No.: 0938-
August 1993

State/Territory: INDIANA

Citation		
42 CFR 447.201 42 CFR 447.302 52 FR 28648 1902(a)(13)(E) 1903(a)(1) and (n), 1920, and 1926 of the Act	4.19(b)	In addition to the services specified in paragraphs 4.19(a), (d), (k), (l), and (m), the Medicaid agency meets the following requirements: (1) Section 1902(a)(13)(E) of the Act regarding payment for services furnished by Federally qualified health centers (FQHCs) under section 1905(a)(2)(C) of the Act. The agency meets the requirements of section 6303 of the State Medicaid Manual (HCFA-Pub. 45-6) regarding payment for FQHC services. ATTACHMENT 4.19-B describes the method of payment and how the agency determines the reasonable costs of the services (for example, cost-reports, cost or budget reviews, or sample surveys). (2) Sections 1902(a)(13)(E) and 1926 of the Act, and 42 CFR Part 447, Subpart D, with respect to payment for all other types of ambulatory services provided by rural health clinics under the plan. ATTACHMENT 4.19-B describes the methods and standards used for the payment of each of these services except for inpatient hospital, nursing facility services and services in intermediate care facilities for the mentally retarded that are described in other attachments.
1902(a)(10) and 1902(a)(30) of the Act		SUPPLEMENT 1 to ATTACHMENT 4.19-B describes general methods and standards used for establishing payment for Medicare Part A and B deductible/coinsurance.

*U.S. G.P.O.:1993-342-239:80149

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State INDIANA

Citation		
42 CFR 447.40 AT-78-90	4.19(c)	Payment is made to reserve a bed during a recipient's temporary absence from an inpatient facility.

☒ Yes. The State's policy is described in ATTACHMENT 4.19-C.

☐ No.

Revision: HCFA-PM-87- 9 (BERC)
AUGUST 1987

OMB No.: 0938-0193

State/Territory: Indiana

Citation 4.19 (d)
42 CFR 447.252
47 FR 47964
48 FR 56046
42 CFR 447.280
47 FR 31518
52 FR 28141

/X/ (1) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, with respect to payments for skilled nursing and intermediate care facility services.

ATTACHMENT 4.19-D describes the methods and standards used to determine rates for payment for skilled nursing and intermediate care facility services.

(2) The Medicaid agency provides payment for routine skilled nursing facility services furnished by a swing-bed hospital.

/ / At the average rate per patient day paid to SNFs for routine services furnished during the previous calendar year.

/ / At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

/X/ Not applicable. The agency does not provide payment for SNF services to a swing-bed hospital.

(3) The Medicaid agency provides payment for routine intermediate care facility services furnished by a swing-bed hospital.

/ / At the average rate per patient day paid to ICFs, other than ICFs for the mentally retarded, for routine services furnished during the previous calendar year.

/ / At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

/X/ Not applicable. The agency does not provide payment for ICF services to a swing-bed hospital.

/ / (4) Section 4.19(d)(1) of this plan is not applicable with respect to intermediate care facility services; such services are not provided under this State plan.

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State INDIANA

Citation		
42 CFR 447.45(c) AT-79-50	4.19(e)	The Medicaid agency meets all requirements of 42 CFR 447.45 for timely payment of claims. ATTACHMENT 4.19-E specifies, for each type of service, the definition of a claim for purposes of meeting these requirements.

Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

State/Territory: Indiana

Citation		
42 CFR 447.15 AT-78-90 AT-80-34 48 FR 5730	4.19 (f)	The Medicaid agency limits participation to providers who meet the requirements of 42 CFR 447.15. No provider participating under this plan may deny services to any individual eligible under the plan on account of the individual's inability to pay a cost sharing amount imposed by the plan in accordance with 42 CFR 431.55(g) and 447.53. This service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the cost sharing change.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State INDIANA

Citation		
42 CFR 447.201 42 CFR 447.202 AT-78-90	4.19(g)	The Medicaid agency assures appropriate audit of records when payment is based on costs of services or on a fee plus cost of materials.

Revision: HCFA-AT-80-60 (BPP)
August 12, 1980

State INDIANA

Citation		
42 CFR 447.201 42 CFR 447.203 AT-78-90	4.19(h)	The Medicaid agency meets the requirements of 42 CFR 447.203 for documentation and availability of payment rates.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State INDIANA

Citation		
42 CFR 447.201 42 CFR 447.204 AT-78-90	4.19(i)	The Medicaid agency's payments are sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State: Indiana

Citation

42 CFR 447.201 and 447.205	4.19(j)	The Medicaid agency meets the requirements of 42 CFR 447.205 for public notice of any changes in Statewide method or standards for setting payment rates.
1903(v) of the Act	(k)	The Medicaid agency meets the requirements of section 1903(v) of the Act with respect to payment for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Payment is made only for care and services that are necessary for the treatment of an emergency medical condition, as defined in section 1903(v) of the Act.

Revision: HCFA-PM-92-7 (MB)
October 1992

State/Territory: Indiana

Citation		
1903(i)(14) of the Act	4.19(l)	The Medicaid agency meets the requirements of section 1903(i)(14) of the Act with respect to payment for physician services furnished to children under 21 and pregnant women. Payment for physician services furnished by a physican to a child or a pregnant woman is made only to physicians who meet one of the requirements listed under this section of the Act.

Revision: HCFA-PM-94-8 (MB)
OCTOBER 1994

State/Territory: Indiana

Citation

4.19 (m) Medicaid Reimbursement for Administration of Vaccines under the Pediatric Immunization Program

1928 (c)(2)(C)
(ii) of the Act (i) A provider may impose a charge for the administration of a qualified pediatric vaccine as stated in 1928 (c)(2)(C)(ii) of the Act. Within this overall provision, Medicaid reimbursement to providers will be administered as follows.

(ii) The State:

— sets a payment rate at the level of the regional maximum established by the DHHS Secretary.

— is a Universal Purchase State and sets a payment rate at the level of the regional maximum established in accordance with State law.

X sets a payment rate below the level of the regional maximum established by the DHHS Secretary.

— is a Universal Purchase State and sets a payment rate below the level of the regional maximum established by the Universal Purchase State.

The State pays the following rate for the administration of a vaccine:

$15.00

1926 of the Act (iii) Medicaid beneficiary access to immunizations is assured through the following methodology:

Option C – Practitioner Participation, as set out in Notice with comment MB-84-NC, printed in the Federal Register dated October 3, 1994.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State INDIANA

Citation
42 CFR 447.25(b)
AT-78-90

4.20 Direct Payments to Certain Recipients for Physicians' or Dentists' Services

Direct payments are made to certain recipients as specified by, and in accordance with, the requirements of 42 CFR 447.25.

☐ Yes, for ☐ physicians' services

☐ dentists' services

ATTACHMENT 4.20-A specifies the conditions under which such payments are made.

☒ Not applicable. No direct payments are made to recipients.

Revision: HCFA-AT-81-34 (BPP) 10-81

State INDIANA

Citation	4.21	Prohibition Against Reassignment of Provider Claims
42 CFR 447.10(c) AT-78-90 46 FR 42699		Payment for Medicaid services furnished by any provider under this plan is made only in accordance with the requirements of 42 CFR 447.10.

TN # 81-9
Supersedes TN #

Approval Date 11-27-81 Effective Date 7-1-81

Citation

4.22 Third Party Liability

42 CFR 433.137

(a) The Medicaid agency meets all requirements of:(1) 42 CFR 433.138 and 433,139,
(2) 42 CFR 433.145 through 433.148.
(3) 42 CFR 433,151 through 433.154.
(4) Sections 1902(a)(25)(H) and (I) of the

1902(a)(25)(H) and (I) Act, of the Act

42 CFR 433.138(f)

(b) ATTACHMENT 4.22-A --

(1) Specifies the frequency with which the data exchanges required in S433.138(d)(1),(d)(3) and (d) (4) and the diagnosis and trauma code edits required in §433.138(e) are conducted;

42 CFR 433.138(g)(1)(ii) and (2)(ii)

(2) Describes the methods the agency uses for meeting the follow up requirements contained in S433.138(g)(1)(i) and (g)(2)(i);

42 CFR 433.138(g)(3) (i) and (iii)

(3) Describes the methods the agency uses for following up on information obtained through the State motor vehicle accident report file data exchange required under S433.138(d)(4)(ii) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the follow up that identifies legally liable third party resources; and

42 CFR 433,1JS(g)(4)(i) through (iii)

(4) Describes the methods the agency uses for following up on paid claims identified under §433.138(e) (methods include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the follow up that identifies legally liable third partyresources.

Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994

Citation State/Territory: Indiana

42 CFR 433.139(b)(3) x (c) Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalfchild support enforcement is being carried outby the State IV-D agency.

Effective December 31, 2021, system edits will be updated to require TPL resource validation prior to making payment determinations for claims that contain services for prenatal care including labor and delivery and postpartum care.

Claims for services relating to pediatric preventative care are excluded from cost avoidance and will follow the pay and chase methodology, unless the state has made a determination related to cost-effectiveness and access to care that warrants cost avoidance for up to 90 days.

When coordination of benefits decisions are the result of child support enforcement, claims will not be subject to cost avoidance for up to 100 days following the date the claim has been submitted in accordance with the flexibilities outlined in 1902(a)(25)(F).

(d) ATTACHMENT 4.22-B specifies the following:

42 CFR 433.139(b)(3) (ii) (C)

(1) The method used in determining a provider's compliance with the third party billing requirements at S433.139(b)(3) (ii) (C).

42 CFR 433.139(f)(2)

(2) The threshold amount or other guideline used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency deterines that seeking recovery of reimbursement would not be cost effective.

42 CFR 433.139(f)(3)

(3) The dollar amount or time period the state uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.

42 CFR 447.20

(e) The Medicaid agency ensures that the provider furnishing a service for which a third party isliable follows the restrictions specified in 42 CFR 447.20.

Citation

4.22 (continued)

42 CFR 433.151(a)

(f) The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State as a condition of eligibility for medical assistance with the following: (Check as appropriate.)

_x_ State title IV-D agency. The requirements of 42 CFR 433.152(b) are met.

_x_ Other appropriate State agency(s)-- State Police, Worker's CompensationDivision of Employment and Training

Other appropriate agency(s) of another State--

1902(a)(60) of the Act

Courts and law enforcement officials.

1906 of the Act

(g) The Medicaid agency assures that the State hasin effect the laws relating to medical child support under section 1908 of the Act.

(h) The Medicaid agency specifies the guidelines used in determining the cost effectiveness of an employer-based group health plan by selecting one of the following.

The Secretary's method as provided in the State Medicaid Manual, Section 3910.

J The State provides methods for determining cost effectiveness on ATTACHMENT 4.22-C4

Revision: HCFA-AT-84-2 (BERC)
01-84

State/Territory: Indiana

Citation 4.23 Use of Contracts

42 CFR 434.4
48 FR 54013

The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 434. All contracts meet the requirements of 42 CFR Part 434.

/ / Not applicable. The State has no such contracts.

42 CFR Part 438

The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 438. All contracts meet the requirements of 42 CFR Part 438. Risk contracts are procured through an open, competitive procurement process that is consistent with 45 CFR Part 74. The risk contract is with (check all that apply):

_X_ a Managed Care Organization that meets the definition of 1903(m) of the Act and 42 CFR 438.2

___ a Prepaid Inpatient Health Plan that meets the definition of 42 CFR 438.2

___ a Prepaid Ambulatory Health Plan that meets the definition of 42 CFR 438.2.

___ Not applicable.

Revision: HCFA-PM-94-2 (BPD)
APRIL 1994

State/Territory: Indiana

Citation	4.24	Standards for Payments for Nursing Facility and Intermediate Care Facility for the Mentally Retarded Services
42 CFR 442.10 and 442.100 AT-78-90 AT-79-18 AT-80-25 AT-80-34 52 FR 32544 P.L 100-203 (Sec. 4211) 54 FR 5316 56 FR 48826		With respect to nursing facilities and intermediate care facilities for the mentally retarded, all applicable requirements of 42 CFR Part 442, Subparts B and C are met. ___ Not applicable to intermediate care facilities for the mentally retarded; such services are not provided under this plan.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State INDIANA

Citation
42 CFR 431.702
AT-78-90

4.25 Program for Licensing Administrators of Nursing Homes

The State has a program that, except with respect to Christian Science sanatoria, meets the requirements of 42 CFR Part 431, Subpart N, for the licensing of nursing home administrators.

Revision: HCFA-PM- (MB)

State/Territory: INDIANA

Citation

1927(g) 42 CFR 456.700 — 4.26 Drug Utilization Review Program

A.1. The Medicaid agency meets the requirements of Section 1927(g) of the Act for a drug use review (DUR) program for outpatient drug claims.

1927(g)(1)(A)

2. The DUR program assures that prescriptions for outpatient drugs are:

-Appropriate
-Medically necessary
-Are not likely to result in adverse medical results

1927(g)(1)(a) 42 CFR 456.705(b) and 456.709(b)

B. The DUR program is designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and patients or associated with specific drugs as well as:

-Potential and actual adverse drug reactions
-Therapeutic appropriateness
-Overutilization and underutilization
-Appropriate use of generic products
-Therapeutic duplication
-Drug disease contraindications
-Drug-drug interactions
-Incorrect drug dosage or duration of drug treatment
-Drug-allergy interactions
-Clinical abuse/misuse

1927(g)(1)(B) 42 CFR 456.703 (d)and(f)

C. The DUR program shall assess data use against predetermined standards whose source materials for their development are consistent with peer-reviewed medical literature which has been critically reviewed by unbiased independent experts and the following compendia:

-American Hospital Formulary Service Drug Information
-United States Pharmacopeia-Drug Information
-American Medical Association Drug Evaluations

Revision: HCFA-PM- (MB)

State/Territory: INDIANA

Citation

1927(g)(1)(D)
42 CFR 456.703(b)

D. DUR is not required for drugs dispensed to residents of nursing facilities that are in compliance with drug regimen review procedures set forth in 42 CFR 483.60. The State has never-the-less chosen to include nursing home drugs in:

___ Prospective DUR
___ Retrospective DUR.

1927(g)(2)(A)
42 CFR 456.705(b)

E.1. The DUR program includes prospective review of drug therapy at the point of sale or point of distribution before each prescription is filled or delivered to the Medicaid recipient.

1927(g)(2)(A)(i)
42 CFR 456.705(b), (1)-(7))

2. Prospective DUR includes screening each prescription filled or delivered to an individual receiving benefits for potential drug therapy problems due to:

-Therapeutic duplication
-Drug-disease contraindications
-Drug-drug interactions
-Drug-interactions with non-prescription or over-the-counter drugs
-Incorrect drug dosage or duration of drug treatment
-Drug allergy interactions
-Clinical abuse/misuse

1927(g)(2)(A)(ii)
42 CFR 456.705 (c) and (d)

3. Prospective DUR includes counseling for Medicaid recipients based on standards established by State law and maintenance of patient profiles.

1927(g)(2)(B)
42 CFR 456.709(a)

F.1. The DUR program includes retrospective DUR through its mechanized drug claims processing and information retrieval system or otherwise which undertakes ongoing periodic examination of claims data and other records to identify:

-Patterns of fraud and abuse
-Gross overuse
-Inappropriate or medically unnecessary care among physicians, pharmacists, Medicaid recipients, or associated with specific drugs or groups of drugs.

Revision: HCFA-PM- (MB)

State/Territory: INDIANA

Citation		
927(g)(2)(C) 42 CFR 456.709(b)	F.2.	The DUR program assesses data on drug use against explicit predetermined standards including but not limited to monitoring for: -Therapeutic appropriateness -Overutilization and underutilization -Appropriate use of generic products -Therapeutic duplication -Drug-disease contraindications -Drug-drug interactions -Incorrect drug dosage/duration of drug treatment -Clinical abuse/misuse
1927(g)(2)(D) 42 CFR 456.711	3.	The DUR program through its State DUR Board, using data provided by the Board, provides for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems to improve prescribing and dispensing practices.
1927(g)(3)(A) 42 CFR 456.716(a)	G.1.	The DUR program has established a State DUR Board either: X Directly, or ___ Under contract with a private organization
1927(g)(3)(B) 42 CFR 456.716 (A) AND (B)	2.	The DUR Board membership includes health professionals (one-third licensed actively practicing pharmacists and one-third but no more than 51 percent licensed and actively practicing physicians) with knowledge and experience in one or more of the following: - Clinically appropriate prescribing of covered outpatient drugs. - Clinically appropriate dispensing and monitoring of covered outpatient drugs. - Drug use review, evaluation and intervention. - Medical quality assurance.
927(g)(3)(C) 42 CFR 456.716(d)	3.	The activities of the DUR Board include: - Retrospective DUR, - Application of Standards as defined in section 1927(g)(2)(C), and - Ongoing interventions for physicians and pharmacists targeted toward therapy problems or individuals identified in the course of retrospective DUR.

Revision: HCFA-PM- (MB) OMB No.

State/Territory: INDIANA

Citation

1927(g)(3)(C) 42 CFR 456.711 (a)-(d)	G.4	The interventions include in appropriate instances: - Information dissemination - Written, oral, and electronic reminders - Face-to-Face discussions - Intensified monitoring/review of prescribers/dispensers
1927(g)(3)(D) 42 CFR 456.712 (A) and (B)	H.	The State assures that it will prepare and submit an annual report to the Secretary, which incorporates a report from the State DUR Board, and that the State will adhere to the plans, steps, procedures as described in the report.
1927(h)(1) 42 CFR 456.722	___ I.1.	The State establishes, as its principal means of processing claims for covered outpatient drugs under this title, a point-of-sale electronic claims management system to perform on-line: - real time eligibility verification - claims data capture - adjudication of claims - assistance to pharmacists, etc. applying for and receiving payment.
1927(g)(2)(A)(i) 42 CFR 456.705(b)	___ 2.	Prospective DUR is performed using an electronic point of sale drug claims processing system.
1927(j)(2) 42 CFR 456.703(c)	J.	Hospitals which dispense covered outpatient drugs are exempted from the drug utilization review requirements of this section when facilities use drug formulary systems and bill the Medicaid program no more than the hospital's purchasing cost for such covered outpatient drugs.

* U.S. G.P.O.:1993-342-239:80043

State/Territory: INDIANA

Citation

1902(oo)

K. Indiana Medicaid has fully implemented Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (P. L. 115-271). The State is in compliance with the new drug review and utilization requirements set forth in section 1902(oo) of the Act, as follows:

1. Claims Review Requirements
   A. Safety Edits Including Early, Duplicate, and Quantity Limits
      i. The state has implemented the following prospective opioid safety edits:
         (1) quantity limits, including days' supply limits
         (2) length of therapy limits
         (3) refill frequency (percent to refill) limits
         (4) duplicate fills
         (5) maximum Morphine Milligram Equivalents (MME)/day limits
      ii. The state has implemented the following retrospective opioid safety reviews:
         (1) quantity limits, including days' supply limits
         (2) length of therapy limits
         (3) refill frequency (percent to refill) limits
         (4) duplicate fills
         (5) maximum MME/day reviews

   B. Concurrent Utilization Alerts
      i. Opioid and Benzodiazepines Current Fill Reviews
         (1) The state has implemented and monitors results of prior authorization requirements for concomitant opioids and benzodiazepines
      ii. Opioid and Antipsychotic Concurrent Fill Reviews
         (1) The state has implemented and monitors results of DUR edits

2. Program to Monitor Antipsychotic Medications by Children
   A. The state has implemented and monitors results of the following:
      i. age restrictions
      ii. quantity limits
      iii. prior authorization requirements for duplicate antipsychotic therapy
      iv. Department of Child Services Psychotropic Medications report

3. Fraud and Abuse Identification Requirements

State/Territory: INDIANA

A. The state has implemented and monitors results including but not necessarily limited to the following:

i. limits on number of opioid prescribers over a period of time
ii. prior authorization requirements for concomitant opioid and buprenorphine-based substance use disorder treatment
iii. ad hoc PDMP reviews corresponding to prior authorization requests
iv. pharmacy claims audits

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State INDIANA

Citation
42 CFR 431.115(c)
AT-78-90
AT-79-74

4.27 Disclosure of Survey Information and Provider or Contractor Evaluation

The Medicaid agency has established procedures for disclosing pertinent findings obtained from surveys and provider and contractor evaluations that meet all the requirements in 42 CFR 431.115.

Revision: HCFA-PM-93-1
January 1993

(BPD)

State/Territory: INDIANA

Citation		
42 CFR 431.152; AT-79-18 S2 FR 22444; Secs. 1902(a)(28)(D)(i) and 1919(e)(7) of the Act; P.L. 100-203 (Sec. 4211(c)).	4.28	Appeals Process

(a) The Medicaid agency has established appeals procedures for NFs as specified in 42 CFR 431.153 and 431.154. The Medicaid Agency has delegated these procedures to Indiana's Office of Administrative Law Proceedings (OALP).

(b) The State provides an appeals system that meets the requirements of 42 CFR 431 Subpart E, 42 CFR 483.12, and 42 CFR 483 subpart **E** for residents who wish to appeal a notice of intent to transfer or discharge from a NF and for individuals adversely affected by the preadmission and annual resident review requirements of 42 CFR 483 Subpart C.

New: HCFA-PM-99-3
JUNE 1999

State: Indiana

Citation

1902(a)(4)(C) of the Social Security Act P.L. 105-33	4.29 Conflict of Interest Provisions The Medicaid agency meets the requirements of Section 1902(a)(4)(C) of the Act concerning the Prohibition against acts, with respect to any activity Under the plan, that is prohibited by section 207 or 208 of title 18, United States Code.
1902(a)(4)(D) of the Social Security Act P.L. 105-33 1932(d)(3) 42 CFR 438.58	The Medicaid agency meets the requirements of 1902(a)(4)(D) of the Act concerning the safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423).

Revision: HCFA-PM-87-14 (BERC) OMB No.: 0938-0193
OCTOBER 1987

State/Territory: Indiana

Citation	4.30 Exclusion of Providers and Suspension of Practitioners and Other Individuals
42 CFR 1002.203 AT-79-54 48 FR 3742 51 FR 34772	(a) All requirements of 42 CFR Part 1002, Subpart B are met. /X/ The agency, under the authority of State law, imposes broader sanctions.

Revision: HCFA-AT-87-14 (BERC) OMB No.: 0938-0193
OCTOBER 1987

State/Territory: Indiana

Citation		
	(b)	The Medicaid agency meets the requirements of –
1902(p) of the Act		(1) Section 1902(p) of the Act by excluding from participation—
		(A) At the State's discretion, any individual or entity for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII in accordance with sections 1128, 1128A, or 1866(b)(2).
42 CFR 438.808		(B) An MCO (as defined in section 1903(m) of the Act), or an entity furnishing services under a waiver approved under section 1915(b)(1) of the Act, that –
		(i) Could be excluded under section 1128(b)(8) relating to owners and managing employees who have been convicted of certain crimes or received other sanctions, or
		(ii) Has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1128(b)(8)(B) of the Act.
1932(d)(1) 42 CFR 438.610		(2) An MCO, PIHP, PAHP, or PCCM may not have prohibited affiliations with individuals (as defined in 42 CFR 438,610(b)) suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No. 12549. If the State finds that an MCO, PCCM, PIPH, or PAHP is not in compliance the State will comply with the requirements of 42 CFR 438.610(c)

Revision: HCFA-AT-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193

State/Territory: Indiana

Citation	
1902(a)(39) of the Act P.L. 100-93 (sec. 8(f))	(2) Section 1902(a)(39) of the Act by--
	(A) Excluding an individual or entity from participation for the period specified by the Secretary, when required by the Secretary to do so in accordance with sections 1128 or 1128A of the Act; and
	(B) Providing that no payment will be made with respect to any item or service furnished by an individual or entity during this period.
	(c) The Medicaid agency meets the requirements of--
1902(a)(41) of the Act P.L. 96-272, (sec. 308(c))	(1) Section 1902(a)(41) of the Act with respect to prompt notification to HCFA whenever a provider is terminated, suspended, sanctioned, or otherwise excluded from participating under this State plan; and
1902(a)(49) of the Act P.L. 100-93 (sec. 5(a)(4))	(2) Section 1902(a)(49) of the Act with respect to providing information and access to information regarding sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1921 of the Act.

Revision: HCFA-PM-87-14 (BERC) OMB No.: 0938-0193
OCTOBER 1987

State/Territory: Indiana

Citation

455.103
44 FR 41644
1902(a)(38)
of the Act
P.L. 100-93
(sec. 8(f))

4.31 Disclosure of Information by Providers and Fiscal Agents

The Medicaid agency has established procedures for the disclosure of information by providers and fiscal agents as specified in 42 CFR 455.104 through 455.106 and sections 1128(b)(9) and 1902(a)(38) of the Act.

435.940
through 435.960
52 FR 5967
54 FR 8738

4.32 Income and Eligibility Verification System

(a) The Medicaid agency has established a system for income and eligibility verification in accordance with the requirements of 42 CFR 435.940 through 435.960.

(b) ATTACHMENT 4.32-A describes, in accordance with 42 CFR 435.948(a)(6), the information that will be requested in order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested.

Revision: HCFA-PM-87-14 (BERC) OMB No.: 0938-0193
OCTOBER 1987

State/Territory: Indiana

Citation
1902(a)(48) of the Act, P.L. 99-570 (Section 11005) P.L 100-93 (sec. 5(a)(3))

4.33 Medicaid Eligibility Cards for Homeless Individuals

(a) The Medicaid agency has a method for making cards evidencing eligibility for medical assistance available to an individual eligible under the State's approved plan who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

(b) ATTACHMENT 4.33-A specifies the method for issuance of Medicaid eligibility cards to homeless individuals.

☆ U.S. GOVERNMENT PRINTING OFFICE: 1987— 201-818/60437

Revision: HCFA-PM-88-10 (BERC)
SEPTEMBER 1988

OMB No.: 0938-0193

State/Territory: Indiana

Citation 1137 of the Act

P.L. 99-603 (sec. 121)

4.34 Systematic Alien Verification for Entitlements

The State Medicaid agency has established procedures for the verification of alien status through the Immigration & Naturalization Service (INS) designated system, Systematic Alien Verification for Entitlements (SAVE), effective October 1, 1988.

☐ The state Medicaid agency has elected to participate in the option period of October 1, 1987 to September 30, 1988 to verify alien status through the INS designated system (SAVE).

☐ The State Medicaid agency has received the following type(s) of waiver from participation in SAVE.

- ☐ Total waiver
- ☐ Alternative system
- ☐ Partial implementation

Revision: HCFA-PM-90- 2 (BPD)
JANUARY 1990

OMB No.: 0938-0193

State/Territory: Indiana

Citation

4.35 Remedies for Skilled Nursing and Intermediate Care Facilities that Do Not Meet Requirements of Participation

1919(h)(1) and (2) of the Act, P.L. 100-203 (Sec. 4213(a))

(a) The Medicaid agency meets the requirements of section 1919(h)(2)(A) through (D) of the Act concerning remedies for skilled nursing and intermediate care facilities that do not meet one or more requirements of participation. ATTACHMENT 4.35-A describes the criteria for applying the remedies specified in section 1919(h)(2)(A)(i) through (iv) of the Act.

/ / Not applicable to intermediate care facilities; these services are not furnished under this plan.

/X/ (b) The agency uses the following remedy(ies):

(1) Denial of payment for new admissions.

(2) Civil money penalty.

(3) Appointment of temporary management.

(4) In emergency cases, closure of the facility and/or transfer of residents.

1919(h)(2)(B)(ii) of the Act

/ / (c) The agency establishes alternative State remedies to the specified Federal remedies (except for termination of participation). ATTACHMENT 4.35-B describes these alternative remedies and specifies the basis for their use.

1919(h)(2)(F) of the Act

/ / (d) The agency uses one of the following incentive programs to reward skilled nursing or intermediate care facilities that furnish the highest quality care to Medicaid residents:

/ / (1) Public recognition.

/ / (2) Incentive payments.

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: Indiana

Citation

4.35 Enforcement of Compliance for Nursing Facilities

42 CFR §488.402(f)

(a) Notification of Enforcement Remedies

When taking an enforcement action against a non-State operated NF, the State provides notification in accordance with 42 CFR 488.402(f).

(i) The notice (except for civil money penalties and State monitoring) specifies the:

(1) nature of noncompliance,
(2) which remedy is imposed,
(3) effective date of the remedy, and
(4) right to appeal the determination leading to the remedy.

42 CFR §488.434

(ii) The notice for civil money penalties is in writing and contains the information specified in 42 CFR 488.434.

42 CFR §488.402(f)(2)

(iii) Except for civil money penalties and State monitoring, notice is given at least 2 calendar days before the effective date of the enforcement remedy for immediate jeopardy situations and at least 15 calendar days before the effective date of the enforcement remedy when immediate jeopardy does not exist.

42 CFR §488.456(c)(d)

(iv) Notification of termination is given to the facility and to the public at least 2 calendar days before the remedy's effective date if the noncompliance constitutes immediate jeopardy and at least 15 calendar days before the remedy's effective date if the noncompliance does not constitute immediate jeopardy. The State must terminate the provider agreement of an NF in accordance with procedures in parts 431 and 442.

(b) Factors to be Considered in Selecting Remedies

42 CFR §488.488.404(b)(1)

(i) In determining the seriousness of deficiencies, the State considers the factors specified in 42 CFR 488.404(b)(1) & (2).

___ The State considers additional factors. Attachment 4.35-A describes the State's other factors.

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: Indiana

Citation

c) Application of Remedies

42 CFR §488.410

(i) If there is immediate jeopardy to resident health or safety, the State terminates the NF's provider agreement within 23 calendar days from the date of the last survey or immediately imposes temporary management to remove the threat within 23 days.

42 CFR §488.417(b) §1919(h)(2)(C) of the Act.

(ii) The State imposes the denial of payment (or its approved alternative) with respect to any individual admitted to an NF that has not come into substantial compliance within 3 months after the last day of the survey.

42 CFR §488.414 §1919(h)(2)(D) of the Act.

(iii) The State imposes the denial of payment for new admissions remedy as specified in §488.417 (or its approved alternative) and a State monitor as specified at §488.422, when a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys.

42 CFR §488.408 1919(h)(2)(A) of the Act.

(iv) The State follows the criteria specified at 42 CFR §488.408(c)(2), §488.408(d)(2), and §488.408(e)(2), when it imposes remedies in place of or in addition to termination.

42 CFR §488.412(a)

(v) When immediate jeopardy does not exist, the State terminates an NF's provider agreement no later than 6 months from the finding of noncompliance, if the conditions of 42 CFR 488.412(a) are not met.

(d) Available Remedies

42 CFR §488.406(b) §1919(h)(2)(A) of the Act.

(i) The State has established the remedies defined in 42 CFR 488.406(b).

- X (1) Termination
- X (2) Temporary Management
- X (3) Denial of Payment for New Admissions
- X (4) Civil Money Penalties
- X (5) Transfer of Residents; Transfer of Residents with Closure of Facility
- X (6) State Monitoring

Attachments 4.35-B through 4.35-G describe the criteria for applying the above remedies.

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: Indiana

Citation

42 CFR
§488.406(b)
§1919(h)(2)(B)(ii)
of the Act.

(ii) ___ The State uses alternative remedies. The State has established alternative remedies that the State will impose in place of a remedy specified in 42 CFR 488.406(b).

___ (1) Temporary Management
___ (2) Denial of Payment for New Admissions
___ (3) Civil Money Penalties
___ (4) Transfer of Residents; Transfer of Residents with Closure of Facility
___ (5) State Monitoring.

Attachments 4.35-B through 4.35-G describe the alternative remedies and the criteria for applying them.

42 CFR
§488.303(b)
1910(h)(2)(F)
of the Act.

(e) ___ State Incentive Programs

___ (1) Public Recognition
___ (2) Incentive Payments

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: Indiana

Citation	4.36	Required Coordination Between the Medicaid and WIC Programs
1902(a)(11)(C) and 1902(a)(53) of the Act		The Medicaid agency provides for the coordination between the Medicaid program and the Special Supplemental Food Program for Women, Infants, and Children (WIC) and provides timely notice and referral to WIC in accordance with section 1902(a)(53) of the Act.

Revision: HCFA-PM-91- 10 (BPD)
DECEMBER 1991

State/Territory: INDIANA

Citation			
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).	4.38		Nurse Aide Training and Competency Evaluation for Nursing Facilities
		(a)	The State assures that the requirements of 42 CFR 483.150(a), which relate to individuals deemed to meet the nurse aide training and competency evaluation requirements, are met.
	___	(b)	The State waives the competency evaluation requirements for individuals who meet the requirements of 42 CFR 483.150(b)(1).
	X	(c)	The State deems individuals who meet the requirements of 42 CFR 483.150(b)(2) to have met the nurse aide training and competency evaluation requirements.
		(d)	The State specifies any nurse aide training and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.152 and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.154.
	___	(e)	The State offers a nurse aide training and competency evaluation program that meets the requirements of 42 CFR 483.152.
	X	(f)	The State offers a nurse aide competency evaluation program that meets the requirements of 42 CFR 483.154.

State/Territory: INDIANA

Citation	
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).	(g) If the State does not choose to offer a nurse aide training and competency evaluation program or nurse aide competency evaluation program, the State reviews all nurse aide training and competency evaluation programs and competency evaluation programs upon request.
	(h) The State survey agency determines, during the course of all surveys, whether the requirements of 483.75(e) are met.
	(i) Before approving a nurse aide training and competency evaluation program, the State determines whether the requirements of 42 CFR 483.152 are met.
	(j) Before approving a nurse aide competency evaluation program, the State determines whether the requirements of 42 CFR 483.154 are met.
	(k) For program reviews other than the initial review, the State visits the entity providing the program.
	(l) The State does not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in certain facilities as described in 42 CFR 483.151(b)(2) and (3).

State/Territory: INDIANA

Citation			
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).		(m)	The State, within 90 days of receiving a request for approval of a nurse aide training and competency evaluation program or competency evaluation program, either advises the requestor whether or not the program has been approved or requests additional information from the requestor.
		(n)	The State does not grant approval of a nurse aide training and competency evaluation program for a period longer than 2 years.
		(o)	The State reviews programs when notified of substantive changes (e.g., extensive curriculum modification).
		(p)	The State withdraws approval from nurse aide training and competency evaluation programs and competency evaluation programs when the program is described in 42 CFR 483.151(b)(2) or (3).
	X	(q)	The State withdraws approval of nurse aide training and competency evaluation programs that cease to meet the requirements of 42 CFR 483.152 and competency evaluation programs that cease to meet the requirements of 42 CFR 483.154.
		(r)	The State withdraws approval of nurse aide training and competency evaluation programs and competency evaluation programs that do not permit unannounced visits by the State.

State/Territory: INDIANA

Citation		
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).		(s) When the State withdraws approval from a nurse aide training and competency evaluation program or competency evaluation program, the State notifies the program in writing, indicating the reasons for withdrawal of approval.
		(t) The State permits students who have started a training and competency evaluation program from which approval is withdrawn to finish the program.
		(u) The State provides for the reimbursement of costs incurred in completing a nurse aide training and competency evaluation program or competency evaluation program for nurse aides who become employed by or who obtain an offer of employment from a facility within 12 months of completing such program.
		(v) The State provides advance notice that a record of successful completion of competency evaluation will be included in the State's nurse aide registry.
		(w) Competency evaluation programs are administered by the State or by a State-approved entity which is neither a skilled nursing facility participating in Medicare nor a nursing facility participating in Medicaid.
	X	(x) The State permits proctoring of the competency evaluation in accordance with 42 CFR 483.154(d).
		(y) The State has a standard for successful completion of competency evaluation programs.

State/Territory: INDIANA

Citation			
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).		(z)	The State includes a record of successful completion of a competency evaluation within 30 days of the date an individual is found competent.
	X	(aa)	The State imposes a maximum upon the number of times an individual may take a competency evaluation program (any maximum imposed is not less than 3).
		(bb)	The State maintains a nurse aide registry that meets the requirements in 42 CFR 483.156.
	___	(cc)	The State includes home health aides on the registry.
	___	(dd)	The State contracts the operation of the registry to a non State entity.
	___	(ee)	ATTACHMENT 4.38 contains the State's description of registry information to be disclosed in addition to that required in 42 CFR 483.156(c)(1)(iii) and (iv).
	X	(ff)	ATTACHMENT 4.38-A contains the State's description of information included on the registry in addition to the information required by 42 CFR 483.156(c).

Revision: HCFA-PM-93-1 (BPD)
January 1993

State/Territory: INDIANA

Citation
Secs.
1902(a)(28)(D)(i)
and 1919(e)(7) of
the Act;
P.L. 100-203
(Sec. 4211(c));
P.L. 101-508
(Sec. 4801(b)).

4.39 Preadmission Screening and Annual Resident Review in Nursing Facilities

(a) The Medicaid agency has in effect a written agreement with the State mental health and mental retardation authorities that meet the requirements of 42 (CFR) 431.621(c).

(b) The State operates a preadmission and annual resident review program that meets the requirements of 42 CFR 483.100-138.

(c) The State does not claim as "medical assistance under the State Plan" the cost of services to individuals who should receive preadmission screening or annual resident review until such individuals are screened or reviewed.

(d) With the exception of NF services furnished to certain NF residents defined in 42 CFR 483.118(c)(1), the State does not claim as "medical assistance under the State plan" the cost of NF services to individuals who are found not to require NF services.

X (e) ATTACHMENT 4.39 specifies the State's definition of specialized services.

Revision: HCFA-PM-93-1 (BPD)
January 1993

State/Territory: INDIANA

4.39 (Continued)

____ (f) Except for residents identified in 42 CFR 483.118(c)(1), the State mental health or mental retardation authority makes categorical determinations that individuals with certain mental conditions or levels of severity of mental illness would normally require specialized services of such an intensity that a specialized services program could not be delivered by the State in most, if not all, NFs and that a more appropriate placement should be utilized.

(g) The State describes any categorical determinations it applies in ATTACHMENT 4.39-A.

Revision: HCFA-PM-92-3 (HSQB) OMB No.:
APRIL 1992

State/Territory: INDIANA

Citation Sections		
	4.40 Survey & Certification Process	
1919(g)(1) thru (2) and 1919(g)(4) thru (5) of the Act P.L. 100-203 (Sec. 4212(a))	(a)	The State assures that the requirements of 1919(g)(1)(A) through (C) and section 1919(g)(2)(A) through (E)(iii) of the Act which relate to the survey and certification of non-State owned facilities based on the requirements of section 1919(b), (c) and (d) of the Act, are met.
1919(g)(1)(B) of the Act	(b)	The State conducts periodic education programs for staff and residents (and their representatives). **Attachment 4.40-A** describes the survey and certification educational program.
1919(g)(1)(C) of the Act	(c)	The State provides for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility. **Attachment 4.40-B** describes the State's process.
1919(g)(1)(C) of the Act	(d)	The State agency responsible for surveys and certification of nursing facilities or an agency delegated by the State survey agency conducts the process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property. If not the State survey agency, what agency? _____
1919(g)(1)(C) of the Act	(e)	The State assures that a nurse aide, found to have neglected or abused a resident or misappropriated resident property in a facility, is notified of the finding. The name and finding is placed on the nurse aide registry.
1919(g)(1)(C) of the Act	(f)	The State notifies the appropriate licensure authority of any licensed individual found to have neglected or abused a resident or misappropriated resident property in a facility.

Revision: HCFA-PM-92-3 (HSQB) OMB No:
APRIL 1992

State/Territory: INDIANA

1919(g)(2)(A)(i) of the Act	(g)	The State has procedures, as provided for at section 1919(g)(2)(A)(i), for the scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice through the scheduling procedures and the conduct of the surveys themselves. **Attachment 4.40-C** describes the State's procedures.
1919(g)(2)(A)(ii) of the Act	(h)	The State assures that each facility shall have a standard survey which includes (for a case-mix stratified sample of residents) a survey of the quality of care furnished, as measured by indicators of medical, nursing and rehabilitative care, dietary and nutritional services, activities and social participation, and sanitation, infection control, and the physical environment, written plans of care and audit of resident's assessments, and a review of compliance with resident's rights not later than 15 months after the date of the previous standard survey.
1919(g)(2)(A)(iii)(I) of the Act	(i)	The State assures that the Statewide average interval between standard surveys of nursing facilities does not exceed 12 months.
1919(g)(2)(A)(iii)(II) of the Act	(j)	The State may conduct a special standard or special abbreviated standard survey within 2 months of any change of ownership, administration, management, or director of nursing of the nursing facility to determine whether the change has resulted in any decline in the quality of care furnished in the facility.
1919(g)(2)(B) of the Act	(k)	The State conducts extended surveys immediately or, if not practicable, not later that 2 weeks following a completed standard survey in a nursing facility which is found to have provided substandard care or in any other facility at the Secretary's or State's discretion.
1919(g)(2)(C) of the Act	(l)	The State conducts standard and extended surveys based upon a protocol, i.e., survey forms, methods, procedures and guidelines developed by HCFA, using individuals in the survey team who meet minimum qualifications established by the Secretary.

Revision: HCFA-PM-92-3 (HSQB) OMB No:
APRIL 1992

State/Territory: INDIANA

1919(g)(2)(D) of the Act	(m)	The State provides for programs to measure and reduce inconsistency in the application of survey results among surveyors. Attachment 4.40-D describes the State's programs.
1919(g)(2)(E)(i) of the Act	(n)	The State uses a multidisciplinary team of professionals including a registered professional nurse.
1919(g)(2)(E)(ii) of the Act	(o)	The State assures that members of a survey team do not serve (or have not served within the previous two years) as a member of the staff or consultant to the nursing facility or has no personal or familial financial interest in the facility being surveyed.
1919(g)(2)(E)(iii) of the Act	(p)	The State assures that no individual shall serve as a member of any survey team unless the individual has successfully completed a training and test program in survey and certification techniques approved by the Secretary.
1919(g)(4) of the Act	(q)	The State maintains procedures and adequate staff to investigate complaints of violations of requirements by nursing facilities and onsite monitoring. Attachment 4.40-E describes the State's complaint procedures.
1919(g)(5)(A) of the Act	(r)	The State makes available to the public information respecting surveys and certification of nursing facilities including statements of deficiencies, plans of correction, copies of cost reports, statements of ownership and the information disclosed under section 1126 of the Act.
1919(g)(5)(B) of the Act	(s)	The State notifies the State long-term care ombudsman of the State's finding of non-compliance with any of the requirements of subsection (b), (c), and (d) or of any adverse actions taken against a nursing facility.
1919(g)(5)(C) of the Act	(t)	If the State finds substandard quality of care in a facility, the State notifies the attending physician of each resident with respect to which such finding is made and the nursing facility administrator licensing board.
1919(g)(5)(D) of the Act	(u)	The State provides the State Medicaid fraud and abuse agency access to all information concerning survey and certification actions.

Revision: HCFA-PM-92- 2 (HSQB)
MARCH 1992

State/Territory: INDIANA

Citation	4.41 Resident Assessment for Nursing Facilities	
Sections 1919(b)(3) and 1919 (e)(5) of the Act	(a)	The State specifies the instrument to be used by nursing facilities for conducting a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity as required in §1919(b)(3)(A) of the Act.
1919(e)(5) (A) of the Act	(b)	The State is using: X the resident assessment instrument designated by the Health Care Financing Administration (see Transmittal #241 of the State Operations Manual) [§1919(e)(5)(A)]; or
1919(e)(5) (B) of the Act		____ a resident assessment instrument that the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines as specified by the Secretary (see Section 4470 of the State Medicaid Manual for the Secretary's approval criteria) [§1919(e)(5)(B)].

Citation 1902(a)(68) of the Act, P.L. 109-171 (section 6032)

4.42 Employee Education About False Claims Recoveries.

(a) The Medicaid agency meets the requirements regarding establishment of policies and procedures for the education of employees of entities covered by section 1902(a)(68) of the Social Security Act (the Act) regarding false claims recoveries and methodologies for oversight of entities' compliance with these requirements.

(1) Definitions.

(A) An "entity" includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, which receives or makes payments, under a State Plan approved under title XIX or under any waiver of such plan, totaling at least $5,000,000 annually.

If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of section 1902(a)(68) apply if the aggregate payments to that entity meet the $5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an "entity" (e.g., a state mental

health facility or school district providing school-based health services). A government agency which merely administers the Medicaid program, in whole or part (e.g., managing the claims processing system or determining beneficiary eligibility), is not, for these purposes, considered to be an entity.

An entity will have met the $5,000,000 annual threshold as of January 1, 2007, if it received or made payments in that amount in Federal fiscal year 2006. Future determinations regarding an entity's responsibility stemming from the requirements of section 1902(a)(68) will be made by January 1 of each subsequent year, based upon the amount of payments an entity either received or made under the State Plan during the preceding Federal fiscal year.

(B) An "employee" includes any officer or employee of the entity.

(C) A "contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of, Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity.

(2) The entity must establish and disseminate written policies which must also be adopted by its contractors or agents. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents. The entity need not create an employee handbook if none already exists.

(3) An entity shall establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A). The entity shall include in those written policies detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

(4) The requirements of this law should be incorporated into each State's provider enrollment agreements.

(5) The State will implement this State Plan amendment on January 1, 2007.

(b) ATTACHMENT 4.42-A describes, in accordance with section 1902(a)(68) of the Act, the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Indiana

Citation	
1902(a)(69) of the Act, P.L. 109-171 (section 6034)	4.43 Cooperation with Medicaid Integrity Program Efforts. The Medicaid agency assures it complies with such requirements Determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under section 1936 of the Act.

Section 4 – General Program Administration

4.44 Medicaid Prohibition on Payments to Institutions or Entities Located Outside of the United States

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Citation

Section 1902(a)(80) of the Social Security Act, P.L. 111-148 (Section 6505)

__X__ The State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: **Indiana**

Section 4 – General Program Administration

Citation	
1902(a)(77) 1902(a)(39) 1902(kk); P.L. 111-148 and P.L. 111-152	**4.46 Provider Screening and Enrollment** The State Medicaid agency gives the following assurances:
42 CFR 455 Subpart E	PROVIDER SCREENING X Assures that the State Medicaid agency complies with the process for screening providers under section 1902(a)(39), 1902(a)(77) and 1902(kk) of the Act.
42 CFR 455.410	ENROLLMENT AND SCREENING OF PROVIDERS X Assures enrolled providers will be screened in accordance with 42 CFR 455.400 et seq. X Assures that the State Medicaid agency requires all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the Plan as a participating provider.
42 CFR 455.412	VERIFICATION OF PROVIDER LICENSES X Assures that the State Medicaid agency has a method for verifying providers licensed by a State and that such providers licenses have not expired or have no current limitations.
42 CFR 455.414	REVALIDATION OF ENROLLMENT X Assures that providers will be revalidated regardless of provider type at least every 5 years.
42 CFR 455.416	TERMINATION OR DENIAL OF ENROLLMENT X Assures that the State Medicaid agency will comply with section 1902(a)(39) of the Act and with the requirements outlined in 42 CFR 455.416 for all terminations or denials of provider enrollment.
42 CFR 455.420	REACTIVATION OF PROVIDER ENROLLMENT X Assures that any reactivation of a provider will include re-screening and payment of application fees as required by 42 CFR 455.460.

42 CFR 455.422

APPEAL RIGHTS

X Assures that all terminated providers and providers denied enrollment as a result of the requirements of 42 CFR 455.416 will have appeal rights available under procedures established by State law or regulation.

42 CFR 455.432

SITE VISITS

X Assures that pre-enrollment and post-enrollment site visits of providers who are in "moderate" or "high" risk categories will occur.

42 CFR 455.434

CRIMINAL BACKGROUND CHECKS

X Assures that providers, as a condition of enrollment, will be required to consent to criminal background checks including fingerprints, if required to do so under State law, or by the level of screening based on risk of fraud, waste or abuse for that category of provider.

42 CFR 455.436

FEDERAL DATABASE CHECKS

X Assures that the State Medicaid agency will perform Federal database checks on all providers or any person with an ownership or controlling interest or who is an agent or managing employee of the provider.

42 CFR 455.440

NATIONAL PROVIDER IDENTIFIER

X Assures that the State Medicaid agency requires the National Provider Identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.

42 CFR 455.450

SCREENING LEVELS FOR MEDICAID PROVIDERS

X Assures that the State Medicaid agency complies with 1902(a)(77) and 1902(kk) of the Act and with the requirements outlined in 42 CFR 455.450 for screening levels based upon the categorical risk level determined for a provider.

42 CFR 455.460

APPLICATION FEE

X Assures that the State Medicaid agency complies with the requirements for collection of the application fee set forth in section 1866(j)(2)(C) of the Act and 42 CFR 455.460.

42 CFR 455.470

TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS

X Assures that the State Medicaid agency complies with any temporary moratorium on the enrollment of new providers or provider types imposed by the Secretary under section 1866(j)(7) and 1902(kk)(4) of the Act, subject to any determination by the State and written notice to the Secretary that such a temporary moratorium would not adversely impact beneficiaries' access to medical assistance.

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State INDIANA

SECTION 5 PERSONNEL ADMINISTRATION

Citation
42 CFR 432.10(a)
AT-78-90
AT-79-23
AT-80-34

5.1 Standards of Personnel Administration

(a) The Medicaid agency has established and will maintain methods of personnel administration in conformity with standards prescribed by the U.S. Civil Service Commission in accordance with Section 208 of the Intergovernmental Personnel Act of 1970 and the regulations on Administration of the Standards for a Merit System of Personnel Administration, 5 CFR Part 900, Subpart F. All requirements of 42 CFR 432.10 are met.

☐ The plan is locally administered and State-supervised. The requirements of 42 CFR 432.10 with respect to local agency administration are met.

(b) Affirmative Action Plan

The Medicaid agency has in effect an affirmative action plan for equal employment opportunity that includes specific action steps and timetables and meets all other requirements of 5 CFR Part 900, Subpart F.

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State INDIANA

5.2 [Reserved]

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State INDIANA

Citation
42 CFR Part 432,
Subpart B
AT-78-90

5.3 Training Programs; Subprofessional and Volunteer Programs

The Medicaid agency meets the requirements of 42 CFR Part 432, Subpart B, with respect to a training program for agency personnel and the training and use of subprofessional staff and volunteers.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State INDIANA

SECTION 6 FINANCIAL ADMINISTRATION

Citation
42 CFR 433.32
AT-79-29

6.1 Fiscal Policies and Accountability

The Medicaid agency and, where applicable, local agencies administering the plan, maintains an accounting system and supporting fiscal records adequate to assure that claims for Federal funds are in accord with applicable Federal requirements. The requirements of 42 CFR 433.32 are met.

Revision: HCFA-AT-81- (BPP)

State INDIANA

Citation
42 CFR 433.34
47 FR 17490

6.2 Cost Allocation

There is an approved cost allocation plan on file with the Department in accordance with the requirements contained in 45 CFR Part 95, Subpart E.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State INDIANA

Citation
42 CFR 433.33
AT-79-29
AT-80-34

6.3 State Financial Participation

(a) State funds are used in both assistance and administration.

☒ State funds are used to pay all of the non-Federal share of total expenditures under the plan.

☐ There is local participation. State funds are used to pay not less than 40 percent of the non-Federal share of the total expenditures under the plan. There is a method of apportioning Federal and State funds among the political subdivisions of the State on an equalization or other basis which assures that lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of care and services or level of administration under the plan in any part of the State.

(b) State and Federal funds are apportioned among the political subdivisions of the State on a basis consistent with equitable treatment of individuals in similar circumstances throughout the State.

Revision: HCFA-PM-91- 4 (BPD) OMB No. 0938-
AUGUST 1991

State/Territory: Indiana

SECTION 7 - GENERAL PROVISIONS

Citation	7.1	Plan Amendments
42 CFR 430.12(c)		The plan will be amended whenever necessary to reflect new or revised Federal statutes or regulations or material change in State law, organization, policy or State agency operation.

Revision: HCFA-PM-91- 4 (BPD) OMB No. 0938-
AUGUST 1991

State/Territory: Indiana

Citation 7.2 Nondiscrimination

45 CFR Parts 80 and 84

In accordance with title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70b), and the regulations at 45 CFR Parts 80 and 84, the Medicaid agency assures that no individual shall be subject to discrimination under this plan on the grounds of race, color, national origin, or handicap.

The Medicaid agency has methods of administration to assure that each program or activity for which it receives Federal financial assistance will be operated in accordance with title VI regulations. These methods for title VI are described in ATTACHMENT 7.2-A.

Revision: HCFA-PM-91- 4 (BPD) OMB No. 0938-
AUGUST 1991

State/Territory: INDIANA

Citation 7.3 Maintenance of AFDC Efforts

1902(c) of the Act /XX The State agency has in effect under its approved AFDC plan payment levels that are equal to or more than the AFDC payment levels in effect on May 1, 1988.

Revision: HCFA-PM-91-4 (BPD) OMB No. 0938-
AUGUST 1991

State/Territory: Indiana

Citation 7.4 State Governor's Review

42 CFR 430.12(b) The Medicaid agency will provide opportunity for the Office of the Governor to review State plan amendments, long-range program planning projections, and other periodic reports thereon, excluding periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Health Care Financing Administration with such documents.

☒ Not applicable. The Governor--

☒ Does not wish to review any plan material.

☐ Wishes to review only the plan materials specified in the enclosed document.

I hereby certify that I am authorized to submit this plan on behalf of

Office of Medicaid Policy and Planning
(Designated Single State Agency)

Date: 10/16/91

James M. Verdin
(Signature)

ASST. SEC. MEDICAID POLICY AND PLANNING
(Title)

TN No. 91-16
Supersedes TN No. 78-5
Approval Date 3-13-92 Effective Date 1-1-92

HCFA ID: 7982E

Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

Indiana reserves the right to terminate any of the emergency provisions in this amendment prior to the end of the emergency period through submission of a recission SPA to CMS. Indiana Medicaid policy will provide detail on which requirements are amended.

The following provisions are to be end dated as of June 1, 2020:
Section D6: Drug Benefit, 90 day fills of maintenance drugs.

The following provisions are to be end dated as of August 31, 2020:
Section E2: Home Health COVID expense reimbursement is available through August 31, 2021.

The following provisions are to be end dated as of October 21, 2020:
Section D5: Telehealth IATV technology requirement

The following provisions are to be end dated as of December 31, 2020:
Section G: Therapeutic leave for individuals with IID/IDD living in intermediate care facilities.

The following provisions are to be end dated as of February 28, 2021:
Section E4: In-state EMS providers applying for relief will be reimbursed for reported COVID-19 related expenses incurred for dates of service through February 28, 2021.

The following provisions are to be end dated as of March 31, 2021:

Section E1: 4.2% per diem rate increase for Nursing Facilities for states of service through March 31, 2021.
Section E3: Assisted Living providers applying for relief will be reimbursed for reported COVID-19 related expenses incurred on behalf of Medicaid A&D and TBI waiver members. Assisted living providers have through July 31, 2021 to request reimbursement for COVID-19 related expenses incurred for dates of service prior to March 31, 2021.

The following provisions are to be end dated as of June 30, 2021:
Section E1: 3% per diem rate increase for Nursing facilities for dates of service between April 1, 2021 and June 30, 2021.
Section D2 and E1b: The reimbursement and coverage for treat/no transport is effective for dates of service through June 30, 2021.
Section E5: Indiana Medicaid will pay federally qualified health centers (FQHCs) and rural health clinics (RHCs) for COVID vaccine administration fees in addition to (but billed separately from) the prospective payment system (PPS) rate effective for dates of service on or after 1/18/21.
Section E6: Indiana Medicaid will pay for COVID vaccine administration fees at a higher rate than the rate methodology stated in the Indiana state plan.
Section E7: Indiana Medicaid will pay for COVID treatment administration fees at a higher rate than the rate methodology stated in the Indiana state plan.

The following provisions are to be end dated as of July 10, 2021:
Section D5: Remaining telehealth provisions

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

__X__ The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. __X___ SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. __X___ Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. _____ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [insert name of state] Medicaid state plan, as described below:

Please describe the modifications to the timeline.

Section A – Eligibility

1. _____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

   a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

   Income standard: _____

   -or-

   b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

   Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

Less restrictive income methodologies:

Less restrictive resource methodologies:

4. __X___ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. _____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

   a. _____ The agency uses a simplified paper application.

   b. _____ The agency uses a simplified online application.

   c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. _____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).

2. _____ The agency suspends enrollment fees, premiums and similar charges for:

   a. _____ All beneficiaries

   b. _____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. _____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. _____ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. _x___ The agency makes the following adjustments to benefits currently covered in the state plan:

42 CFR 440.130(c) Preventative Benefit: Beginning March 1, 2020 and through June 30, 2021, Indiana Medicaid will provide coverage when care is provided by certified paramedics or emergency medical technicians in response to an emergency call to a member's home or on a scene, when an ambulance is dispatched, and treatment is provided to the patient without the patient being transported to another site. This is referred to as treat/no transport and is provided under the preventive services benefit at 42 CFR 440.130(c). The response must originate through a 9-1-1 call. Services provided are recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized practice under State law and administered by a paramedic licensed by the Indiana emergency medical services commission or an emergency medical technician certified by the Indiana emergency medical services commission.

3. ___X__ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. __X___ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

    a. __X__ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

b. ____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Telehealth:

5. __X___ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Indiana Medicaid will remove the technology requirement that providers must use an "IATV" technology, a specification which is end-dated for October 21, 2020. Indiana Medicaid will remove the face-to-face requirement to allow for other telemedicine communication types such as phone and voice-only communication. Additionally, Indiana Medicaid will remove the following limitations for telemedicine from the Medicaid State Plan and allow reimbursement for these services/providers when delivered via telemedicine: long term care facilities, including nursing facilities, intermediate care facilities, or community residential facilities for the developmentally disabled; audiological services; optical or optometric services (effective March 01, 2020, end-dated October 21, 2020); podiatric services; physical therapy services. The telemedicine limitations in the Medicaid State Plan will remain as follows: surgical services; home health providers and services; radiological services; laboratory services; anesthesia services; chiropractic services; care coordination services without the member present, unless this type of service is covered as part of the member's benefit plan or package; DME and HME providers; transportation services; and provider to provider consultations.

Drug Benefit:

6. __X___ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.
Until 6/1/2020, Indiana will allow 90 day fills of maintenance drugs to decrease the need for individuals to visit pharmacies.

7. __X___ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. __X___ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. _____ Newly added benefits described in Section D are paid using the following methodology:

   a. ____ Published fee schedules –

      Effective date (enter date of change): _____

      Location (list published location): ___ __

   b. __x__ Other:

The reimbursement for treat/no transport (billed with procedure code A0998) was set at $76.71 for the duration of the public health emergency. This rate is equivalent to Indiana Medicaid's fee for service reimbursement for CPT code 99203, a level 3 new patient E/M

Increases to state plan payment methodologies:

2. __X__ The agency increases payment rates for the following services:

1. Nursing facilities 2. Home Health Agencies 3. Assisted Living Providers 4. Emergency Medical Services (EMS) 5. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) 6. COVID-19 Vaccine Administration 7. COVID-19 Treatment Payments

   a. __X__ Payment increases are targeted based on the following criteria:

1. **Nursing Facilities**

A 4.2% per diem rate increase will be applied to all nursing facility rates effective 3/1/2020 and will remain in effect until 3/31/2021.

A 3% per diem rate increase will be applied to all nursing facility rates effective 4/1/2021 and will remain in effect until 6/30/2021.

Two additional add-on payments will be calculated and paid to qualifying nursing facility providers. Providers that have attested to being "COVID-19 Ready" in accordance with Indiana Department of Health (IDOH) criteria will receive a temporary 2% rate increase for the period beginning 5/1/2020 and ending 8/31/2020. The following COVID-19 Ready add-on payments will be available to providers and effective at the later of 5/1/2020 or the effective date of the COVID-19 Ready attestation if made on or after 6/1/2020:

1. A 2.0% per diem rate increase, calculated exclusive of the 4.2% per diem add-on.

2. A $115.00 per resident day claims-based add-on for COVID-19 positive residents with the primary International Classification of Diseases, Tenth Revision Clinical Modification (ICD-10-CM) diagnosis code of U07.1 – 2019-nCoV acute respiratory disease. The $115.00 per resident day add-on may only be billed while the resident has an active positive COVID-19 diagnosis and is limited to a maximum of 21 days per resident.

2. Home Health Agencies

Home Health agencies applying for relief will be reimbursed for reported COVID-19 related expenses incurred on behalf of fee for service members between March 1, 2020 and August 31, 2020 up to 4.2% of their paid fee for service claims for services provided March 1, 2019 through August 31, 2019.

3. Assisted Living Providers

Assisted Living providers applying for relief will be reimbursed for reported COVID-19 related expenses incurred on behalf of Medicaid A&D and TBI waiver members for dates of service from March 1, 2020 through March 31, 2021 subject to a 3% revenue cap. The revenue cap will be calculated based on average monthly revenue for calendar year 2020.

4. Emergency Medical Services (EMS)

In-state EMS providers applying for relief will be reimbursed for reported COVID-19 related expenses incurred March 1, 2020 through February 28, 2021 subject to a 4.2% revenue cap. The revenue cap will be calculated based on average monthly revenue for calendar year 2020.

5. FQHCs and RHCs

Effective with dates of service December 1, 2020 through the end of the public health emergency, the Indiana Medicaid will pay only Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) that agree to accept this alternate payment methodology (APM), the Medicare Rate for the administration of the COVID-19 vaccine. This payment will be in a supplemental payment in addition to (but billed separately from) the prospective payment system (PPS) rate. Payments under the APM are to cover the additional costs associated with the administration of the COVID-19 vaccines by FQHCs/RHCs during COVID-19 vaccine-only visits.

This APM was developed to support FQHCs/RHCs, as a key COVID-19 vaccine provider. Payments under this APM are to cover the additional costs associated with the

administration of the COVID-19 vaccines by FQHCs/RHCs during COVID-19 vaccine-only visits as the PPS cost base did not include these costs.
Indiana Medicaid will pay federally qualified health centers (FQHCs) and rural health clinics (RHCs) for COVID vaccine administration fees using an alternate payment method (APM) that pays at the Medicare rate, in addition to (but billed separately from) the prospective payment system (PPS) rate effective for dates of service on or after 12/1/2020. Indiana Medicaid opted to pay at the Medicare rate to encourage the administration of the COVID-19 vaccine to Medicaid members. Payment will be made to FQHCs/RHCs on a per claim basis for each dose of vaccine administered. (This will include any booster or annual boosters that will be implemented)

The supplemental payments under the APM are only for the COVID-19 vaccine-only visits. If the COVID-19 vaccine is administered as part of a billable encounter visit, then the FQHC/RHC will receive their provider-specific PPS rate. FQHCs/RHCs may not receive a supplement payment under this APM and a PPS payment for encounters that include the COVID-19 vaccine administration.

6. COVID-19 Vaccine Administration
Indiana Medicaid will pay for the COVID-19 Vaccine Administration fees at a higher rate than the rate methodology in the Indiana State Plan.

In addition, FQHCs/RHCs will receive payment for COVID-19 vaccine administration fees using an APM that pays the FQHCs and RHCs at the Medicare rate as a supplemental payment in addition to (but billed separately from) the PPS rate. Payments will be made on a per claim basis for each dose of the COVID-19 vaccine administered to Medicaid members. (This will include any boosters and annual boosters that will be implemented.)

The supplemental payments under the APM are only for the COVID-19 vaccine-only visits. If the COVID-19 vaccine is administered as part of a billable encounter visit, then the FQHC/RHC will receive their provider-specific PPS rate. FQHCs/RHCs may not receive a supplement payment under this APM and a PPS payment for encounters that include the COVID-19 vaccine administration.

7. COVID-19 Treatment Payments
Indiana Medicaid will pay for COVID treatment administration fees at a higher rate than the rate methodology stated in the Indiana state plan.

b. Payments are increased through:

i. ___ A supplemental payment or add-on within applicable upper payment limits:

ii. _x (1, 2, 3, 4, 5, 6, 7)___ An increase to rates as described below.

Rates are increased:

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules --

Effective date (enter date of change): _____

Location (list published location): _____

__x (6, 7)___ Up to the Medicare payments for equivalent services.

__X (1, 2, 3, 4, 5, 6, 7)___ By the following factors:

Nursing Facilities

1. A 4.2% per diem rate increase will be applied to all nursing facility rates effective 3/1/2020 and will remain in effect until 3/31/2021.

A 3% per diem rate increase will be applied to all nursing facility rates effective 4/1/2021 and will remain in effect until 6/30/2021.

The following COVID-19 Ready add-on payments will be available to providers and effective at the later of 5/1/2020 or the effective date of the COVID-19 Ready attestation if made on or after 6/1/2020:

1. A 2.0% per diem rate increase, calculated exclusive of the 4.2% per diem add-on.

2. A $115.00 per resident day claims-based add-on for COVID-19 positive residents with the primary International Classification of Diseases, Tenth Revision Clinical Modification (ICD-10-CM) diagnosis code of U07.1 – 2019-nCoV acute respiratory disease. The $115.00 per resident day add-on may only be billed while the resident has an active positive COVID-19 diagnosis and is limited to a maximum of 21 days per resident.

2. Home Health Agencies

For dates of service from March 1, 2020 through August 31, 2020 Home Health agencies will be reimbursed the lesser of their reported COVID-19 related expenses or 4.2% of Medicaid revenues paid during the relief period.

3. **Assisted Living Providers**

For dates of service from February 2020 through March 2021 Assisted Living providers will be reimbursed the lesser of their reported COVID-19 related expenses or 3% of Medicaid revenues paid during the relief period.

4. Emergency Medical Services (EMS)

For dates of service March 1, 2020 through February 28, 2021 in state Emergency Medical Services will be reimbursed the lesser of their reported COVID-19 related expenses or 4.2% of Medicaid revenues paid during the relief period.

5. FQHCs and RHCs

The COVID vaccine administration fee will be reimbursed in addition to (but billed separately from) the Medicaid PPS rate. For dates of service from 1/18/21 - 2/20/21, the vaccine administration will be $16.94 for the first dose in the two-dose series and $28.39 for the second dose. For dates of service from 2/21/21 through 3/16/21, the vaccine administration fees will be $15.83 and $26.11 (respectively).

For dates of service on or after 3/17/21, the vaccine administration fee will be $37.21, which will apply if the dose is the first or second in the series. These rates apply to any COVID vaccines from any other manufacturer (i.e. AstraZeneca).

6. COVID-19 Vaccine Administration

For dates of service from 12/12/20 (Pfizer vaccine) and 12/18/20 (Moderna vaccine) through 2/20/21, the vaccine administration will be $16.94 for the first dose in the two-dose series and $28.39 for the second dose. For dates of service from 2/21/21 through 3/16/21, the vaccine administration fees will be $15.83 and $26.11 (respectively). For dates of service on or after 3/17/21, the vaccine administration fee will be $37.21, which will apply if the dose is the first or second in the series. These rates apply to any COVID vaccines from any other manufacturer (i.e. AstraZeneca). The $16.94 and $28.39 were the nationwide rates and all other rates are Indiana Medicare's specific rates from the CMS physician fee schedule.

7. COVID-19 Treatment Payments

For dates of service from 11/10/20 (bamlanivimab treatment manufactured by Eli Lilly: procedure code M0239) and 11/21/20 (casirivimab and imdevimab treatment manufactured by Regeneron: procedure code M0243) through 12/31/21, the COVID treatment administration fee will be $309.60. For dates of service from 1/21/21 through 5/5/21, the treatment administration fee will be $278.98 when billed on a professional claim. For dates of service on or after 5/6/21, the treatment administration fee will be $403.66. The $309.60 rate was the nationwide COVID treatment administration rate and $279.98 $403.66 are Indiana Medicare's specific rates from the 2021 CMS physician fee schedule. Outpatient reimbursement for COVID treatment administration followed Indiana Medicaid's state plan outpatient reimbursement methodology for dates of service on or after 1/1/21.

Payment for services delivered via telehealth:

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:

   a. ____ Are not otherwise paid under the Medicaid state plan;

   b. ____ Differ from payments for the same services when provided face to face;

   c. ____ Differ from current state plan provisions governing reimbursement for telehealth;

   d. _x_ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

      i. ____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

      ii. _x_ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. ___x__ Other payment changes:

Effective for dates of service on or after March 1, 2020, EMS providers transporting COVID-19 positive or symptomatic individuals will be trips scheduled as and reimbursed as basic life support (BLS), unless the individual meets medical necessity for advanced life support (ALS).

Section F – Post-Eligibility Treatment of Income

1. ____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:
   a. ____ The individual's total income
   b. ____ 300 percent of the SSI federal benefit rate
   c. ____ Other reasonable amount: _____
2. ____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

   The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

Hospitalizations Indiana Medicaid removes the requirement for automatic discharge of individuals with intellectual or developmental disabilities (IID/IDD) from intermediate care facilities (ICFs) who are hospitalized more than 30 days. Therapeutic Leave of Absence Modifies the current limit of 60 calendar days of leave to 180 calendar days for only therapeutic reasons through December 31, 2020. Reimburse providers at the bed-hold rate for the duration of the extended leave periods. Removes the requirement for a physician's order for these leaves. Indiana Medicaid will reimburse CLIA certified pharmacy providers for COVID-19 tests, included under their certification, ordered by pharmacists employed by the facility, and administered by qualified pharmacists, pharmacist interns, and pharmacy technicians.

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 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. 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. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

Describe shorter period here.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

___x__ The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. __x___ SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. __x___ Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. _____ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [insert name of state] Medicaid state plan, as described below:

Please describe the modifications to the timeline.

Section A – Eligibility

1. _____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

Include name of the optional eligibility group and applicable income and resource standard.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

   a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

   Income standard: _____

   -or-

   b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

   Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

   Less restrictive income methodologies:

Less restrictive resource methodologies:

4. __X___ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. _____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

    a. _____ The agency uses a simplified paper application.

    b. _____ The agency uses a simplified online application.

    c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. ___X__ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g). The State suspends all cost sharing.

2. ___X__ The agency suspends enrollment fees, premiums and similar charges for:

    a. __X___ All beneficiaries

b. _____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. _____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. _____ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. _____ The agency makes the following adjustments to benefits currently covered in the state plan:

3. _____ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. _____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

   a. ____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

   b. ____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Telehealth:

5. _____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Please describe.

Drug Benefit:

6. _____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. _____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. _____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. _____ Newly added benefits described in Section D are paid using the following methodology:

    a. ____ Published fee schedules –

State/Territory: Indiana

Effective date (enter date of change): _____

Location (list published location): _____

b. ____ Other:

Describe methodology here.

Increases to state plan payment methodologies:

2. _____ The agency increases payment rates for the following services:

Please list all that apply.

a. _____ Payment increases are targeted based on the following criteria:

Please describe criteria.

b. Payments are increased through:

i. ____ A supplemental payment or add-on within applicable upper payment limits:

Please describe.

ii. ____ An increase to rates as described below.

Rates are increased:

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Please describe.

Payment for services delivered via telehealth:

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:

    a. ____ Are not otherwise paid under the Medicaid state plan;

    b. ____ Differ from payments for the same services when provided face to face;

    c. ____ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

    d. ____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

        i. ____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

        ii. ____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. _____ Other payment changes:

Please describe.

Section F – Post-Eligibility Treatment of Income

1. ____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

    a. ____ The individual's total income

    b. ____ 300 percent of the SSI federal benefit rate

    c. ____ Other reasonable amount: _____

2. ____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

   The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

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 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. 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. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

Indiana reserves the right to terminate any of the emergency provisions in this amendment prior to the end of the emergency period through submission of an updated SPA to CMS. Indiana Medicaid policy will provide detail on which requirements are amended.

The following provisions are to be end dated as of August 31, 2020:
Section E2: Home Health COVID expense reimbursement is available through August 31, 2021.

The following provisions are to be end dated as of February 28, 2021:
Section E4: In-state EMS providers applying for relief will be reimbursed for reported COVID-19 related expenses incurred for dates of service through February 28, 2021.

The following provisions are to be end dated as of March 31, 2021:
Section E1: 4.2% per diem rate increase for Nursing Facilities for states of service through March 31, 2021.
Section E3: Assisted Living providers applying for relief will be reimbursed for reported COVID-19 related expenses incurred on behalf of Medicaid A&D and TBI waiver members. Assisted living providers have through July 31, 2021 to request reimbursement for COVID-19 related expenses incurred for dates of service prior to March 31, 2021.

The following provisions are to be end dated as of June 30, 2021:
Section E1: 3% per diem rate increase for Nursing facilities for dates of service between April 1, 2021 and June 30, 2021.

Section E5: Indiana Medicaid will pay federally qualified health centers (FQHCs) and rural health clinics (RHCs) for COVID vaccine administration fees in addition to (but billed separately from) the prospective payment system (PPS) rate effective for dates of service on or after 12/1/20
Section E6: Indiana Medicaid will pay for COVID vaccine administration fees at a higher rate than the rate methodology stated in the Indiana state plan.
Section E7: Indiana Medicaid will pay for COVID treatment administration fees at a higher rate than the rate methodology stated in the Indiana state plan.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

__X__ The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. __X___ SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. __X___ Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. _____ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [insert name of state] Medicaid state plan, as described below:

Please describe the modifications to the timeline.

Section A – Eligibility

1. _____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

   a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

      Income standard: _____

      -or-

   b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

      Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

   Less restrictive income methodologies:

   Less restrictive resource methodologies:

4. _____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency

is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. _____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

   a. _____ The agency uses a simplified paper application.

   b. _____ The agency uses a simplified online application.

   c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. _____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).

2. _____ The agency suspends enrollment fees, premiums and similar charges for:

   a. ____ All beneficiaries

   b. _____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. _____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. _____ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. ____ The agency makes the following adjustments to benefits currently covered in the state plan:

3. _____ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. _____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

    a. ____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

    b. ____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Telehealth:

5. ____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Drug Benefit:

6. _____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. _____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. _____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. _____ Newly added benefits described in Section D are paid using the following methodology:

   a. ____ Published fee schedules –

      Effective date (enter date of change): _____

      Location (list published location): ___ __

   b. __x__ Other:

The reimbursement for treat/no transport (billed with procedure code A0998) was set at $76.71 for the duration of the public health emergency. This rate is equivalent to Indiana Medicaid's fee for service reimbursement for CPT code 99203, a level 3 new patient E/M

Increases to state plan payment methodologies:

2. __X__ The agency increases payment rates for the following services:

1. Nursing facilities

2. Home Health Agencies
3. Assisted Living Providers
4. Emergency Medical Services (EMS)
5. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)
6. COVID-19 Vaccine Administration
7. COVID-19 Treatment Payments

a. __X__ Payment increases are targeted based on the following criteria:

1. **Nursing Facilities**

A 4.2% per diem rate increase will be applied to all nursing facility rates effective 3/1/2020 and will remain in effect until 3/31/2021.

A 3% per diem rate increase will be applied to all nursing facility rates effective 4/1/2021 and will remain in effect until 6/30/2021.

Two additional add-on payments will be calculated and paid to qualifying nursing facility providers. Providers that have attested to being "COVID-19 Ready" in accordance with Indiana Department of Health (IDOH) criteria will receive a temporary 2% rate increase for the period beginning 5/1/2020 and ending 8/31/2020. The following COVID-19 Ready add-on payments will be available to providers and effective at the later of 5/1/2020 or the effective date of the COVID-19 Ready attestation if made on or after 6/1/2020:

1. A 2.0% per diem rate increase, calculated exclusive of the 4.2% per diem add-on.

2. A $115.00 per resident day claims-based add-on for COVID-19 positive residents with the primary International Classification of Diseases, Tenth Revision Clinical Modification (ICD-10-CM) diagnosis code of U07.1 – 2019-nCoV acute respiratory disease. The $115.00 per resident day add-on may only be billed while the resident has an active positive COVID-19 diagnosis and is limited to a maximum of 21 days per resident.

2. Home Health Agencies

Home Health agencies applying for relief will be reimbursed for reported COVID-19 related expenses incurred on behalf of fee for service members between March 1, 2020 and August 31, 2020 up to 4.2% of their paid fee for service claims for services provided March 1, 2019 through August 31, 2019.

3. Assisted Living Providers

Assisted Living providers applying for relief will be reimbursed for reported COVID-19 related expenses incurred on behalf of Medicaid A&D and TBI waiver members for dates of service from March 1, 2020 through March 31, 2021 subject to a 3% revenue cap. The revenue cap will be calculated based on average monthly revenue for calendar year 2020.

4. Emergency Medical Services (EMS)

In-state EMS providers applying for relief will be reimbursed for reported COVID-19 related expenses incurred March 1, 2020 through February 28, 2021 subject to a 4.2% revenue cap. The revenue cap will be calculated based on average monthly revenue for calendar year 2020.

5. FQHCs and RHCs

Effective with dates of service December 1, 2020 through the end of the public health emergency, the Indiana Medicaid will pay only Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) that agree to accept this alternate payment methodology (APM), the Medicare Rate for the administration of the COVID-19 vaccine. This payment will be a supplemental payment in addition to (but billed separately from) the prospective payment system (PPS) rate. Payments under the APM are to cover the additional costs associated with the administration of the COVID-19 vaccines by FQHCs/RHCs.
This APM was developed to support FQHCs/RHCs, as a key COVID-19 vaccine provider. Payments under this APM are to cover the additional costs associated with the administration of the COVID-19 vaccines by FQHCs/RHCs as the PPS cost base did not include these costs.
Indiana Medicaid will pay federally qualified health centers (FQHCs) and rural health clinics (RHCs) for COVID vaccine administration fees using an alternate payment method (APM) that pays at the Medicare rate, in addition to (but billed separately from) the prospective payment system (PPS) rate effective for dates of service on or after 12/1/2020. Indiana Medicaid opted to pay at the Medicare rate to encourage the administration of the COVID-19 vaccine to Medicaid members. Payment will be made to FQHCs/RHCs on a per claim basis for each dose of vaccine administered. (This will include any booster or annual boosters that will be implemented)

The supplemental payments under the APM are for all COVID vaccine administration services. The payment to FQHC/RHCs for standalone COVID-19 vaccine-only visits will be equivalent to the Medicare COVID-19 vaccine administration rate. FQHC/RHCs will receive their provider-specific PPS rate plus the Medicare COVID-19 vaccine administration rate when a COVID-19 vaccine is administered as part of a billable encounter visit.

6. COVID-19 Vaccine Administration
Indiana Medicaid will pay for the COVID-19 Vaccine Administration fees at a higher rate than the rate methodology in the Indiana State Plan.

In addition, FQHCs and RHCs will receive supplemental payments under the APM for all COVID vaccine administration services. The payment to FQHC/RHCs for standalone COVID-19 vaccine-only visits will be equivalent to the Medicare COVID-19 vaccine administration rate. FQHC/RHCs will receive their provider-specific PPS rate plus the Medicare COVID-19 vaccine administration rate when a COVID-19 vaccine is administered as part of a billable encounter visit.

7. COVID-19 Treatment Payments
Indiana Medicaid will pay for COVID treatment administration fees at a higher rate than the rate methodology stated in the Indiana state plan.

b. Payments are increased through:

i. ___ A supplemental payment or add-on within applicable upper payment limits:

ii. _x (1, 2, 3, 4, 5, 6, 7)__ An increase to rates as described below.

Rates are increased:

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

__x (6, 7)___ Up to the Medicare payments for equivalent services.

__X (1, 2, 3, 4, 5, 6, 7)___ By the following factors:

Nursing Facilities

1. A 4.2% per diem rate increase will be applied to all nursing facility rates effective 3/1/2020 and will remain in effect until 3/31/2021.

A 3% per diem rate increase will be applied to all nursing facility rates effective 4/1/2021 and will remain in effect until 6/30/2021.

The following COVID-19 Ready add-on payments will be available to providers and effective at the later of 5/1/2020 or the effective date of the COVID-19 Ready attestation if made on or after 6/1/2020:

1. A 2.0% per diem rate increase, calculated exclusive of the 4.2% per diem add-on.

2. A $115.00 per resident day claims-based add-on for COVID-19 positive residents with the primary International Classification of Diseases, Tenth Revision Clinical Modification (ICD-10-CM) diagnosis code of U07.1 – 2019-nCoV acute respiratory disease. The $115.00 per resident day add-on may only be billed while the resident has an active positive COVID-19 diagnosis and is limited to a maximum of 21 days per resident.

2. Home Health Agencies

For dates of service from March 1, 2020 through August 31, 2020 Home Health agencies will be reimbursed the lesser of their reported COVID-19 related expenses or 4.2% of Medicaid revenues paid during the relief period.

3. **Assisted Living Providers**

For dates of service from February 2020 through March 2021 Assisted Living providers will be reimbursed the lesser of their reported COVID-19 related expenses or 3% of Medicaid revenues paid during the relief period.

4. Emergency Medical Services (EMS*)*

For dates of service March 1, 2020 through February 28, 2021 in state Emergency Medical Services will be reimbursed the lesser of their reported COVID-19 related expenses or 4.2% of Medicaid revenues paid during the relief period.

5. FQHCs and RHCs

The COVID vaccine administration fee will be reimbursed in addition to (but billed separately from) the Medicaid PPS rate. For dates of service from 1/18/21 - 2/20/21, the vaccine administration will be $16.94 for the first dose in the two-dose series and $28.39 for the second dose. For dates of service from 2/21/21 through 3/16/21, the vaccine administration fees will be $15.83 and $26.11 (respectively). For dates of service on or after 3/17/21, the vaccine administration fee will be $37.21, which will apply if the dose is the first or second in the series. These rates apply to any COVID vaccines from any other manufacturer (i.e. AstraZeneca).

6. COVID-19 Vaccine Administration

For dates of service from 12/12/20 (Pfizer vaccine) and 12/18/20 (Moderna vaccine) through 2/20/21, the vaccine administration will be $16.94 for the first dose in the two-dose series and $28.39 for the second dose. For dates of service from 2/21/21 through 3/16/21, the vaccine administration fees will be $15.83 and $26.11 (respectively). For dates of service on or after 3/17/21, the vaccine administration fee will be $37.21, which will apply if the dose is the first or second in the series. These rates apply to any COVID vaccines from any other manufacturer (i.e. AstraZeneca). The $16.94 and $28.39 were the nationwide rates and all other rates are Indiana Medicare's specific rates from the CMS physician fee schedule.

7. COVID-19 Treatment Payments

For dates of service from 11/10/20 (bamlanivimab treatment manufactured by Eli Lilly: procedure code M0239) and 11/21/20 (casirivimab and imdevimab treatment manufactured by Regeneron: procedure code M0243) through 12/31/21, the COVID treatment administration fee will be $309.60. For dates of service from 1/21/21 through 5/5/21, the treatment administration fee will be $278.98 when billed on a professional claim. For dates of service on or after 5/6/21, the treatment administration fee will be $403.66. The $309.60 rate was the nationwide COVID treatment administration rate and $279.98 $403.66 are Indiana Medicare's specific rates from the 2021 CMS physician fee schedule. Outpatient reimbursement for COVID treatment administration followed Indiana Medicaid's state plan outpatient reimbursement methodology for dates of service on or after 1/1/21.

Payment for services delivered via telehealth:

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:

    a. ____ Are not otherwise paid under the Medicaid state plan;

    b. ____ Differ from payments for the same services when provided face to face;

    c. ___ Differ from current state plan provisions governing reimbursement for telehealth;

    d. __x__ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

        i. ____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

ii. __x__ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. ___x__ Other payment changes:

Effective for dates of service on or after March 1, 2020, EMS providers transporting COVID-19 positive or symptomatic individuals will be trips scheduled as and reimbursed as basic life support (BLS), unless the individual meets medical necessity for advanced life support (ALS).

Section F – Post-Eligibility Treatment of Income

1. ____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

   a. ____ The individual's total income

   b. ____ 300 percent of the SSI federal benefit rate

   c. ____ Other reasonable amount: _____

2. ____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

   The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

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 (Expires 03/31/2021). The time required to complete this

information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. 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. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

Vaccine and Vaccine Administration at Section 1905(a)(4)(E) of the Social Security Act

During the period starting March 11, 2021 and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (the Act):

Coverage

__X__ The state assures coverage of COVID-19 vaccines and administration of the vaccines.[1]

_X___ The state assures that such coverage:

1. Is provided to all eligibility groups covered by the state, including the optional Individuals Eligible for Family Planning Services, Individuals with Tuberculosis, and COVID-19 groups if applicable, with the exception of the Medicare Savings Program groups and the COBRA Continuation Coverage group for which medical assistance consists only of payment of premiums; and
2. Is provided to beneficiaries without cost sharing pursuant to section 1916(a)(2)(H) and section 1916A(b)(3)(B)(xii) of the Act; reimbursement to qualified providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the state plan.

__X__ Applies to the state's approved Alternative Benefit Plans, without any deduction, cost sharing or similar charge, pursuant to section 1937(b)(8)(A) of the Act.

__X_The state provides coverage for any medically necessary COVID-19 vaccine counseling for children under the age of 21 pursuant to §§1902(a)(11), 1902(a)(43), and 1905(hh) of the Act.

__X__ The state assures compliance with the HHS COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration, with respect to the providers that are considered qualified to prescribe, dispense, administer, deliver and/or distribute COVID-19 vaccines.

Additional Information (Optional):

[1] The vaccine will be claimed under this benefit once the federal government discontinues purchasing the vaccine.

Reimbursement

__X__ The state assures that the state plan has established rates for COVID-19 vaccines and the administration of the vaccines for all qualified providers pursuant to sections 1905(a)(4)(E) and 1902(a)(30)(A) of the Act.

List Medicaid state plan references to payment methodologies that describe the rates for COVID-19 vaccines and their administration for each applicable Medicaid benefit:

4.19B page 1a.1

__X__ The state is establishing rates for COVID-19 vaccines and the administration of the vaccines pursuant to sections 1905(a)(4)(E) and 1902(a)(30)(A) of the Act.

__X__ The state's rates for COVID-19 vaccines and the administration of the vaccines are consistent with Medicare rates for COVID-19 vaccines and the administration of the vaccines, including any future Medicare updates at the:

____ Medicare national average, OR

__X__ Associated geographically adjusted rate.

____ The state is establishing a state specific fee schedule for COVID-19 vaccines and the administration of the vaccines pursuant to sections 1905(a)(4)(E) and 1902(a)(30)(A) of the Act.

The state's rate is as follows and the state's fee schedule is published in the following location:

The Medicaid allowed amount for COVID-19 vaccine administration will be equal to Indiana Medicare's allowed amount for these services and is published at www.in.gov/medicaid.

__X__ The state's fee schedule is the same for all governmental and private providers.

__x__ The below listed providers are paid differently from the above rate schedules and payment to these providers for COVID-19 vaccines and the administration of the vaccines are described under the benefit payment methodology applicable to the provider type:

Federally qualified health centers (FQHCs) and rural health clinics (RHCs).

__X__The payment methodologies for COVID-19 vaccines and the administration of the vaccines for providers listed above are described below:

Attachment 4.19-B page 2a.1 Attachment 4.19-B page 3d.1

_X_ The state is establishing rates for any medically necessary COVID-19 vaccine counseling for children under the age of 21 pursuant to sections 1905(a)(4)(E), 1905(r)(1)(B)(v) and 1902(a)(30)(A) of the Act.

__X_ The state's rate is as follows and the state's fee schedule is published in the following location:

The rate is equal to the rate for procedure code 99401 and is published at www.in.gov/medicaid IHCP Bulletin BT202247 BT202247 (indianamedicaid.com) IHCP Bulletin BT202278 BT202278 (indianamedicaid.com)

PRA Disclosure Statement *Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 75). Public burden for all of the collection of information requirements under this control number is estimated to take up to 1 hour per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

COVID-19 Testing at section 1905(a)(4)(F) of the Social Security Act

During the period starting March 11, 2021 and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (the Act):

Coverage

_X__ The states assures coverage of COVID-19 testing consistent with the Centers for Disease Control and Prevention (CDC) definitions of diagnostic and screening testing for COVID-19 and its recommendations for who should receive diagnostic and screening tests for COVID-19.

__X_ The state assures that such coverage:

1. Includes all types of FDA authorized COVID-19 tests;
2. Is provided to all categorically needy eligibility groups covered by the state that receive full Medicaid benefits;
3. Is provided to the optional COVID-19 group if applicable; and
4. Is provided to beneficiaries without cost sharing pursuant to section 1916(a)(2)(I) and 1916A(b)(3)(B)(xiii) of the Act; reimbursement to qualified providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the state plan.

Please describe any limits on amount, duration or scope of COVID-19 testing consistent with 42 CFR 440.230(b).

Pharmacy: Allowable two (2) at-home SARS-CoV-2 test kits per seven days per member. Additional per medical necessity.

__X_ Applies to the state's approved Alternative Benefit Plans, without any deduction, cost sharing, or similar charge, pursuant to section 1937(b)(8)(B) of the Act.

_X__The state assures compliance with the HHS COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration.

Additional Information (Optional):

Reimbursement

__X__ The state assures that it has established state plan rates for COVID-19 testing consistent with the CDC definitions of diagnostic and screening testing for COVID-19 and its recommendations for who should receive diagnostic and screening tests for COVID-19.

List references to Medicaid state plan payment methodologies that describe the rates for COVID-19 testing for each applicable Medicaid benefit:

Attachment 4.19-B page 1c www.in.gov/medicaid/providers/business-transactions/billing-and-remittance/ihcp-fee-schedules/

____ The state is establishing rates for COVID-19 testing pursuant to pursuant to sections 1905(a)(4)(F) and 1902(a)(30)(A) of the Act.

____ The state's rates for COVID-19 testing are consistent with Medicare rates for testing, including any future Medicare updates at the:

____ Medicare national average, OR

____ Associated geographically adjusted rate.

____ The state is establishing a state specific fee schedule for COVID-19 testing pursuant to sections 1905(a)(4)(F) and 1902(a)(30)(A) of the Act.

The state's rate is as follows and the state's fee schedule is published in the following location:

__X__ The state's fee schedule is the same for all governmental and private providers.

__X__ The below listed providers are paid differently from the above rate schedules and payment to these providers for COVID-19 testing is described under the benefit payment methodology applicable to the provider type:

Federally qualified health centers (FQHCs) and rural health clinics (RHCs).

Additional Information (Optional):

__X_The payment methodologies for COVID-19 testing for providers listed above are described below:

Attachment 4.19-B page 2a.1 Attachment 4.19-B page 3d.1

PRA Disclosure Statement *Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 75). Public burden for all of the collection of information requirements under this control number is estimated to take up to 1 hour per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

COVID-19 Treatment at section 1905(a)(4)(F) of the Social Security Act

During the period starting March 11, 2021 and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (the Act):

Coverage for the Treatment and Prevention of COVID

__X_ The states assures coverage of COVID-19 treatment, including specialized equipment and therapies (including preventive therapies).

__X_ The state assures that such coverage:

1. Includes any non-pharmacological item or service described in section 1905(a) of the Act, that is medically necessary for treatment of COVID-19;
2. Includes any drug or biological that is approved (or licensed) by the U.S. Food & Drug Administration (FDA) or authorized by the FDA under an Emergency Use Authorization (EUA) to treat or prevent COVID-19, consistent with the applicable authorizations;
3. Is provided without amount, duration or scope limitations that would otherwise apply when covered for purposes other than treatment or prevention of COVID-19;
4. Is provided to all categorically needy eligibility groups covered by the state that receive full Medicaid benefits;
5. Is provided to the optional COVID-19 group, if applicable; and
6. Is provided to beneficiaries without cost sharing pursuant to section 1916(a)(2)(I) and 1916A(b)(3)(B)(xiii) of the Act; reimbursement to qualified providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the state plan.

__X_ Applies to the state's approved Alternative Benefit Plans, without any deduction, cost sharing, or similar charge, pursuant to section 1937(b)(8)(B) of the Act.

_X__The state assures compliance with the HHS COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration.

Additional Information (Optional):

Coverage will apply to any drug or biological that is approved (or licensed) by the U.S. Food & Drug Administration (FDA) or authorized by the FDA under an Emergency Use Authorization (EUA) to treat or prevent COVID-19, regardless of the Medicaid Drug Rebate Program status.

Coverage for a Condition that May Seriously Complicate the Treatment of COVID

__X_ The states assures coverage of treatment for a condition that may seriously complicate the treatment of COVID-19 during the period when a beneficiary is diagnosed with or is presumed to have COVID-19.

_X__ The state assures that such coverage:

1. Includes items and services, including drugs, that were covered by the state as of March 11, 2021;
2. Is provided without amount, duration or scope limitations that would otherwise apply when covered for other purposes;
3. Is provided to all categorically needy eligibility groups covered by the state that receive full Medicaid benefits;
4. Is provided to the optional COVID-19 group, if applicable; and
5. Is provided to beneficiaries without cost sharing pursuant to section 1916(a)(2)(I) and 1916A(b)(3)(B)(xiii) of the Act; reimbursement to qualified providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the state plan.

_x_ Applies to the state's approved Alternative Benefit Plans, without any deduction, cost sharing, or similar charge, pursuant to section 1937(b)(8)(B) of the Act.

_X__The state assures compliance with the HHS COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration.

Additional Information (Optional):

Reimbursement

__X__ The state assures that it has established state plan rates for COVID-19 treatment, including specialized equipment and therapies (including preventive therapies).

List references to Medicaid state plan payment methodologies that describe the rates for COVID-19 treatment for each applicable Medicaid benefit:

4.19B page 1a.1

__X__ The state is establishing rates or fee schedule for COVID-19 treatment, including specialized equipment and therapies (including preventive therapies) pursuant to sections 1905(a)(4)(F) and 1902(a)(30)(A) of the Act.

The Medicaid allowed amount for COVID-19 monoclonal antibody infusion administration will be equal to Indiana Medicare's allowed amount for these services.

__X__ The state's rates or fee schedule is the same for all governmental and private providers.

__X__ The below listed providers are paid differently from the above rate schedules and payment to these providers for COVID-19 vaccines and the administration of the vaccines are described under the benefit payment methodology applicable to the provider type:

Federally qualified health centers (FQHCs) and rural health clinics (RHCs).

Additional Information (Optional):

Attachment 4.19-B page 2a.1

Attachment 4.19-B page 3d.1

PRA Disclosure Statement *Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 75). Public burden for all of the collection of information requirements under this control number is estimated to take up to 1 hour per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

ATTACHMENT 1.1-A

State of Indiana

ATTORNEY GENERAL'S CERTIFICATION

I certify that:

X the Office of Medicaid Policy and Planning will be ~~is~~ the single State agency responsible for:

administering the plan.

The legal authority under which the agency administers the plan on a Statewide basis ~~is~~ after December 31, 1991 is Public Law 9-1991, Article 6, Chapter 6, Sec. 1-3.

(statutory citation)

___ supervising the administration of the plan by local political subdivisions.

The legal authority under which the agency supervises the administration of the plan on a Statewide basis is contained in:

(statutory citation)

The agency's legal authority to make rules and regulations that are binding on the political subdivisions adminstering the plan is:

(statutory citation)

12-2-91
Date

Signature

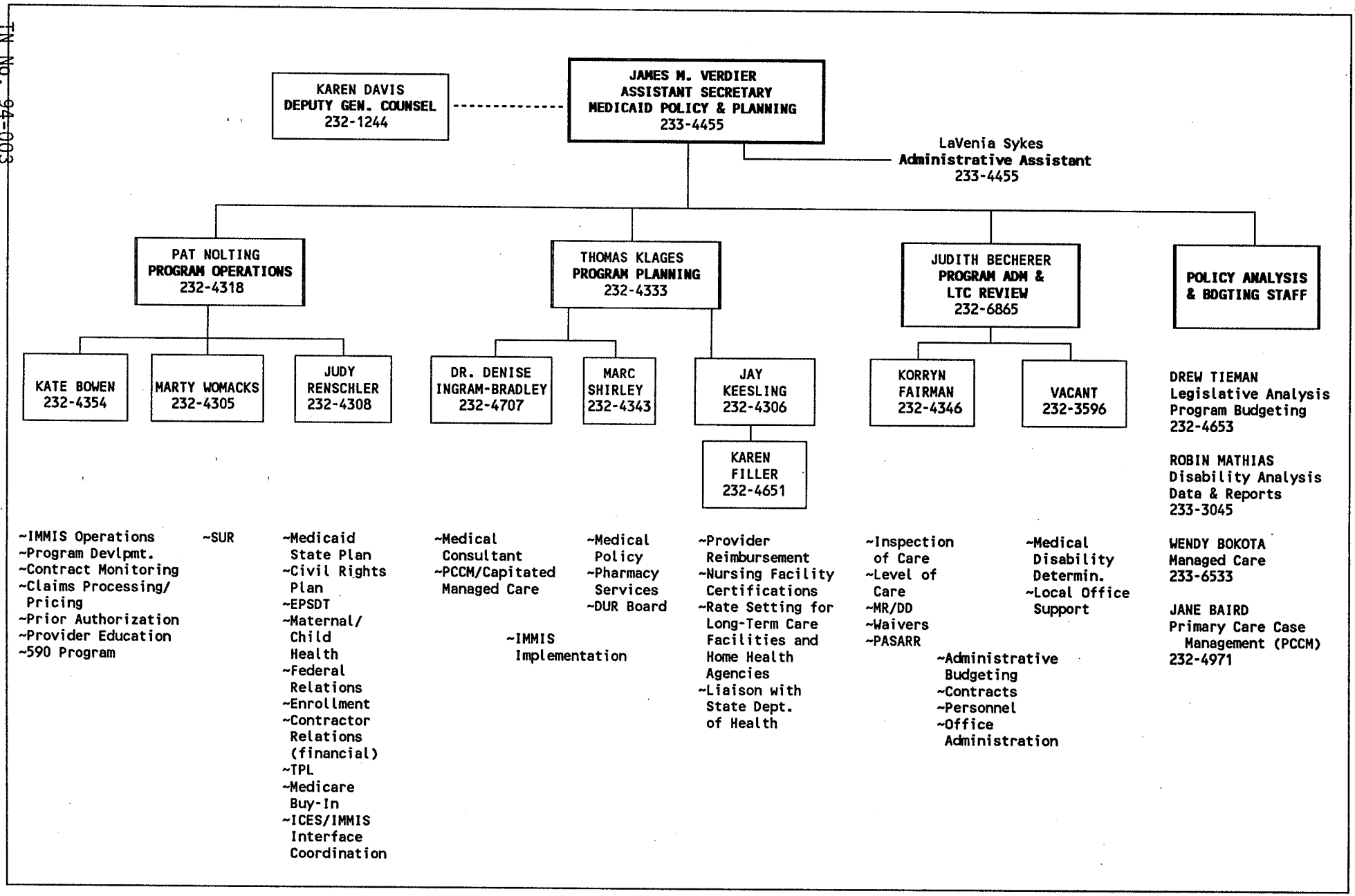
Attorney General of Indiana
Title

ORGANIZATION OF THE OFFICE OF MEDICAID POLICY AND PLANNING

The administrator of the Single State Agency responsible for administration of Indiana's medical assistance program (Medicaid) is the Assistant Secretary, Office of Medicaid Policy and Planning. This position is appointed by the Secretary, Family and Social Services Administration. In accordance with Indiana law (P.L. 9-1991), the Office has developed a written Memorandum of Understanding with each of three divisions within the Family and Social Services Administration. These divisions are: Aging and Rehabilitative Services, Family and Children, and Mental Health.

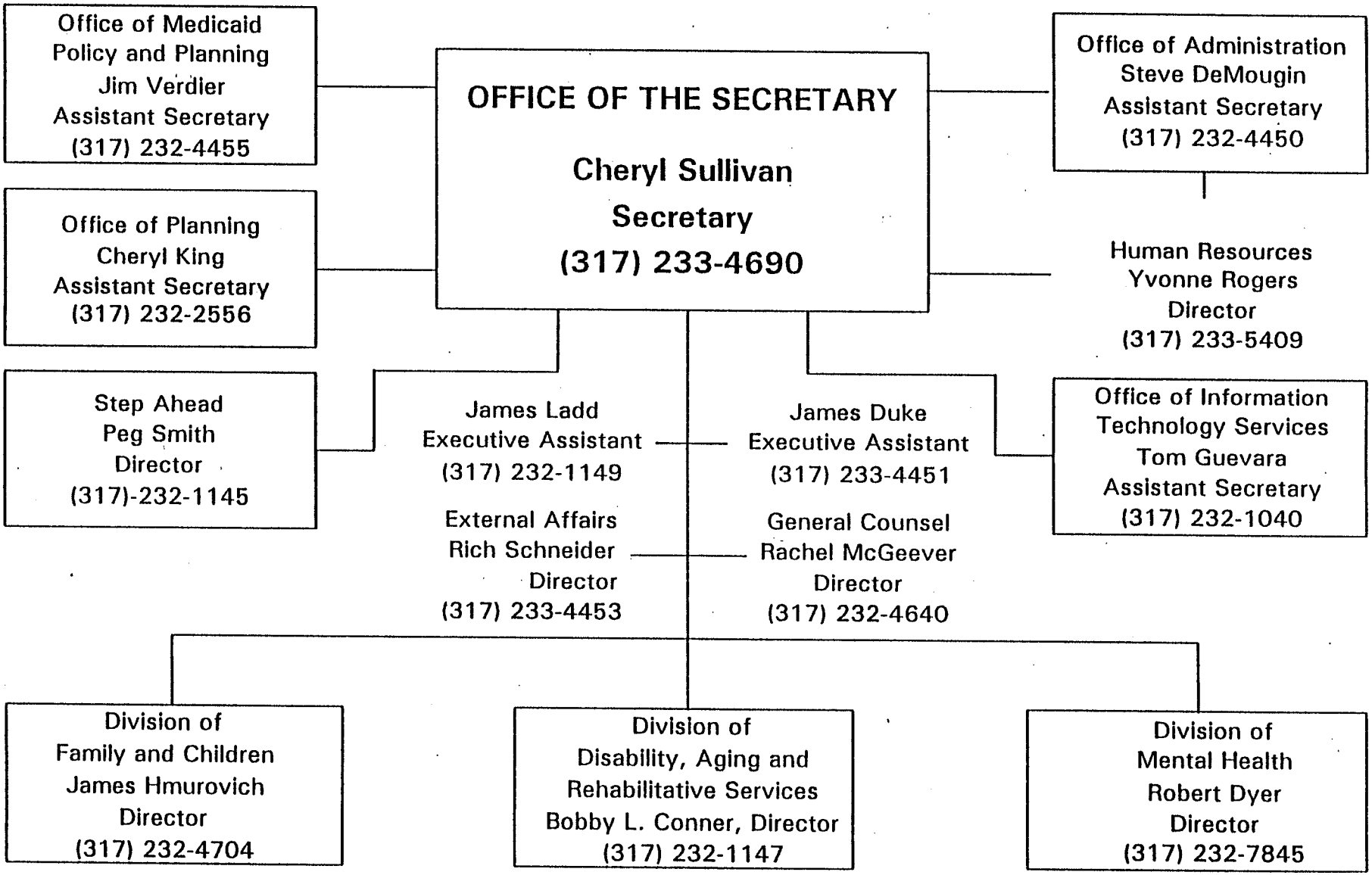
In the Office of Medicaid Policy and Planning, the Director of Program Operations, the Director of Program Planning, and the Director of Disability and Long Term Care Review, report to the Assistant Secretary and oversee operations of the three functional areas of the Office. The chart on Page 2 of this Attachment illustrates the organization and function of the Office of Medicaid Policy and Planning (OMPP), followed by a chart on Page 3 of this Attachment which illustrates the organization of the umbrella agency in which the OMPP resides. In addition to the State's Medicaid Program, the Office administers a state-funded medical assistance program known as the 590 Program.

OFFICE OF MEDICAID POLICY AND PLANNING



Supersedes TN No. 92-22
TN No. 94-003
Approval Date 3/25/94
Effective Date 1-1-94

FAMILY AND SOCIAL SERVICES ADMINISTRATION



18NOV93

TN No. 94-003
Supersedes
TN No. 92-22

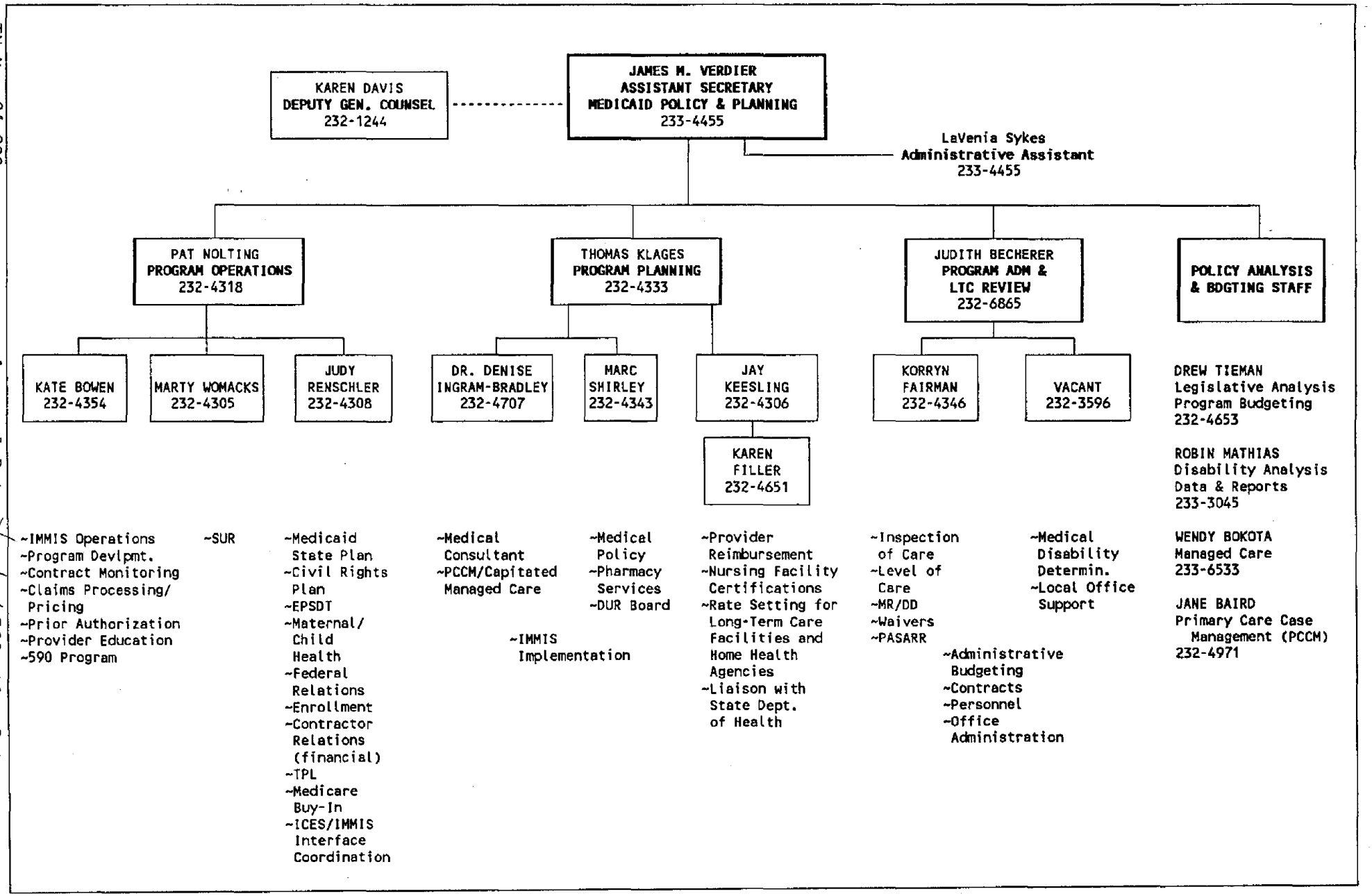
Approval Date 3/25/94

Effective Date 1-1-94

Medical Assistance Unit

The chart on Page 2 of this Attachment illustrates the organization and function of the Medical Assistance Unit, comprised of three functional areas within the Office of Medicaid Policy and Planning.

OFFICE OF MEDICAID POLICY AND PLANNING



Professional Medical and Supporting Staff

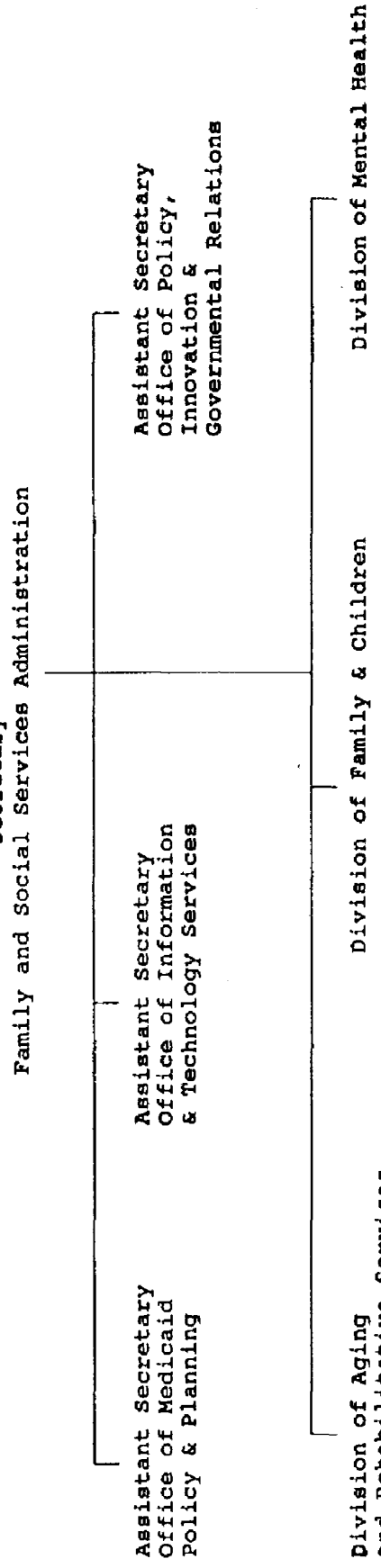
Medical Staff	Unit
Marilyn Barnard, R.N.	Level of Care
David Bruns, M.D.	Medical Review Team
Mary Gordon, R.N.	Inspection of Care
Nina Wright, R.N.	Pre-Admission Screening
Denise Ingram-Bradley, M.D.	Medical Policy/Primary Care Case Management
Dennis Rhyne, M.D.	Medical Review Team
Marc Shirley, R.Ph.	Medical Policy/ Pharmacy Services

Support Staff	Unit
Sharon Bahney, Clerk Typist V	Level of Care
Sandra Riczo, Account Clerk IV	Pre-Admission Screening
Nancy Hopkins, Clerk Typist IV	Level of Care
Debbie Schaefer, Clerk/Typist IV	Medical Policy

Staff Making Eligibility Determinations

In accordance with Indiana statute (P.L. 9-1991) the Office of Medicaid Policy and Planning and the Division of Family and Children have formulated written protocols that specify that the county offices of the Division of Family and Children (aka county departments of public welfare) are responsible for all eligibility determinations made under the state medical assistance program.

The chart on Page 2 of this Attachment illustrates the organization of the Division and Family and Children within the Family and Social Services Administration.


Secretary
Family and Social Services Administration
Assistant Secretary
Office of Policy,
Innovation &
Governmental Relations
Assistant Secretary
Office of Information
& Technology Services
Assistant Secretary
Office of Medicaid
Policy & Planning
Division of Mental Health
Division of Family & Children
Division of Aging
and Rehabilitative Services
District Directors
&
Local Operations
92 county offices
Division of Family
and Children

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Indiana

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citation(s)	Groups Covered

The following groups are covered under this plan.

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups

42 CFR 435.110 1. Recipients of AFDC

The approved State AFDC plan includes:

Division of Family Resources, Family and Social Services Administration

/X/ Families with an unemployed parent for the mandatory 6-month period and an optional extension of 6 months.

/ / Pregnant women with no other eligible children.

/ / AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.

The standards for AFDC payments are listed in Supplement 1 of ATTACHMENT 2.6-A.

42 CFR 435.115 2. Deemed Recipients of AFDC

a. Individuals denied a title IV-A cash payment solely because the amount would be less than $10.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
		2. Deemed Recipients of AFDC.
	1902(a)(10)(A)(i)(I) of the Act	b. Effective October 1, 1990, participants in a work supplementation program under title IV-A and any child or relative of such individual (or other individual living in the same household as such individuals) who would be eligible for AFDC if there were no work supplementation program, in accordance with section 482(e)(6) of the Act.
	402(a)(22)(A) of the Act	c. Individuals whose AFDC payments are reduced to zero by reason of recovery of overpayment of AFDC funds.
	406(h) and 1902(a)(10)(A)(i)(I) of the Act	d. An assistance unit deemed to be receiving AFDC for a period of four calendar months because the family becomes ineligible for AFDC as a result of collection or increased collection of support and meets the requirements of section 406(h) of the Act.
	1902(a) of the Act	e. Individuals deemed to be receiving AFDC who meet the requirements of section 473(b)(1) or (2) for whom an adoption assistance agreement is in effect or foster care maintenance payments are being made under title IV-E of the Act.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	407(b), 1902 (a)(10)(A)(i) and 1905(m)(1) of the Act	3. Qualified Family Members Effective October 1, 1990, qualified family members who would be eligible to receive AFDC under section 407 of the Act because the principal wage earner is unemployed. /X Qualified family members are not included because cash assistance payments may be made to families with unemployed parents for 12 months per calendar year.
	1902(a)(52) and 1925 of the Act	4. Families terminated from AFDC solely because of earnings, hours of employment, or loss of earned income disregards entitled up to twelve months of extended benefits in accordance with section 1925 of the Act. (This provision expires on September 30, 1998.)

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.113

5. Individuals who are ineligible for AFDC solely because of eligibility requirements that are specifically prohibited under Medicaid. Included are:

   a. Families denied AFDC solely because of income and resources deemed to be available from--

      (1) Stepparents who are not legally liable for support of stepchildren under a State law of general applicability;

      (2) Grandparents;

      (3) Legal guardians; and

      (4) Individual alien sponsors (who are not spouses of the individual or the individual's parent);

   b. Families denied AFDC solely because of the involuntary inclusion of siblings who have income and resources of their own in the filing unit.

   c. Families denied AFDC because the family transferred a resource without receiving adequate compensation.

*Agency that determines eligibility for coverage..

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.114

6. Individuals who would be eligible for AFDC except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.

___ Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).

___ Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).

___ Not applicable with respect to intermediate care facilities; State did or does not cover this service.

1902(a)(10)(A)(i)(III) and 1905(n) of the Act

7. Qualified Pregnant Women and Children.

a. A pregnant woman whose pregnancy has been medically verified who--

(1) Would be eligible for an AFDC cash payment (or who would be eligible if the State had an AFDC-unemployed parents program) if the child had been born and was living with her;

*Agency that determines eligibility for coverage.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: INDIANA

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation (s)	Groups Covered
	A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	7. a. (2) Is a member of a family that would be eligible for aid to families with dependent children of unemployed parents if the State had an AFDC-unemployed parents program; or
	(3) Would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.
1902 (a) (10) (A) (i) (III) and 1905 (n) of the Act	b. Children born after September 30, 1983 who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan. ____ Children born after _____ (specify optional earlier date) who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: INDIANA

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
	A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
1902(a)(10)(A)(i)(IV) and 1902(l)(1)(A) and (B) of the Act	8. Pregnant women and infants under 1 year of age with family incomes up to 133 percent of the Federal poverty level who are described in section 1902(a)(10)(A)(i)(IV) and 1902(l)(1)(A) and (B) of the Act. The income level for this group is specified in Supplement 1 to ATTACHMENT 2.6-A.
	X The State uses a percentage greater than 133 but not more than 185 percent of the Federal poverty level, as established in its State plan, State legislation, or State appropriations as of December 19, 1989.
	9. Children:
1902(a)(10)(A)(i)(VI) 1902(l)(1)(C) of the Act	a. who have attained 1 year of age but have and not attained 6 years of age, with family incomes at or below 133 percent of the Federal poverty levels.
1902(a)(10)(A)(i)(VII) and 1902(l)(1)(D) of the Act	b. born after September 30, 1983, who have attained 6 years of age but have not attained 19 years of age, with family incomes at or below 100 percent of the Federal poverty levels.
	XX Children born after 03/31/79 (specify optional earlier date) who have attained 6 years of age but have not attained 19 years of age, with family incomes at or below 100 percent of the Federal poverty levels.
	Income levels for these groups are specified in Supplement 1 to ATTACHMENT 2.6A.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: INDIANA

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
	A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
1902(a)(10)(A)(i)(V) and 1905(m) of the Act	~~10. Individuals other than qualified pregnant women and children under item A.7. above who are members of a family that would be receiving AFDC under section 407 of the Act if the State had not exercised the option under section 407(b)(2)(B)(i) of the Act to limit the number of months for which a family may receive AFDC.~~
1902(e)(5) of the Act	11. a. A woman who, while pregnant, was eligible for, applied for, and receives Medicaid under the approved State plan on the day her pregnancy ends. The woman continues to be eligible, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan for a 60-day period (beginning on the last day of her pregnancy) and for any remaining days in the month in which the 60th day falls.
1902(e)(6) of the Act	b. A pregnant woman who would otherwise lose eligibility because of an increase in income (of the family in which she is a member) during the pregnancy or the postpartum period which extends through the end of the month in which the 60-day period (beginning on the last day of pregnancy) ends.

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation (s) | Groups Covered

A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

1902 (e) (4) of the Act

12. A child born to a woman who is eligible for and receiving Medicaid as categorically needy on the date of the child's birth. The child is deemed eligible for one year from the birth as long as the mother remains eligible or would remain eligible if still pregnant and the child remains in the same household as the mother.

45 CFR 435.120

13. Aged, Blind, and Disabled Individuals Receiving Cash Assistance

x a. Individuals receiving SSI.

This includes beneficiaries' eligible spouses and persons receiving SSI benefits pending a final determination of blindness or disability or pending disposal of excess resources under an agreement with the Social Security Administration; and beginning January 1, 1981, persons receiving SSI under section 1619(a) of the Act or considered to be receiving SSI under section 1619 (b) of the Act.

x Aged
x Blind
x Disabled

Citation (s) Groups Covered

A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

435.121

13. [ ] b. Individuals who meet more restrictive requirements for Medicaid than the SSI requirements. (This includes persons who qualify for benefits under section 1619(a) of the Act or who meet the requirements for SSI status under section 1619(b)(I) of the Act and who met the State's more restrictive requirements for Medicaid in the month before the month they qualified for SSI under section 1619(a) or met the requirements under section 1619(b)(l) of the Act. Medicaid eligibility for these individuals continues as long as they continue to meet the 1619(a) eligibility standard or the requirements of section 1619(b) of the Act.)

1619(b)(l) of the Act

___ Aged
___ Blind
___ Disabled
___ Blind and disabled individuals receiving SSI and except for receipt of SSI would be eligible for AFDC

The more restrictive categorical eligibility criteria are described below:

(Financial criteria are described in ATTACHMENT 2.6A)

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	1902(a)(10)(A)(i)(II) and 1905(q) of the Act	14. Qualified severely impaired blind and disabled individuals under age 65, who--
		a. For the month preceding the first month of eligibility under the requirements of section 1905(q)(2) of the Act, received SSI, a State supplemental payment under section 1616 of the Act or under section 212 of P.L. 93-66 or benefits under section 1619(a) of the Act and were eligible for Medicaid; or
		b. For the month of June 1987, were considered to be receiving SSI under section 1619(b) of the Act and were eligible for Medicaid. These individuals must--
		(1) Continue to meet the criteria for blindness or have the disabling physical or mental impairment under which the individual was found to be disabled;
		(2) Except for earnings, continue to meet all nondisability-related requirements for eligibility for SSI benefits;
		(3) Have unearned income in amounts that would not cause them to be ineligible for a payment under section 1611(b) of the Act;

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

(4) Be seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment; and

(5) Have earnings that are not sufficient to provide for himself or herself a reasonable equivalent of the Medicaid, SSI (including any federally administered SSP), or public funded attendant care services that would be available if he or she did have such earnings.

7 Not applicable with respect to individuals receiving only SSP because the State either does not make SSP payments or does not provide Medicaid to SSP-only recipients.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)
	1619 (b) (3) of the Act	___ The State applies more restrictive eligibility for Medicaid than under SSI and under 42 CFR 435.121. Individuals who qualify for benefits under section 1619 (a) of the Act or individuals described above who meet the eligibility requirements for SSI benefits under section 1619 (b) (1) of the Act and who met the State's more restrictive requirements in the month before the month they qualified for SSI under section 1619 (a) or met the requirements of section 1619 (b) (1) of the Act are covered. Eligibility for these individuals continues as long as they continue to qualify for benefits under section 1619(a) of the Act or meet the SSI requirements under section 1619 (b)(1) of the Act.

*Agency that determines eligibility for coverage

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

1634 (c) of the Act

15. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, blind or disabled individuals who—
    a. Are at least 18 years of age;

    b. Lose SSI eligibility because they become entitled to OASDI child's benefits under Section 202 (d) of the Act or an increase in these benefits based on their disability. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absent their OASDI eligibility.

    c. ___ The State applies more restrictive eligibility requirements than those under SSI, and part or all of the amount of the OASDI benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

    d. ___ The State applies more restrictive requirements than those under SSI, and none of the OASDI benefit is deducted in determining the amount of countable income for categorically needy eligibility.

42 CFR 435.122

16. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, individuals who are ineligible for SSI or optional State supplements (If the agency provides Medicaid under §435.230), because of requirements that do not apply under title XIX of the act.

42 CFR 435.130

17. Individuals receiving mandatory state supplements.

*Agency that determines eligibility for coverage

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.131 18. Individuals who in December 1973 were eligible for Medicaid as an essential spouse and who have continued, as spouse, to live with and be essential to the well-being of a recipient of cash assistance. The recipient with whom the essential spouse is living continues to meet the December 1973 eligibility requirements of the State's approved plan for OAA, AB, APTD, or AABD and the spouse continues to meet the December 1973 requirements for having his or her needs included in computing the cash payment.

/ / In December 1973, Medicaid coverage of the essential spouse was limited to the following group(s):

___ Aged ___ Blind ___ Disabled

/X/ Not applicable. In December 1973, the essential spouse was not eligible for Medicaid.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)		Groups Covered
		A.	Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	42 CFR 435.132	19.	Institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of title XIX medical institutions or residents of title XIX intermediate care facilities, if, for each consecutive month after December 1973, they--
			a. Continue to meet the December 1973 Medicaid State plan eligibility requirements; and
			b. Remain institutionalized; and
			c. Continue to need institutional care.
	42 CFR 435.133	20.	Blind and disabled individuals who--
			a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; and
			b. Were eligible for Medicaid in December 1973 as blind or disabled; and
			c. For each consecutive month after December 1973 continue to meet December 1973 eligibility criteria.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.134

21. Individuals who would be SSI/SSP eligible except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.

/7 Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).

/7 Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).

/7 Not applicable with respect to intermediate care facilities; the State did or does not cover this service.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.135

22. Individuals who—

a. Are becoming OASDI and were receiving SSI/SSP but became ineligible for SSI/SSP after April 1977; and

b. Would still be eligible for SSI or SSP if cost-of-living increases in OASDI paid under section 215(i) of the Act received after the last month for which the individual was eligible for and received SSI/SSP and OASDI, concurrently, were deducted from income.

—— Not applicable with respect to individuals receiving only SSP because the State either does not make such payments or does not provide Medicaid to SSP-only recipients.

—— Not applicable because the State applies more restrictive eligibility requirements than those under SSI.

—— The State applies more restrictive eligibility requirements than those under SSI and the amount of increase that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

1634 of the Act

23. Disabled widows and widowers who would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by section 134 Pub. L. 98-21 and who are deemed, for purposes of title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under section 1634 (b) of the Act.

—— Not applicable with respect to individuals receiving only SSP because the State either does not make these payments or does not provide Medicaid to SSP-only recipients.

—— The State applies more restrictive eligibility standards than those under SSI and considers these individuals to have income equaling the SSI Federal benefit rate, or the SSP benefit rate for individuals who would be eligible for SSP only, when determining countable income for Medicaid categorically needy eligibility.

*Agency that determines eligibility for coverage.

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation (s) | Groups Covered

1634(d) of the Act

A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

24. Disabled widows, disabled widowers, and disabled unmarried divorced spouses who had been married to the insured individual for a period of at least ten years before the divorce became effective, who have attained the age of 50, who are receiving title II income lost eligibility for SSI or SSP which they received in the month prior to the month in which they began to receive title II payments, who would be eligible for SSI or SSP if the amount of the title II benefit were not counted as income, and who are not entitled to Medicare Part A.

___ The State applies more restrictive eligibility requirements for its blind or disabled than those of the SSI program.

_X_ In determining eligibility as categorically needy, the State disregards the amount of the title II benefits identified in §1634(d)(1)(A) in determining the income of the individual, but does not disregard any more of this income than would reduce the individual's income to the SSI income standard.

___ In determining eligibility as categorically needy, the State disregards only part of the amount of the benefits identified in §1634(d)(1)(A) in determining the income of the individual, which amount would not reduce the individual's income below the SSI income standard. The amount of these benefits to disregard is specified in Supplement 4 to Attachment 2.6-A.

___ In determining as categorically needy, the State chooses not to deduct any of the benefit identified in §1634(d)(1)(A) in determining the income of the individual.

State: Indiana

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)
	1902(a)(10)(E)(i), 1905(p) and 1860D-14(a)(3)(D) of the Act	25. Qualified Medicare Beneficiaries – a. Who are entitled to hospital insurance benefits under Medicare Part A, (but not pursuant to an enrollment under Section 1818A of the Act); b. Whose income does not exceed 100 percent of the Federal poverty level; and c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index. (Medical assistance for this group is limited to Medicare cost-sharing as defined in item 3.2 of this plan.)
	1902(a)(10)(E)(ii) 1905(p)(3)(A)(i), 1905(p) of the Act	26. Qualified Disabled and Working Individuals— a. Who are entitled to hospital insurance benefits under Medicare Part A under section 1818A of the Act; b. Whose income does not exceed 200 percent of the Federal poverty level; and c. Whose resources do not exceed twice the maximum standard under SSI. d. Who are not otherwise eligible for medical assistance under Title XIX of the Act. (Medical assistance for this group is limited to Medicare Part A premiums under section 1818A of the Act.)

State: Indiana

Agency	Citation(s)	Groups Covered
		A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)
	1902(a)(10)(E)(iii). 1905(p)(3)(A)(ii), and 1860D-14(a)(3)(D) of the Act	27. Specified Low-Income Medicare Beneficiaries— a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act); b. Whose income is greater than 100 percent but less than 120 percent of the Federal poverty level; and c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index. (Medical assistance for this group is limited to Medicare Part B premiums under section 1839 of the Act.)
	1902(a)(10)(E)(iv) and 1905(p)(3)(A)(ii) and 1860D-14(a)(3)(D) of the Act	28. Qualifying Individuals – a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act; b. Whose income is at least 120 percent but less than 135 percent of the Federal poverty level; c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

28.

1634 (e) of the Act

____ a. Each person to whom SSI benefits by reason of disability are not payable for any month solely by reason of clause (i) or (v) of section 1611 (e) (3) (A) shall be treated, for purposes of title XIX, as receiving SSI benefits for the month.

____ b. The State applies more restrictive eligibility standards than those under SSI.

Individuals whose eligibility for SSI benefits are based solely on disability who are not payable for any months solely by reason of clause (i) or (v) of section 1611 (e) (3) (A), and who continue to meet the more restrictive requirements for Medicaid eligibility under the State plan, are eligible for Medicaid as categorically needy.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy

42 CFR 435.210 1902(a)(10)(A)(ii) and 1905(a) of the Act

/ / 1. Individuals described below who meet the income and resource requirements of AFDC, SSI, or an optional State supplement as specified in 42 CFR 435.230, but who do not receive cash assistance.

/ / The plan covers all individuals as described above.

/ / The plan covers only the following group or groups of individuals:

___ Aged
___ Blind
___ Disabled
___ Caretaker relatives
___ Pregnant women

42 CFR 435.211

/ / 2. Individuals who would be eligible for AFDC, SSI or an optional State supplement as specified in 42 CFR 435.230, if they were not in a medical institution.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy
(Continued)

42 CFR 435.212 & 1902(e)(2) of the Act, P.L. 99-272 (section 9517) P.L. 101-508(section 4732)

[ ] 3. The State deems as eligible those individuals who became otherwise ineligible for Medicaid while enrolled in an HMO qualified under Title XIII of the Public Health Service Act, or a managed care organization (MCO), or a primary care case management (PCCM) program, but who have been enrolled in the entity for less than the minimum enrollment period listed below. Coverage under this section is limited to MCO or PCCM services and family planning services described in section 1905(a)(4)(C) of the Act.

___ The State elects not to guarantee eligibility.

___ The State elects to guarantee eligibility. The minimum enrollment period is __ months (not to exceed six).

The State measures the minimum enrollment period from:

[ ] The date beginning the period of enrollment in the MCO or PCCM, without any intervening disenrollment, regardless of Medicaid eligibility.

[ ] The date beginning the period of enrollment in the MCO or PCCM as a Medicaid patient (including periods when payment is made under this section), without any intervening disenrollment.

[ ] The date beginning the last period of enrollment in the MCO or PCCM as a Medicaid patient (not including periods when payment is made under this section) without any intervening disenrollment or periods of enrollment as a privately paying patient. (A new minimum enrollment period begins each time the individual becomes Medicaid eligible other than under this section).

*Agency that determines eligibility for coverage.

State: Indiana

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than Medically Needy
(continued)

1932(a)(4) of the Act

The Medicaid Agency may elect to restrict the disenrollment of Medicaid enrollees of MCSs, PIHPs, PAHPs, and PCCMs in accordance with the regulations at 42 CFR 438.56. This requirement applies unless a recipient can demonstrate good cause for disenrolling or if he/she moves out of the entity's service area or becomes ineligible.

X Disenrollment rights are restricted for a period of twelve (12) months (not to exceed 12 months).

During the first three months of each enrollment period the recipient may disenroll without cause. The State will provide notification, at least once per year, to recipients enrolled with such organization of their right to and restrictions of terminating such enrollment.
This requirement would only apply to the Hoosier Healthwise program.

X No restrictions upon disenrollment rights.
This requirement would only apply to the Care Select program.

1903(m)(2)(H), 1902(a)(52)of the Act
P.L. 101-508
42 CFR 438.56(g)

In the case of individuals who have become ineligible for Medicaid for the brief period described in section 1903(m)(2)(H) and who were enrolled with an MCO, PIHP, PAHP, or PCCM when they became ineligible, the Medicaid agency may elect to reenroll those individuals in the same entity if that entity still has a contract.

X The agency elects to reenroll the above individuals who are ineligible in a month but in the succeeding two months become eligible, into the same entity in which they were enrolled at the time eligibility was lost.
This requirement would only apply to the Hoosier Healthwise program.

__ The agency elects not to enroll above individuals into the same entity in which they were previously enrolled.

X The agency elects to reenroll or not to reenroll the above individuals, in accordance with the individual's preference, into the same entity in which they were enrolled at the time eligibility was lost.
This requirement would only apply to the Care Select program.

*Agency that determines eligibility for coverage.

State/Territory: Indiana

Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
	42 CFR 435.217	x 4. A group or groups of individuals who would be eligible for Medicaid under the plan if they were in a NF or an ICF/MR, who but for the provision of home and community-based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the waiver. The group or groups covered are listed in the waiver request. This option is effective on the effective date of the State's section 1915(c) waiver under which this group(s) is covered. In the event an existing 1915(c) waiver is amended to cover this group(s), this option is effective on the effective date of the amendment.
		x 5. PACE enrollees.

* Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

1902(a)(10)(A)(ii)(VII) of the Act

/_/ 5. Individuals who would be eligible for Medicaid under the plan if they were in a medical institution, who are terminally ill, and who receive hospice care in accordance with a voluntary election described in section 1905(o) of the Act.

/_/ The State covers all individuals as described above.

/_/ The State covers only the following group or groups of individuals:

___ Aged
___ Blind
___ Disabled
___ Individuals under the age of--
___ 21
___ 20
___ 19
___ 18
___ Caretaker relatives
___ Pregnant women

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.220

☑ 6. Individuals who would be eligible for AFDC if their work-related child care costs were paid from earnings rather than by a State agency as a service expenditure. The State's AFDC plan deducts work-related child care costs from income to determine the amount of AFDC.

☑ The State covers all individuals as described above.

1902(a)(10)(A)(ii) and 1905(a) of the Act

☑ The State covers only the following group or groups of individuals:

___ Individuals under the age of--
___ 21
___ 20
___ 19
___ 18
___ Caretaker relatives
___ Pregnant women

42 CFR 435.2
1902(a)(10)(A)(ii) and 1905(a)(i) of the Act

7. ☑ a. All individuals who are not described in section 1902(a)(10)(A)(i) of the Act, who meet the income and resource requirements of the AFDC State plan, and who are 21 years of age or younger as indicated below.

___ 20
___ 19
___ 18

State: Indiana

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.222

/ / b. Reasonable classifications of individuals described in (a) above, as follows:

___ (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:

___ (a) In foster homes (and are under the age of _____).

___ (b) In private institutions (and are under the age of _____).

___ (c) In addition to the group under b.(1)(a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of _____).

___ (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of _____).

___ (3) Individuals in NFs (who are under the age of _____). NF services are provided under this plan.

___ (4) In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of _____).

Agency* Citation(s) Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

X (5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of 21). Inpatient psychiatric services for individuals under age 21 are provided under this plan.

X (6) Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.

Agency*	Citation(s)		Groups Covered
			B. Optional Groups Other Than the Medically Needy (Continued)
	1902(a)(10)(A)(ii)(VIII) of the Act	/Y	8. A child for whom there is in effect a State adoption assistance agreement (other than under title IV-E of the Act), who, as determined by the State adoption agency, cannot be placed for adoption without medical assistance because the child has special needs for medical or rehabilitative care, and who before execution of the agreement-- a. Was eligible for Medicaid under the State's approved Medicaid plan; or b. Would have been eligible for Medicaid if the standards and methodologies of the title IV-E foster care program were applied rather than the AFDC standards and methodologies. The State covers individuals under the age of-- ___ 21 ___ 20 ___ 19 _X_ 18

Agency*	Citation (s).	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.223 /7 9. Individuals described below who would be eligible for AFDC if coverage under the State's AFDC plan were as broad as allowed under title IV-A:

1902(a)(10)(A)(ii) and 1905(a) of the Act

___ Individuals under the age of--
___ 21
___ 20
___ 19
___ 18
___ Caretaker relatives
___ Pregnant women

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation (s) | Groups Covered

B. Optional Groups Other Than the Medically Needy
(Continued)

42 CFR 435.230 | X | 10. States using SSI criteria with agreements under sections 1616 and 1634 of the Act.

The following groups of individuals who receive only a State supplementary payment (but no SSI payment) under an approved optional State supplementary payment program that meets the following conditions. The supplement is –

a. Based on need and paid in cash on a regular basis

b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.

c. Available to all individuals in the State.

d. Paid to one or more of the classifications of individuals listed below, who would be eligible for SSI except for the level of their income.

___ (1) All aged individuals

___ (2) All blind individuals

___ (3) All disabled individuals.

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation (s) Groups Covered

B. Optional Groups Other Than the Medically Needy
(Continued)

X	(4)	Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.
X	(5)	Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.
X	(6)	Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.
___	(7)	Individuals receiving a Federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.
___	(8)	Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.
___	(9)	Individuals in additional classifications approved by the Secretary as follows:

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

___ Yes.

_X_ No.

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.230
435.121
1902 (a) (10)
(A) (ii) (XI)
of the Act

[ ] 11. Section 1902 (f) States and SSI criteria States without agreements under section 1616 or 1634 of the Act.

The following groups of individuals who receive a State supplementary payment under an approved optional State supplementary payment program that meets the following conditions. The supplement is—

a. Based on need and paid in cash on a regular basis.

b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.

c. Available to all individuals in each classification and available on a Statewide basis.

d. Paid to one or more of the classifications of individuals listed below, who would be eligible for SSI except for the level of their income.

___ (1) All aged individuals.

___ (2) All blind individuals.

___ (3) All disabled individuals.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
	42 CFR 435.230	___ (4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.
		___ (5) Blind individuals in domiciliary facilities or other group living arrangements as defined by SSI.
		___ (6) Disabled individuals in domiciliary facilities or other group living arrangements as defined by SSI.
		___ (7) Individuals receiving a Federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.
		___ (8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.
		___ (9) Individuals in additional classifications approved by the Secretary as follows:

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

___ Yes.

___ No.

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)		Groups Covered
		B.	Optional Groups Other Than the Medically Needy (Continued)
42 CFR 435.231 1902(a)(10)(A)(ii)(V) of the Act	/X/ 7-1-91	12.	Individuals who are in institutions for at least 30 consecutive days and who are eligible under a special income level. Eligibility begins on the first day of the 30-day period. These individuals meet the income standards specified in Supplement 1 to ATTACHMENT 2.6-A.
		/_/	The State covers all individuals as described above.
		/X/	The State covers only the following group or groups of individuals:
1902(a)(10)(A)(ii) and 1905(a) of the Act		X	Aged
		X	Blind
		X	Disabled
		___	Individuals under the age of--
		___	21
		___	20
		___	19
		___	18
		___	Caretaker relatives
		___	Pregnant women

Agency*	Citation(s)		Groups Covered
		B.	Optional Groups Other Than the Medically Needy (Continued)
	1902(e)(3) of the Act	/7	13. Certain disabled children age 18 or under who are living at home, who would be eligible for Medicaid under the plan if they were in an institution, and for whom the State has made a determination as required under section 1902(e)(3)(B) of the Act. Supplement 3 to ATTACHMENT 2.2-A describes the method that is used to determine the cost effectiveness of caring for this group of disabled children at home.
	1902(a)(10)(A)(ii)(IX) and 1902(l) of the Act	KY	14. The following individuals who are not mandatory categorically needy whose income does not exceed the income level (established at an amount above the mandatory level and not more than 185 percent of the Federal poverty income level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size, including the woman and unborn child or infant and who meet the resource standards specified in Supplement 2 to ATTACHMENT 2.6-A: a. Women during pregnancy (and during the 60-day period beginning on the last day of pregnancy); and b. Infants under one year of age.

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

1902(a)(10)(A)(ii)(IX) and 1902(l)(1)(D) of the Act

☐ 15. The following individuals who are not mandatory categorically needy, who have income that does not exceed the income level (established at an amount up to 100 percent of the federal poverty level) specified in Supplement 1 of ATTACHMENT 2.6-A for a family of the same size.

Children who are born after September 30, 1983 and who have attained 6 years of age but have not attained--

☐ 7 years of age: or

☐ 8 years of age.

Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
	1902(a)(10)(ii)(X) and 1902 (m) (1) and (3) of the Act	[x] 16. Individuals—
		a. Who are 65 years of age or older or who are disabled as determined under section 1614 (a) (2) of the Act. Both aged and disabled individuals are covered under this eligibility group.
		b. Whose income does not exceed the income level (established at an amount up to 100 percent of the Federal income poverty level, specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size; and
		c. Whose resources do not exceed the maximum amount allowed under SSI; under the State's more restrictive financial criteria; or under the State's medically needy program as specified in ATTACHMENT 2.6-A.

*Agency that determines eligibility for coverage

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: INDIANA

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
	B. Optional Groups Other Than the Medically Needy (Continued)
1902 (a) (47) And 1920 of The Act	_X__17. Pregnant women who are determined by a "qualified provider" (as defined in §1920 (b) (2) of the Act) based on preliminary information, to meet the highest applicable income criteria specified in this plan under ATTACHMENT 2.6-A and are therefore determined to be presumptively eligible during a presumptive eligibility period in accordance with Section 1920 of the Act.

State/Territory: Indiana

Citation	Groups Covered
	B. Optional Groups Other Than the Medically Needy (Continued)
1906 of the Act	18. Individuals required to enroll in cost-effective employer-based group health plans remain eligible for a minimum enrollment period of _____ months.
1902(a)(10)(F) and 1902(u)(1) of the Act	19. Individuals entitled to elect COBRA continuation coverage and whose income as determined under Section 1612 of the Act for purposes of the SSI program, is no more than 100 percent of the Federal poverty level, whose resources are no more than twice the SSI resource limit for an individual, and for whom the State determines that the cost of COBRA premiums is likely to be less than the Medicaid extenditures for an equivalent set of services. See Supplement 11 to Attachment 2.6-A.

State INDIANA

Citation	Groups Covered
	B. Optional Groups other than the medically needy (continued)
1902(e)(12) of the Act	_X_ 20. A child under age __3__ (not to exceed 19) who has been determined eligible is deemed to be eligible for a total of __12__ months (not to exceed 12 months) regardless of changes in circumstances other than attainment of the maximum age stated above.

STATE: Indiana

Citation	Group Covered

B. Optional Coverage Other Than the Medically Needy (Continued)

1902(a)(10)(A)(ii)(XVIII) of the Act

X [24]. Women who:

a. have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act in accordance with the requirements of section 1504 of that Act and need treatment for breast or cervical cancer, including a pre-cancerous condition of the breast or cervix;

b. are not otherwise covered under creditable coverage, as defined in section 2701 (c) of the Public Health Service Act;

c. are not eligible for Medicaid under any mandatory categorically needy eligibility group; and

d. have not attained age 65.

1920B of the Act

___ [25]. Women who are determined by a "qualified entity" (as defined in 1920B(b) based on preliminary information, to be a woman described in 1902(aa) of the Act related to certain breast and cervical cancer patients.

The presumptive period begins on the day that the determination is made. The period ends on the date that the State makes a determination with respect to the woman's eligibility for Medicaid, or if the woman does not apply for Medicaid (or a Medicaid application was not made on her behalf) the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on that last day.

State: INDIANA

Citation			Groups Covered
B.	Optional Groups Other Than the Medically Needy (Continued)		
1902 (a)(10)(A) (ii)(XIII) of the Act	[ ]	23.	BBA Work Incentives Eligibility Group- Individuals with a disability whose net family income is below 250 percent of the Federal poverty level for a family of the size involved and who, except for earned income, meet all criteria for receiving benefits under the SSI program. See page 12c of Attachment 2.6-A
1902 (a)(10)(A) (ii)(XV) of the Act	[X]	24.	TWWIIA Basic Coverage Group - Individuals with a disability at least 16 but less than 65 years of age whose income and resources do not exceed a standard established by the State. See page 12d of Attachment 2.6-A
1902 (a)(10)(A) (ii)(XVI) of the Act	[X]	25.	TWWIIA Medical Improvement Group - Employed individuals at least 16 but less that 65 years of age with a medically improved disability whose income and resources do not exceed a standard established by the State. See page 12h of Attachment 2.6-A. NOTE: If the State elects to cover this group, it MUST also cover Basic Coverage Group described in no. 24 above.

STATE: Indiana

Citation	Groups Covered
	B. Optional groups other than the Medically Needy (Continued)
1902(a)(10)(A)(ii)(XVII) of the Act	X 26. Individuals who are independent foster care adolescents as defined in Section 1905(w) (1) of the Act. The State covers all such individuals who: a. are less than 21 years of age; b. were in foster care under the responsibility of the State on their 18th birthday; and c. have countable income that does not exceed 200% of the federal poverty guidelines for the family size involved. The State does not apply an asset test.

Citation	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

1902(a)(10)(A)(ii)(XXI)
1902(ii)

X **27.** Individuals who are *not* pregnant and whose income does not exceed the State established income standard of 133 % of the Federal Poverty Level. This amount does not exceed the highest income limit for pregnant women in this State Plan, which is 200 % of the Federal Poverty Level.

In determining eligibility for this group, the State will use the following household composition:

X The State will count all the members of the family in the household unit

__ The State will use the methodology that is currently used for pregnant women under the State plan, which increases the household size by one.

In determining eligibility for this group, the State will use the following income methodology:

X The State considers the income of the applicant and all legally responsible household members (ex. parents and spouses)

__ The State considers only the income of the applicant or recipient

__ The State uses another methodology described below

Note: Services are limited to family planning services and family planning-related services as described in section 4.c (i) of Attachment 3.1-A, Addendum Page 2.

Presumptive Eligibility Option for Family Planning

1920C

X The State elects to provide a period of presumptive eligibility for family planning services to individuals determined by a qualified entity, based on preliminary information from the individual, described in the group the State has elected to make eligible under the above option. The period of presumptive eligibility ends on the earlier of the date a formal determination of Medicaid eligibility is made under 1902(a)(10)(A)(ii)(XXI), or, when no application has been filed, the last day of the month following the month during which the qualified entity determines the individual presumptively eligible.

__ In addition to family planning services, the State elects to cover family planning-related services to such individuals during the period of presumptive eligibility.

Groups Covered

Optional Groups other than the Medically Needy

In addition to providing State plan HCBS to individuals described in 1915(i)(1), the state may **also** cover the optional categorically needy eligibility group of individuals described in 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the FPL, or who are eligible for HCBS under a waiver approved for the state under Section 1915(c), (d) or (e) or Section 1115 (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate. See 42 CFR § 435.219. (*Select one*):

☐ No. Does not apply. State does not cover optional categorically needy groups.

☑ Yes. State covers the following optional categorically needy groups.
(Select all that apply):

(a) ☑ Individuals not otherwise eligible for Medicaid who meet the needs-based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services. There is no resource test for this group. Methodology used:
(Select one):

☑ SSI. The state uses the following less restrictive 1902(r)(2) income disregards for this group. (*Describe, if any*):

For BPHC members only, after SSI countable income, the State disregards income in the amount of the difference between 150% of the Federal Poverty Level (FPL) and 300% of the FPL.

☐ OTHER (*describe*):

(b) ☐ Individuals who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d) or (e) (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate.
Income limit: (*Select one):*

☐ 300% of the SSI/FBR

☐ Less than 300% of the SSI/FBR (*Specify):* _____%

Specify the applicable 1915(c), (d), or (e) waiver or waivers for which these individuals would be eligible: *(Specify waiver name(s) and number(s)):*

(c) ☐ Individuals eligible for 1915(c), (d) or (e) -like services under an approved 1115 waiver. The income and resource standards and methodologies are the same as the applicable approved 1115 waiver.

Specify the 1115 waiver demonstration or demonstrations for which these individuals would be eligible. *(Specify demonstration name(s) and number(s)):*

Agency*	Citation(s)	Groups Covered

C. Optional Coverage of the Medically Needy

42 CFR 35.301

This plan includes the medically needy.

/XX/ No.

/ / Yes. This plan covers:

1. Pregnant women who, except for income and/or resources, would be eligible as categorically needy under title XIX of the Act.

1902(e) of the Act

2. Women who, while pregnant, were eligible for and have applied for Medicaid and receive Medicaid as medically needy under the approved State plan on the date the pregnancy ends. These women continue to be eligible, as though they were pregnant, for all pregnancy-related and postpartum services under the plan for a 60-day period, beginning with the date the pregnancy ends, and any remaining days in the month in which the 60th day falls.

1902(a)(10)(C)(ii)(I) of the Act

3. Individuals under age 18 who, but for income and/or resources, would be eligible under section 1902(a)(10)(A)(i) of the Act.

Agency*	Citation(s)	Groups Covered

C. Optional Coverage of Medically Needy (Continued)

1902(e)(4) of the Act

4. Newborn children born on or after October 1, 1984 to a woman who is eligible as medically needy and is receiving Medicaid on the date of the child's birth. The child is deemed to have applied and been found eligible for Medicaid on the date of birth and remains eligible for one year so long as the woman remains eligible and the child is a member of the woman's household.

42 CFR 435.308

5. /7 a. Financially eligible individuals who are not described in section C.3. above and who are under the age of--

___ 21
___ 20
___ 19
___ 18 or under age 19 who are full-time students in a secondary school or in the equivalent level of vocational or technical training

/7 b. Reasonable classifications of financially eligible individuals under the ages of 21, 20, 19, or 18 as specified below:

___ (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:

___ (a) In foster homes (and are under the age of _____).

___ (b) In private institutions (and are under the age of _____).

Agency* Citation(s) Groups Covered

C. Optional Coverage of Medically Needy (Continued)

___ (c) In addition to the group under b.(1)(a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of ___ ___).

___ (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of _____).

___ (3) Individuals in NFs (who are under the age of _____). NF services are provided under this plan.

___ (4) In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of _____).

___ (5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of ___). Inpatient psychiatric services for individuals under age 21 are provided under this plan.

___ (6) Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.

Agency*	Citation(s)	Groups Covered

C. Optional Coverage of Medically Needy (Continued)

42 CFR 435.310 /_/ 6. Caretaker relatives.

42 CFR 435.320 and 435.330 /_/ 7. Aged individuals.

42 CFR 435.322 and 435.330 /_/ 8. Blind individuals.

42 CFR 435.324 and 435.330 /_/ 9. Disabled individuals.

42 CFR 435.326 /_/ 10. Individuals who would be ineligible if they were not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212 and the same rules apply to medically needy individuals.

435.340 11. Blind and disabled individuals who:

a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria;

b. Were eligible as medically needy in December 1973 as blind or disabled; and

c. For each consecutive month after December 1973 continue to meet the December 1973 eligibility criteria.

Citation(s)	Groups Covered
	C. Optional Coverage of Medically Needy (Continued)
1906 of the Act	12. Individuals required to enroll in cost effective employer-based group health plans remain eligible for a minimum enrollment period of _____ months.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Indiana

REQUIREMENTS RELATING TO DETERMINING ELIGIBILITY FOR MEDICARE PRESCRIPTION DRUG LOW-INCOME SUBSIDIES

Citation (s)	Provisions
1935(a) and 1902(a)(66) 42 CFR 423.774 and 423.904	The agency provides for making Medicare prescription drug Low Income Subsidy determinations under Section 1935(a) of the Social Security Act. 1. The agency makes determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D-14 of the Social Security Act; 2. The agency provides for informing the Secretary of such determinations in cases in which such eligibility is established or redetermined; 3. The agency provides for screening of individuals for Medicare cost-sharing described in Section 1905(p)(3) of the Act and offering enrollment to eligible individuals under the State plan or under a waiver of the State plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: INDIANA

REASONABLE CLASSIFICATIONS OF INDIVIDUALS UNDER THE AGE OF 21, 20, 19, AND 18

1. Individuals age 18, 19, 20 who meet all AFDC requirements except for the 18 year old limitation. (10-1-81)

2. Individuals under the age of 18 who are legally in the custody of or supervision of the County Departments of Public Welfare or the Indiana Family & Social Services Administration.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: INDIANA

Method for Determining Cost Effectiveness of Caring for Certain Disabled Children At Home

N/A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: INDIANA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	A. General Conditions of Eligibility
	Each individual covered under the plan:
42 CFR Part 435, Subpart G	1. Is financially eligible (using the methods and standards described in Parts B and C of this Attachment) to receive services.
42 CFR Part 435, Subpart F	2. Meets the applicable non-financial eligibility conditions.
	a. For the categorically needy:
	(i) Except as specified under items A.2.a.(ii) and (iii) below, for AFDC-related individuals, meets the non-financial eligibility conditions of the AFDC program.
	(ii) For SSI-related individuals, meets the non-financial criteria of the SSI program or more restrictive SSI-related categorically needy criteria.
1902(l) of the Act	(iii) For financially eligible pregnant women, infants or children covered under sections 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII), and 1902(a)(10)(A)(ii)(IX) of the Act, meets the non-financial criteria of section 1902(l) of the Act.
1902(m) of the Act	(iv) For financially eligible aged and disabled individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, meets the non-financial criteria of section 1902(m) of the Act.

Citation	Condition or Requirement
	b. For the medically needy, meets the non-financial eligibility conditions of 42 CFR Part 435.
1905(p) of the Act	c. For financially eligible qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, meets the non-financial criteria of section 1905(p) of the Act.
1905(s) of the Act	d. For financially eligible qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, meets the non-financial criteria of section 1905(s).
42 CFR 435.402	3. Is residing in the United States and--
	a. Is a citizen;
Sec. 245A of the Immigration and	b. Is an alien lawfully admitted for permanent residence or otherwise permanently residing in the Nationality Act United States under color of law, as defined in 42 CFR 435.408;
1902(a) and 1903(v) of the Act and 245A(h)(3)(B) of the Immigration & Nationality Act	c. Is an alien granted lawful temporary resident status under section 245A and 210A of the Immigration and Nationality Act if the individual is aged, blind, or disabled as defined in section 1614(a)(1) of the Act, under 18 years of age or a Cuban/Haitian entrant as defined in section 501(e)(1) and (2)(A) of P.L. 96-422;

Citation	Condition or Requirement
	d. Is an alien granted lawful temporary resident status under section 210 of the Immigration and Nationality Act not within the scope of c. above (coverage must be restricted to certain emergency services during the five-year period beginning on the date the alien was granted such status); or
	e. Is an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law (coverage must be restricted to certain emergency services).
42 CFR 435.403 1902(b) of the Act	4. Is a resident of the State, regardless of whether or not the individual maintains the residence permanently or maintains it at a fixed address.
	☐ State has interstate residency agreement with the following States:
	☐ State has open agreement(s).
	☐ Not applicable; no residency requirement.

Citation	Condition or Requirement
42 CFR 435.1008	5. a. Is not an inmate of a public institution. Public institutions do not include medical institutions, intermediate care facilities, or publicly operated community residences that serve no more than 16 residents, or certain child care institutions.
42 CFR 435.1008 1905(a) of the Act	b. Is not a patient under age 65 in an institution for mental diseases except as an inpatient under age 22 receiving active treatment in an accredited psychiatric facility or program. /7 Not applicable with respect to individuals under age 22 in psychiatric facilities or programs. Such services are not provided under the plan.
42 CFR 433.145 1912 of the Act 7-1-85	6. Is required, as a condition of eligibility, to assign his or her own rights, or the rights of any other person who is eligible for Medicaid and on whose behalf the individual has legal authority to execute an assignment, to medical support and payments for medical care from any third party. (Medical support is defined as support specified as being for medical care by a court or administrative order.)

Citation		Condition or Requirement
		An applicant or recipient must also cooperate in establishing the paternity of any eligible child and in obtaining medical support and payments for himself or herself and any other person who is eligible for Medicaid and on whose behalf the individual can make an assignment; except that individuals described in §1902 (l) (1) (A) of the Social Security Act (pregnant women and women in post-partum period) are exempt from these requirements involving paternity and obtaining support. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate. An applicant or recipient must also cooperate in identifying any third party who may be liable to pay for care that is covered under the State plan and providing information to assist in pursuing these third parties. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate. _X_ Assignment of rights is automatic because of State law.
42 CFR 435.910	7.	Is required, as a condition of eligibility, to furnish his/her social security account number (or numbers, if he/she has more than one number).

Citation	Condition or Requirement
1902(c)(2)	8. Is not required to apply for AFDC benefits under title IV-A as a condition of applying for, or receiving, Medicaid if the individual is a pregnant woman, infant, or child that the State elects to cover under sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.
1902(e)(10)(A) and (B) of the Act	9. Is not required, as an individual child or pregnant woman, to meet requirements under section 402(a)(43) of the Act to be in certain living arrangements. (Prior to terminating AFDC individuals who do not meet such requirements under a State's AFDC plan, the agency determines if they are otherwise eligible under the State's Medicaid plan.)

Citation	Condition or Requirement
1906 of the Act	10. Is required to apply for enrollment in an employer-based cost-effective group health plan, if such plan is available to the individual. Enrollment is a condition of eligibility except for the individual who is unable to enroll on his/her own behalf (failure of a parent to enroll a child does not affect a child's eligibility).

Citation	Condition or Requirement
	B. Posteligibility Treatment of Institutionalized Individuals' Incomes
	1. The following items are not considered in the posteligibility process:
1902(o) of the Act	a. SSI and SSP benefits paid under §1611(e)(1)(E) and (G) of the Act to individuals who receive care in a hospital, nursing home, SNF, or ICF.
Bondi v. Sullivan (SSI)	b. Austrian Reparation Payments (pension (reparation) payments made under §500 - 506 of the Austrian General Social Insurance Act). Applies only if State follows SSI program rules with respect to the payments.
1902(r)(1) of the Act	c. German Reparations Payments (reparation payments made by the Federal Republic of Germany).
105/206 of P. L. 100-383	d. Japanese and Aleutian Restitution Payments.
1. (a) of P.L. 103-286	e. Netherlands Reparation Payments based on Nazi, but not Japanese, persecution (during World War II).
10405 of P.L. 101-239	f. Payments from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent orange product liability litigation, M.D.L. No.381 (E.D.N.Y.)
6(h)(2) of P.L. 101-426	g. Radiation Exposure Compensation.
12005 of P. L. 103-66	h. VA pensions limited to $90 per month under 38 U.S.C. 5503.

State: INDIANA

Citation	Condition or Requirement
1924 of the Act 435.725 435.733 435.832	2. The following monthly amounts for personal needs are deducted from total monthly income in the application of an institutionalized individual's or couple's income to the cost of institutionalized care: Personal Needs Allowance (PNA) of not less than $30 For Individuals and $60 For Couples For All Institutionalized Persons. a. Aged, blind, disabled: Individuals $ 52.00 Couples $ 104.00 For the following persons with greater need: Supplement 12 to Attachment 2.6-A describes the greater need describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met. b. AFDC related: Children $ 52.00 Adults $ 52.00 For the following persons with greater need: Supplement 12 to Attachment 2.6-A describes the greater need describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met. c. Individual under age 21 covered in the plan as specified in Item B. 7. of Attachment 2.2 -A. $ 52.00

State: INDIANA

Citation	Condition or Requirement
	For the following persons with greater need: Supplement 12 to Attachment 2.6-A describes the greater need describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.
1924 of the Act	3. In addition to the amounts under item 2. , the following monthly amounts are deducted from the remaining income of an institutionalized individual with a community spouse: a. The monthly income allowance for the community spouse, calculated using the formula in §1924(d)(2), is the amount by which the maintenance needs standard exceeds the community spouse's income. The maintenance needs standard cannot exceed the maximum prescribed in §1924 (d)(3)(C). The maintenance needs standard consists of a poverty level component plus an excess shelter allowance. __X__ The poverty level component is calculated using the applicable percentage (set out §1924(d)(3)(B) of the Act) of the official poverty level. ____ The poverty level component is calculated using a percentage greater than the applicable percentage, equal to _____%, of the official poverty level (still subject to maximum maintenance needs standard). _____ The maintenance needs standard for all community spouses is set at the maximum permitted by §1924(d)(3)(C). Except that, when applicable, the State will set the community spouse's monthly income allowance at the amount by which exceptional maintenance needs, established at a fair hearing, exceed the community spouse's income, or at the amount of any court-ordered support.

Citation	Condition or Requirement

In determining any excess shelter allowance, utility expenses are calculated using:

__X__ the standard utility allowance under §5(e) of the Food Stamp Act of 1977 or

__X__ the actual unreimbursable amount of the community spouse's utility expenses less any portion of such amount included in condominium or cooperative charges.

b. The monthly income allowance for other dependent family members living with the community spouse is:

__X__ one-third of the amount by which the poverty level component (calculated under §1924(d)(3)(A)(i) of the Act, using the applicable percentage specified in §1924 (d)(3)(B)) exceeds the dependent family member's monthly income.

____ a greater amounted calculated as follows:

The following definition is used in lieu of the definition provided by the Secretary to determine the dependency of family members under §1924 (d)(1):

c. Amounts for health care expenses described below that are incurred by and for the institutionalized individual and are not subject to payments by a third party:

(i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments.

(ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amounts are described in Supplement 3 to ATTACHMENT 2.6-A.)

State: INDIANA

Citation	Condition or Requirement
435.725 435.733 435.832	4. In addition to any amounts deductible under the items above, the following monthly amounts are deducted from the remaining monthly income of an institutionalized individual or an institutionalized couple: a. An amount for the maintenance needs of each member of a family living in the institutionalized individual's home with no community spouse living in the home. The amount must be based on a reasonable assessment of need but must not exceed the higher of the: o AFDC level or o Medically needy level: (Check one) --AFDC levels in Supplement 1 --Medically needy level in Supplement 1 --Other: $ b. Amounts for health care expenses described below that have not been deducted under 3.c. above (i.e., for an institutionalized individual with a community spouse), are incurred by and for the institutionalized individual or institutionalized couple, and are not subject to the payment by a third party: (i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments. (ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amount are described in Supplement 3 to ATTACHMENT 2.6-A.)
435.725 435.733 435.832	5. At the option of the State, as specified below, the following is deducted from any remaining monthly income of an institutionalized individual or an institutionalized couple: A monthly amount for the maintenance of the home of the individual or couple for not longer than 6 months if a physician has certified that the individual, or one member of the institutionalized couple, is likely to return to the home within that period: _X_ No. ____ Yes (the applicable amount is shown on page 5a.)

State: INDIANA

Citation	Condition or Requirement
____	Amount for maintenance of home is: $_____.
____	Amount for maintenance of home is the actual maintenance costs not to exceed $_____.
____	Amount for maintenance of home is deductible when countable income is determined under §1924(d)(1) of the Act only if the individual's home and the community spouse's home are different.
____	Amount for maintenance of home is not deductible when countable income is determined under §1924 (d)(1) of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: INDIANA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 CFR 435.711 435.721, 435.831	C. Financial Eligibility For individuals who are AFDC or SSI recipients, the income and resource levels and methods for determining countable income and resources of the AFDC and SSI program apply, unless the plan provides for more restrictive levels and methods than SSI for SSI recipients under section 1902(f) of the Act, or more liberal methods under section 1902(r)(2) of the Act, as specified below. For individuals who are not AFDC or SSI recipients in a non-section 1902(f) State and those who are deemed to be cash assistance recipients, the financial eligibility requirements specified in this section C apply. Supplement 1 to ATTACHMENT 2.6-A specifies the income levels for mandatory and optional categorically needy groups of individuals, including individuals with incomes related to the Federal income poverty level--pregnant women and infants or children covered under sections 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII), and 1902(a)(10)(A)(ii)(IX) of the Act and aged and disabled individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act--and for mandatory groups of qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act.

Citation(s)	Condition or Requirement

x Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for mandatory and optional categorically needy poverty level related groups, and for medically needy groups.

___ Supplement 7 to ATTACHMENT 2.6-A specifies the income levels for categorically needy aged, blind, and disabled persons who are covered under requirements more restrictive than SSI.

___ Supplement 4 to ATTACHMENT 2.6-A specifies the methods for determining income eligibility used by States that have more restrictive methods than SSI, permitted under Section 1902 (f) of the Act.

___ Supplement 5 to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States that have more restrictive methods than SSI, permitted under section 1902 (f) of the Act.

x Supplement 8a to ATTACHMENT 2.6-A specifies the methods for determining income eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902 (r) (2) of the Act.

x Supplement 8b to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902 (r) (2) of the Act.

___ Supplement 14 to ATTACHMENT 2.6-A specifies income levels used by States for determining eligibility of Tuberculosis-infected individuals whose eligibility is determined under §1902 (z) (1) of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: INDIANA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(r)(2) of the Act	1. Methods of Determining Income a. AFDC-related individuals (except for poverty level related pregnant women, infants, and children).
* and for individuals who would be eligible for AFDC but for the receipt of SSI,	(1) In determining countable income for AFDC-related individuals,* the following methods are used: ___ (a) The methods under the State's approved AFDC plan only; or ___ (b) The methods under the State's approved AFDC plan and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.
	(2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.
1902(e)(6) the Act	(3) Agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 CFR 435.721 435.831, and 1902 (m) (1) (B) (m) (4) and 1902 (r) (2) of the Act	b. Aged individuals. In determining countable income for aged individuals, including aged individuals with incomes up to the the Federal poverty level described in section (1902) (m) (1) of the Act, the following methods are used: ___ The methods of the SSI program only. x The methods of the SSI program and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

Citation(s)	Condition or requirement

[ ] For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902 (f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A; and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

[ ] For institutional couples, the methods specified under section 1611 (e) (5) of the Act.

[ ] For optional State supplement recipients under § 435.230, income methods more liberal than SSI, as specified in Supplement 8a to ATTACHMEMT 2.6-A.

[ ] For optional State supplement recipients in Section 1902 (f) States and SSI criteria States without section 1616 or 1634 agreements—

___ SSI methods only.

___ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.

___ Methods more restrictive and/or more liberal than SSI. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are described in Supplement 8a to ATTACHMENT 2.6-A.

In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses.

Citation(s)	Condition or Requirement
42 CFR 435.721 435.831, and 1902 (m) (1) (B) (m) (4) and 1902 (r) (2) of the Act	c. Blind individuals. In determining countable income for blind individuals, the following methods are used: ___The methods of the SSI program only. x SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. ___ For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902 (f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A, and any more liberal methods described in Supplement 8a to Attachment 2.6-A. ___ For institutional couples, the methods specified under section 1611 (e) (5) of the Act. ___ For optional State supplement recipients under § 435.230, income methods more liberal than SSI, as specified in Supplement 8 to ATTACHMENT 2.6-A. ___For optional State supplement recipients in section 1902 (f) States and SSI criteria States without section 1616 or 1634 agreements— ___ SSI methods only. ___ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A ___ Methods more restrictive and/or more liberal than SSI. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are described in Supplement 8a to ATTACHMENT 2.6-A.

Citation(s)	Condition or Requirement
	In determining relative responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.
42 CFR 435.721 435.831, and 1902 (m) (1) (B) (m) (4) and 1902 (r) (2) of the Act	d. Disabled individuals. In determining countable income for disabled individuals, including individuals with income up to the Federal poverty level described in section 1902 (m) of the Act, the following methods are used: ___ The methods of the SSI program. __x__ SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. ___ For institutional couples: the methods specified under section 1611 (e) (5) of the Act. ___ For optional State supplement recipients under §435.230, income methods more liberal than SSI, as specified in Supplement 8a to ATTACHMENT 2.6-A. ___ For individuals other than optional State supplement recipients (except aged and disabled individuals described in section 1903 (m) (1) of the Act): more restrictive methods than SSI, applied under the provisions of section 1902 (f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A; and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

Citation(s)	Condition or Requirement

___ For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements—

___ SSI methods only

___ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A

___ Methods more restrictive and/or more liberal than SSI, except for aged and disabled individuals described in section 1902 (m) (1) of the Act. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are specified in Supplement 8a to ATTACHMENT 2.6-A.

In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouse and the income of parents as available to children living with parents until the children become 21.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: INDIANA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation	Condition or Requirement
1902 (l)(3)(E) and 1902(r)(2) of the Act	e. Poverty level pregnant women, infants, and children. For pregnant women and infants or children covered under the provisions of section 1902(a)(10)(A)(i)(IV), (VI), and (VII), and 1902(a)(10)(A)(ii)(IX) of the Act -- (1) The following methods are used in determining countable income: __ The methods of the State's approved AFDC plan. __ The methods of the approved title IV-E Plan. _X_ The methods of the approved AFDC State plan and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6A. __ The methods of the approved title IV-E plan and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6A .

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	(2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.
1902 (e) (6) of the Act	(3) The agency continues to treat women eligible under the provisions of sections 1902 (a) (10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month on which the 60th day falls.
1905 (p) (1), 1902 (m) (4), and 1902 (r) (2) of the Act	f. Qualified Medicare beneficiaries. In determining countable income for qualified Medicare beneficiaries covered under section 1902 (a) (10) (E) (i) of the Act, the following methods are used: ___ The methods of the SSI program only. x SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A. ___ For institutional couples, the methods specified under section 1611 (e) (5) of the Act.

Citation	Condition or Requirement
	If an individual receives a title II benefit, any amounts attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level. For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period. For individuals not receiving title II income, the revised poverty levels are effective no later than the date of publication.
1905(s) of the Act	g. (1) Qualified disabled and working individuals. In determining countable income for qualified disabled and working individuals covered under 1902(a)(10)(E)(ii) of the Act, the methods of the SSI program are used.
1905(p) of the Act	(2) Specified low-income Medicare beneficiaries. In determining countable income for specified low-income Medicare beneficiaries covered under 1902(a)(10)(E)(iii) of the Act, the same method as in f. is used.

* U.S. G.P.O.:1993-342-239:80032

Citation	Condition or Requirement
1902(u) of the Act	(h) COBRA Continuation Beneficiaries

In determining countable income for COBRA continuation beneficiaries, the following disregards are applied:

_____ The disregards of the SSI program;

_____ The agency uses methodologies for treatment of income more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A.

NOTE: For COBRA continuation beneficiaries specified at 1902(u)(4), costs incurred from medical care or for any other type of remedial care shall not be taken into account in determining income, except as provided in section 1612(b)(4)(B)(ii).

State: INDIANA

Citation		Condition or Requirement
1902 (a)(10)(A) (ii) (XIII) of the Act	(i)	Working Individuals with Disabilities - BBA In determining countable income and resources for working individuals with disabilities under the BBA, the following methodologies are applied: ____ The methodologies of the SSI program. ____ The agency uses methodologies for treatment of income and resources more restrictive that the SSI program. These more restrictive methodologies are described in Supplement 4 (income) and/or Supplement 5 (resources) to Attachment 2.6-A ____ The agency uses more liberal income and/or resource methodologies than the SSI program. More liberal methodologies are described in Supplement 8a to Attachment 2.6-A. More liberal resource methodologies are described in Supplement 8b to Attachment 2.6-A

State: INDIANA

Citation		Condition or Requirement
1902 (a)(10)(A) (ii)(XV) of the Act	(ii)	Working Individuals with Disabilities - Basic Coverage Group - TWWIIA

In determining financial eligibility for working individuals with disabilities under this provision, the following standards and methodologies are applied:

____ The agency does not apply any income or resource standard.

NOTE: if the above option is chosen, no further eligibility-related options should be elected.

_X_ The agency applies the following income and/or resource standards(s):

- The resource standards of the SSI program are used.
- The income standard is 350% of the Federal poverty guidelines.

Citation(s)	Condition or Requirement
1902 (a) (10) (A) (ii) (XV) of the Act (cont).	Income Methodologies In determining whether an individual meets the income standard described above, the agency uses the following methodologies: ___ The income methodologies of the SSI program. ___ The agency uses methodologies for treatment of income that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A. x__ The agency uses more liberal income methodologies than the SSI program. More liberal income methodologies are described in Supplement 8a to Attachment 2.6-A.

State: INDIANA

Citation	Condition or Requirement
1902 (a) (10) (A) (ii) (XV) of the Act (cont.)	Resource Methodologies In determining whether an individual meets the income standard described above, the agency uses the following methodologies. Unless one of the following items is checked the agency, under the authority of section 1902(r)(2) of the Act, disregards all funds held in retirement funds and accounts, including private retirement accounts such as IRAs and other individual accounts, and employer-sponsored retirement plans such as 401(k) plans, Keogh plans, and employer pension plans. Any disregard involving retirement accounts is separately described in Supplement 8b to Attachment 2.6-A. ____ The agency disregards funds held in employer-sponsored retirement plans, but not private retirement plans. ____ The agency disregards funds in retirement accounts in a manner other than those described above. The agency's disregards are specified in Supplement 8b to Attachment 2.6-A.

Citation(s)	Condition or Requirement
1902 (a) (10) (A) (ii) (XV) of the Act (cont).	___ The agency does not disregard funds in retirement accounts. x The agency uses resource methodologies in addition to any indicated above that are more liberal than those used by the SSI program. More liberal resource methodologies are described in Supplement 8b to Attachment 2.6-A. ___ The agency uses the resource methodologies of the SSI program. ___ The agency uses methodologies for treatment of resources that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 5 to Attachment 2.6-A.

State: INDIANA

Citation		Condition or Requirement
1902 (a)(10)(A) (ii)(XVI) of the Act	(iii)	Working Individuals with Disabilities - Employed Medically Improved Individuals - TWWIIA

In determining financial eligibility for employed medically improved individuals under this provision, the following standards and methodologies are applied:

____ The agency does not apply any income or resource standard.

NOTE: if the above option is chosen, no further eligibility-related options should be elected.

__X__ The agency applies the following income and/or resource standards(s):

- The resource standards of the SSI program are used.
- The income standard is 350% of the Federal poverty guidelines.

Citation(s)	Condition or Requirement
1902 (a) (10) (A) (ii) (XVI) of the Act (cont).	Income Methodologies In determining whether an individual meets the income standard described above, the agency uses the following methodologies: ___ The income methodologies of the SSI program. ___ The agency uses methodologies for treatment of income that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A. x The agency uses more liberal income methodologies than the SSI program. More liberal income methodologies are described in Supplement 8a to Attachment 2.6-A.

State: INDIANA

Citation	Condition or Requirement
1902 (a) (10) (A) (ii) (XVI) of the Act (cont.)	Resource Methodologies In determining whether an individual meets the resource standard described above, the agency uses the following methodologies. Unless one of the following items is checked the agency, under the authority of section 1902(r)(2) of the Act, disregards all funds held in retirement funds and accounts, including private retirement accounts such as IRAs and other individual accounts, and employer-sponsored retirement plans such as 401(k) plans, Keogh plans, and employer pension plans. Any disregard involving retirement accounts is seperately described in Supplement 8b to Attachment 2.6-A. ____ The agency disregards funds held in employer-sponsored retirement plans, but not private retirement plans. ____ The agency disregards funds in retirement accounts in a manner other than those decribed above. The agency's disregards are specified in Supplement 8b to Attachment 2.6-A.

Citation(s)	Condition or Requirement
1902 (a) (10) (A) (ii) (XVI) of the Act (cont).	___ The agency does not disregard retirement accounts. x__ The agency uses resource methodologies in addition to any indicated above that are more liberal than those used by the SSI program. More liberal resource methodologies are described in Supplement 8b to Attachment 2.6-A. ___ The agency uses the resource methodologies of the SSI program. ___ The agency uses methodologies for treatment of resources that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 5 to Attachment 2.6-A.

State: INDIANA

Citation	Condition or Requirement
1902 (a)(10)(A) (ii)(XVI) and 1905 (v) (2) of the Act	Definition of Employed - Employed Medically Improved Individuals - TWWIIA ____ The agency uses the statutory definition of "employed", i.e., earning at least the minimum wage, and working at least 40 hours a month. _X_ The agency uses an alternative definition of "employed" that provides for substantial and reasonable threshold criteria for hours of work, wages, or other measures. The agency's threshold criteria are described below: The individual must be employed and be earning the equivalent of 40 hours per month at minimum wage.

State: INDIANA

Citation	Condition or Requirement
1902 (a)(10)(A)(ii)(XIII), (XV),(XVI), and 1916(g) of the Act	Payment of Premiums or Other Cost Sharing Charges For individuals eligible under the BBA eligibility group described in No. 23 on page 23d of Attachment 2.2-A: ____ The agency requires payment of premiums or other cost-sharing charges on a sliding scale based on income. The premiums or other cost-sharing charges, and how they are applied, are described below:

State: INDIANA

Citation	Condition or Requirement
1902 (a)(10)(A)(ii)(XIII), (XV),(XVI), and 1916(g) of the Act (cont.)	For individuals eligible under the Basic Coverage Group described in No. 24 on page 23d of Attachment 2.2-A, and the Medical Improvement described in No. 25 on page 23d of Attachment 2.2-A NOTE: Regardless of the option selected below, the agency MUST require that individuals whose annual adjusted gross income, as defined under IRS statute, exceeds $75,000 pay 100 percent of premiums. X The agency requires indivduals to pay premiums or other cost-sharing charges on a sliding scale based on income. For individuals with net annual income below 450 percent of the Federal poverty level for a family of the size involved, the amount of premiums cannot exceed 7.5 percent of the individual's income. The premiums or other cost-sharing charges, and how they are applied, are described on page 12o.

State: INDIANA

Citation	Condition or Requirement
1902 (a)(10)(A) (ii) (XV),(XVI), and 1916(g) of the Act (cont.)	Premiums and Other Cost-Sharing Charges

For the Basic Coverage Group and the Medical Improvement Group, the agency's premium or other cost-sharing charges, and how they are applied, are described below.

The gross income of the individual and his or her spouse is used to calculate the amount, if any, of the premium. If the gross income of the individual and his or spouse is less than 150% of the FPL, a premium is not required. If gross income of the individual and spouse is 150% or more, premiums are charged as follows:

	Monthly Premium Amount	
Gross income as a % of FPL	Individual	Married Couple
150% to 175%	$48	$65
More than 175% to 200%	$69	$93
More than 200% to 250%	$107	$145
More than 250% to 300%	$134	$182
More than 300% to 350%	$161	$218
More than 350%	$187	$254

If both members of a married couple are eligible in either the Basic Group or the Medically Improved Group, the premium from the above table based on their combined gross income is a single premium covering both spouses.

An amount paid by the recipient, spouse or parent for private health insurance that covers the recipient is deducted from the premium amount in the table to arrive at an adjusted premium.

The premium for an eligible individual will not increase for 12 consecutive months.

A maximum grace period of 60 days for non payment of the premium is allowed before coverage is discontinued.

Citation	Condition or Requirement
1902(k) of the Act	2. Medicaid Qualifying Trusts In the case of a Medicaid qualifying trust described in section 1902(k)(2) of the Act, the amount from the trust that is deemed available to the individual who established the trust (or whose spouse established the trust) is the maximum amount that the trustee(s) is permitted under the trust to distribute to the individual. This amount is deemed available to the individual, whether or not the distribution is actually made. This provision does not apply to any trust or initial trust decree established before April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded. / / The agency does not count the funds in a trust as described above in any instance where the State determines that it would work an undue hardship. Supplement 10 of ATTACHMENT 2.6-A specifies what constitutes an undue hardship.
1902(a)(10) of the Act	3. Medically needy income levels (MNILs) are based on family size. Supplement 1 to ATTACHMENT 2.6-A specifies the MNILs for all covered medically needy groups. If the agency chooses more restrictive levels under section 1902(f) of the Act, Supplement 1 so indicates.

Citation	Condition or Requirement
42 CFR 435.732, 435.831	4. Handling of Excess Income - Spend-down for the Medically Needy in All States and the Categorically Needy in 1902(f) States Only a. Medically Needy (1) Income in excess of the MNIL is considered as available for payment of medical care and services. The Medicaid agency measures available income for periods of either ____ or ___ month(s) (not to exceed 6 months) to determine the amount of excess countable income applicable to the cost of medical care and services. (2) If countable income exceeds the MNIL standard, the agency deducts the following incurred expenses in the following order: (a) Health insurance premiums, deductibles and coinsurance charges. (b) Expenses for necessary medical and remedial care not included in the plan. (c) Expenses for necessary medical and remedial care included in the plan. ___ Reasonable limits on amounts of expenses deducted from income under a.(2)(a) and (b) above are listed below.
1902(a)(17) of the Act	Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.

Citation	Condition or Requirement
	a. Medically Needy (Continued)
1903(f)(2) of the Act	___ (3) If countable income exceeds the MNIL standard, the agency deducts spenddown payments made to the State by the individual.

Citation	Condition or Requirement
	b. Categorically Needy - Section 1902 (f) States
42 CFR 435.732	The agency applies the following policy under the provisions of section 1902(f) of the Act. The following amounts are deducted from income to determine the individual's countable income: (1) Any SSI benefit received. (2) Any State supplement received that is within the scope of an agreement described in sections 1616 or 1634 of the Act, or a State supplement within the scope of section 1902(a)(10)(A)(ii)(XI) of the Act. (3) Increases in OASDI that are deducted under §§435.134 and 435.135 for individuals specified in that section, in the manner elected by the State under that section. (4) Other deductions from income described in this plan at Attachment 2.6-A, Supplement 4. (5) Incurred expenses for necessary medical and remedial services recognized under State law.
1902(a)(17) of the Act, P.L. 100-203	Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.

Citation	Condition or Requirement
	4.b. Categorically Needy - Section 1902(f) States Continued
1903(f)(2) of the Act	___ (6) Spenddown payments made to the State by the individual.
	NOTE: FFP will be reduced to the extent a State is paid a spenddown payment by the individual.

Citation	Condition or Requirement

5. Methods for Determining Resources

a. AFDC-related individuals (except for poverty level related pregnant women, infants, and children).

(1) In determining countable resources for AFDC-related individuals, the following methods are used:

(a) The methods under the State's approved AFDC plan; and

/7 (b) The methods under the State's approved AFDC plan and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.

(2) In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

Citation(s)	Condition or Requirement
1902 (a) (10) (A), 1902 (a) (10) (C), 1902 (m) (1) (B) and (C), and 1902 (r) of the Act	5. Methods for Determining Resources b. Aged individuals. For aged individuals, the agency uses the following method for treatment of resources: ___ The methods of the SSI program. __x__ SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A. ___ Methods that are more restrictive (except for individuals described in section 1902 (m) (1) of the Act) and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describes the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specifies the more liberal methods.

Citation(s)	Condition or Requirement
1902 (a) (10) (A), 1902 (a) (10) (C), 1902 (m) (1) (B) and 1902 (r) of the Act	c. Blind individuals. For blind individuals, the agency uses the following method for treatment of resources: ___The methods of the SSI program. __x__ SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A. ___ Methods that are more restrictive (except for individuals described in section 1902 (m) (1) of the Act) and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describes the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specifies the more liberal methods. In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

Citation(s)	Condition or Requirement
1902 (a) (10) (A), 1902 (a) (10) (C), 1902 (m) (1) (B) and (C), and 1902 (r) (2) of the Act	d. Disabled individuals, including individuals covered under section 1902(a) (10) (A) (ii) (X) of the Act. The agency uses the following method for the treatment of resources: ___ The methods of the SSI program. __x__ SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A. ___ Methods that are more restrictive (except for individuals described in section 1902 (m) (1) of the Act) and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describes the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specifies the more liberal methods. In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
1902 (l) (3) and 1902 (r) (2) of the Act	e. Poverty-level pregnant women covered under sections 1902 (a) (10) (A) (i) (IV) and 1902 (a) (10) (A) (ii) (IX) (A) of the Act. The agency uses the following methods in the treatment of resources: ___ The methods of the SSI program only. ___ The methods of the SSI program and/or any more liberal methods described in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.

Citation	Condition or Requirement
	___ Methods that are more liberal than those of SSI. The more liberal methods are specified in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.
	X Not applicable. The agency does not consider resources in determining eligibility.
	In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
1902(l)(3) and 1902(r)(2) of the Act	f. Poverty level infants covered under section 1902(a)(10)(A)(i)(IV) of the Act.
	The agency uses the following methods for the treatment of resources:
	___ The methods of the State's approved AFDC plan.
1902(l)(3)(C) of the Act	___ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), in accordance with section 1902(l)(3)(C) of the Act, as specified in Supplement 5a of ATTACHMENT 2.6-A.
1902(r)(2) of the Act	___ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.
	X Not applicable. The agency does not consider resources in determining eligibility.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: INDIANA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)		Condition or Requirement
1902(l)(3) and 1902(r)(2) of the Act	g.	1. Poverty level children covered under section 1902(a)(10)(A)(i)(VI) of the Act. The agency uses the following methods for the treatment of resources: ___ The methods of the State's approved AFDC plan. ___ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), in accordance with section 1902(l)(3)(C) of the Act, as specified in Supplement 5a of ATTACHMENT 2.6-A. 1902(l)(3)(C) of the Act ___ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 8b to ATTACHMENT 2.6-A. 1902(r)(2) of the Act _X_ Not applicable. The agency does not consider resources in determining eligibility. In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: INDIANA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(l)(3) and 1902(r)(2) of the Act	g. 2. Poverty level children under section 1902(a)(10)(A)(i)(VII) The agency uses the following methods for the treatment of resources: ___ The methods of the State's approved AFDC plan. ___ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive) as specified in Supplement 5a of ATTACHMENT 2.6-A. ___ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 8a to ATTACHMENT 2.6-A. _X_ Not applicable. The agency does not consider resources in determining eligibility. In determining relative responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
1902(l)(3)(C) the Act	
1902(r)(2) of the Act	

Citation	Condition or Requirement
1905(p)(1)(C) and (D) and 1902(r)(2) of the Act	5. h. For Qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act the agency uses the following methods for treatment of resources: ___ The methods of the SSI program only. X The methods of the SSI program and/or more liberal methods as described in Supplement 8b to ATTACHMENT 2.6-A.
1905(s) of the Act	i. For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the agency uses SSI program methods for the treatment of resources.
1902(u) of the Act	j. For COBRA continuation beneficiaries, the agency uses the following methods for treatment of resources: ___ The methods of the SSI program only. ___ More restrictive methods applied under section 1902(f) of the Act as described in Supplement 5 to Attachment 2.6-A.

Citation(s)	Condition or Requirement
1902 (a) (10) (E) (iii) of the Act	k. Specified low-income Medicare beneficiaries covered under section 1902 (a) (10) (E) (iii) of the Act— The agency uses the same method as in 5.h. of ATTACHMENT 2.6-A 6. Resource Standard-Categorically Needy a. 1902 (f) States (except as specified under items 6.c. and d. below) for aged, blind, and disabled individuals ___Same as SSI resource standards. ___ More restrictive. The resource standards for other individuals are the same as those in the related cash assistance program. b. Non-1902 (f) States (except as specified under items 6.c. and d. below) The resource standards for other individuals are the same as those in the related cash assistance program. Supplement 8 to ATTACHMENT 2.6.-A specifies for 1902 (f) States the categorically needy resource levels for all covered categorically needy groups.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: INDIANA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(1)(3)(A), (B) and (C) of the Act	c. For pregnant women and infants covered under the provisions of section 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act, the agency applies a resource standard. ___ Yes. Supplement 2 to ATTACHMENT 2.6-A specifies the standard which, for pregnant women, is no more restrictive than the standard under the SSI program; and for infants is no more restrictive than the standard applied in the State's approved AFDC plan. _X_ No. The agency does not apply a resource standard to these individuals.
1902(1)(3)(A) and (C) of the Act	d. For children covered under the provisions of section 1902(a)(10)(A)(i)(VI) of the Act, the agency applies a resource standard. ___ Yes. Supplement 2 to ATTACHMENT 2.6-A specifies the standard which is no more restrictive than the standard applied in the State's approved AFDC plan. _X_ No. The agency does not apply a resource standard to these individuals.

Citation(s)	Condition or Requirement
1902 (m) (1) (C) and (m) (2) (B) of the Act	e. For aged and disabled individuals described in section 1902 (m) (1) of the Act who are covered under section 1902 (a) (10) (A) (ii) (X) of the Act, the resource standard is: x Same as the SSI resource standard. ___ Same as the medically needy resource standards, which are higher than the SSI resource standards (if the State covers the medically needy). Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for these individuals.

Citation	Condition or Requirement
1902(a)(10)(C)(ii) of the Act	7. Resource Standard – Medically Needy a. Resource standards are based on family size. b. A single standard is employed in determining resource eligibility for all groups. __ c. In 1902(f) States, the resource standards are more restrictive than in 7 b above for – ____Aged ____Blind ____Disabled Supplement 2 to ATTACHMENT 2.6-A specifies the resource standards for all covered medically needy groups. If the agency chooses more restrictive levels under 7.c., Supplement 2 to ATTACHMENT 2.6-A so indicates.
1902(A)(10)(E), 1905(p)(1)(D), 1905(p)(2)(B) & 1860D-14(a)(3)(D) of the Act	8. Resource Standard – Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries and Qualifying Individuals For Qualified Medicare Beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, Specified Low-Income Medicare Beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act, and Qualifying Individuals coved under 1902(a)(10)(E)(iv) of the Act, the resource standard is three times the SSI resource limit, adjusted annually since 1996 by the increase in the consumer price index.
1902(a)(10)(E)(ii), 1905(s) and 1860D-14(a)(3)(D) of the Act	9. Resource Standard – Qualified Disabled and Working Individuals For qualified disabled and working individuals covered under section 1902(a)(10(E)(ii)of the Act, the resource standard for an individual or a couple (in the case of an individual with a spouse), is two times the SSI resource limit.

Citation		Condition or Requirement
1902(u) of the Act	9.1	For COBRA continuation beneficiaries, the resource standard is:
	___	Twice the SSI resource standard for an individual.
	___	More restrictive standard as applied under section 1902(f) of the Act as described in Supplement 8 to Attachment 2.6-A.

Citation(s)	Condition or Requirement
1902 (u) of the Act	10. Excess Resources

a. Categorically Needy, Qualified Medicare Beneficiaries, Qualified Disabled and Working Individuals, and Specified Low-Income Medicare Beneficiaries

Any excess resources make the individual ineligible.

b. Categorically Needy Only

__x__ This State has a section 1634 agreement with SSA. Receipt of SSI is provided for individuals while disposing of excess resources.

c. Medically Needy

Any excess resources make the individual ineligible.

Citation	Condition or Requirement
42 CFR 435.914	11. Effective Date of Eligibility

a. Groups Other Than Qualified Medicare Beneficiaries

(1) For the prospective period.

Coverage is available for the full month if the following individuals are eligible at any time during the month.

X Aged, blind, disabled.
X AFDC-related.

Coverage is available only for the period during the month for which the following individuals meet the eligibility requirements.

___ Aged, blind, disabled.
___ AFDC-related.

(2) For the retroactive period.

Coverage is available for three months before the date of application if the following individuals would have been eligible had they applied:

___ Aged, blind, disabled.
___ AFDC-related.

Coverage is available beginning the first day of the third month before the date of application if the following individuals would have been eligible at any time during that month, had they applied..

X Aged, blind, disabled.
X AFDC-related.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: INDIANA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1920 (b) (1) of the Act	_X_ (3) For a presumptive eligibility for pregnant women only. Coverage is available for ambulatory prenatal care for the period that begins on the day a qualified provider determines that a woman meets any of the income eligibility levels specified in ATTACHMENT 2.6-A of this approved plan. If the woman files an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination of presumptive eligibility, the period ends on the day that the State agency makes the determination of eligibility based on that application. If the woman does not file an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination, the period ends on that last day.
1902 (e) (8) and 1905 (a) of the Act	_X_ b. For qualified Medicare beneficiaries defined in section 1905 (p) (1) of the Act coverage is available beginning with the first day of the month after the month in which the individual is first determined to be a qualified Medicare beneficiary under section 1905 (p) (1). The eligibility determination is valid for— _x_ 12 months ____ 6 months ____ ____months (no less than 6 months and no more than 12 months)

Citation(s)	Condition or Requirement
1902 (a) (18) and 1902 (f) of the Act	12. Pre-OBRA 93 Transfer of Resources - Categorically and Medically Needy, Qualified Medicare Beneficiaries, and Qualified Disabled and Working Individuals. The agency complies with the provisions of section 1917 of the Act with respect to the transfer of resources. Disposal of resources at less than fair market value affects eligibility for certain services as detailed in Supplement 9 to Attachment 2.6-A.
1917 (c)	13. Transfer of Assets—All eligibility groups The agency complies with the provisions of section 1917 (c) of the Act, as enacted by OBRA 93, with regard to the transfer of assets. Disposal of assets at less than fair market value affects eligibility for certain services as detailed in Supplement 9 (a) to ATTACHMENT 2.6-A, except in instances where the agency determines that the transfer rules would work an undue hardship.
1917 (d)	14. Treatment of Trusts—All eligibility groups The agency complies with the provisions of section 1917 (d) of the Act, as amended by OBRA 93, with regard to trusts. ___ The agency uses more restrictive methodologies under section 1902 (f) of the Act, and applies those methodologies in dealing with trusts. __x__ The agency meets the requirements in section 1917 (d) (4) (B) of the Act for use of Miller trusts. The agency does not count the funds in a trust in any instance where the agency determines that the transfer would work an undue hardship, as described in Supplement 10 to ATTACHMENT 2.6-A.

Citation	Condition or Requirement
1924 of the Act	13. The agency complies with the provisions of §1924 with respect to income and resource eligibility and posteligibility determinations for individuals who are expected to be institutionalized for at least 30 consecutive days and who have a spouse living in the community. When applying the formula used to determine the amount of resources in initial eligibility determinations, the State standard for community spouses is: ___ the maximum standard permitted by law; __X__ the minimum standard permitted by law; or $___ a standard that is an amount between the minimum and the maximum.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: INDIANA

INCOME ELIGIBILITY LEVELS

A. MANDATORY CATEGORICALLY NEEDY

1. AFDC-Related Groups Other Than Poverty Level Pregnant Women and Infants:

	Unit with a Recipient Parent and/or Caretaker		Unit with Recipient Children Only	
Family Size	Need Standard	Maximum Payment	Need Standard	Maximum Payment
1	155	139	155	139
2	255	229	220	198
3	320	288	285	256
4	385	346	350	315
5	450	405	415	373
6	515	463	480	432
7	580	522	545	490
8	645	580	610	549
9	710	639	675	607
10	775	697	740	666

$65 for each additional member

(A) 2/14/97 KB

2. Pregnant Women and Infants under Section 1902(a)(10)(i)(IV) of the Act:

Effective April 1, 1990, based on the following percent of the official Federal income poverty level--

☐ 133 percent ☒ 150 percent (no more than 185 percent)
(specify)

Family Size	Income Level
1	$
2	$
3	$
4	$
5	$

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: INDIANA

INCOME ELIGIBILITY LEVELS

A. MANDATORY CATEGORICALLY NEEDY (Continued)

3. For children under Section 1902(a)(10)(i)(VI) of the Act (children who have attained age 1 but have not attained age 6), the income eligibility level is 133 percent of the Federal poverty level (as revised annually in the Federal Register) for the size family involved.

4. For children under Section 1902(a)(10)(i)(VII) of the Act (children who were born after September 30, 1983 and have attained age 6 but have not attained age 19), the income eligibility level is 100 percent of the Federal poverty level (as revised annually in the Federal Register) for the size family involved.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: INDIANA

N/A

INCOME ELIGIBILITY LEVELS - (Continued)

B. OPTIONAL CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

1. Pregnant Women and Infants

The levels for determining income eligibility for optional groups of pregnant women and infants under the provisions of sections 1902(a)~~(I)~~(A)(ii)(IX) and 1902(1)(2) of the Act as follows: (10) RS 12/19/97

Based on percent of the official Federal income poverty level (no less than 133 percent and no more than 185 percent).

FAMILY SIZE	INCOME LEVEL
1	
2	
3	
4	
5	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: INDIANA - N/A

INCOME ELIGIBILITY LEVELS (Continued)

B. OPTIONAL CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

2. Children Between Ages 6 and 8

The levels for determining income eligibility for groups of children who are born after September 30, 1983 and who have attained 6 years of age but are under 8 years of age under the provisions of section 1902(l)(2) of the Act are as follows:

Based on _____ percent (no more than 100 percent) of the official Federal income poverty line.

Family Size	Income Level
1	$_____
2	$_____
3	$_____
4	$_____
5	$_____
6	$_____
7	$_____
8	$_____
9	$_____
10	$_____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

INCOME ELIGIBILITY LEVELS (Continued)

The levels for determining income eligibility for groups of aged and disabled individuals under the provisions of section 1902(m)(4) of the Act are as follows:

Based on 100 percent of the official Federal income poverty line.

Family Size	Income Level
1	$11,670
2	$15,730
3	$
4	$
5	$

If an individual receives a title II benefit, any amount attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level.

For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period.

For individuals not receiving title II income, the revised poverty levels are effective no later than the beginning of the month following the date of publication.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

INCOME ELIGIBILITY LEVELS (Continued)

OPTIONAL CATEGORICALLY NEEDY GROUP OF INSTITUTIONALIZED INDIVIDUALS UNDER A SPECIAL INCOME LEVEL (SECTION 1902(A)(10)(A)(II)(V))

Single individual	$2,163
Married couple	$3,246

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

INCOME ELIGIBILITY LEVELS (Continued)

C. QUALIFIED MEDICARE BENEFICIARIES WITH INCOMES RELATED TO THE FEDERAL POVERTY LEVEL

The levels for determining income eligibility for groups of qualified Medicare beneficiaries under the provisions of section 1905 (p) (2) (A) of the Act are as follows:

1. NON-SECTION 1902(f) STATES

a. Based on the following percent of the official Federal income poverty level:

Eff. Jan, 1, 1989: [ ] 85 percent [ ] ___ percent (no more than 100)

Eff. Jan, 1, 1989: [ ] 90 percent [ ] ___ percent (no more than 100)

Eff. Jan. 1, 1991: 100 percent

Eff. Jan 1, 1992: 100 percent

b. Levels:

Family Size	Income Levels
1	$11,670
2	$15,730

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

INCOME ELIGIBILITY LEVELS (Continued)

C. QUALIFIED MEDICARE BENEFICIARIES WITH INCOMES RELATED TO THE FEDERAL POVERTY LEVEL

1. SECTION 1902 (f) STATES WHICH AS OF JANUARY 1, 1987 USED INCOME STANDARDS MORE RESTRICTIVE THAN SSI

a. Based on the following percent of the official Federal income poverty level:

Eff. Jan, 1, 1989: __ 80 percent

Eff. Jan, 1, 1989: __ 85 percent

Eff. Jan. 1, 1991: __ 95 percent

Eff. Jan 1, 1992: 100 percent

b. Levels:

Family Size	Income Levels
1	
2	
3	
4	
5	
6	
7	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: INDIANA - N/A

INCOME LEVELS (Continued)

D. MEDICALLY NEEDY

_____ Applicable to all groups.

_____ Applicable to all groups except those specified below. Excepted group income levels are also listed on an attached page 3.

(1)	(2)	(3)	(4)	(5)
Family Size	Net income level protected for maintenance for _____months /__/ urban only /__/ urban & rural	Amount by which Column (2) exceeds limits specified in 42 CFR 435.1007[1/]	Net income level for persons living in rural areas for _____months	Amount by which Column (4) exceeds limits specified in 42 CFR 435.1007[1/]
1	$	$	$	$
2	$	$	$	$
3	$	$	$	$
4	$	$	$	$
For each additional person, add:	$	$	$	$

[1/] The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: INDIANA - N/A

INCOME LEVELS (Continued)

D. MEDICALLY NEEDY

(1) Family Size	(2) Net income level protected for maintenance for _____months /_/ urban only /_/ urban & rural	(3) Amount by which Column (2) exceeds limits specified in 42 CFR 435.1007[1/]	(4) Net income level for persons living in rural areas for _____months	(5) Amount by which Column (4) exceeds limits specified in 42 CFR 435.1007[1/]
5	$	$	$	$
6	$	$	$	$
7	$	$	$	$
8	$	$	$	$
9	$	$	$	$
10	$	$	$	$
For each additional person, add:	$	$	$	$

[1/] The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: INDIANA

RESOURCE LEVELS - No Resource Standard

A. CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

1. Pregnant Women

a. Mandatory Groups

/_/ Same as SSI resources levels.

/_/ Less restrictive than SSI resource levels and is as follows:

Family Size	Resource Level
1	
2	

b. Optional Groups

/_/ Same as SSI resources levels.

/_/ Less restrictive than SSI resource levels and is as follows:

Family Size	Resource Level
1	
2	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: INDIANA

2. Infants — No Resource Standard

a. Mandatory Group of Infants

/_/ Same as resource levels in the State's approved AFDC plan.

/_/ Less restrictive than the AFDC levels and are as follows:

Family Size	Resource Level
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: INDIANA

b. Optional Group of Infants — No Resource Standard

/_/ Same as resource levels in the State's approved AFDC plan.

/_/ Less restrictive than the AFDC levels and are as follows:

Family Size	Resource Level
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: INDIANA

3. Children — NO RESOURCE STANDARD

a. Mandatory Group of Children under Section 1902(a)(10)(i)(VI) of the Act. (Children who have attained age 1 but have not attained age 6.)

___ Same as resource levels in the State's approved AFDC plan.

___ Less restrictive than the AFDC levels and are as follows:

Family Size	Resource Level
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: INDIANA - N/A

b. Optional Group of Children

/_/ Same as resource levels in the State's approved AFDC plan.

/_/ Less restrictive than the AFDC levels and are as follows:

Family Size	Resource Level
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

4. Aged and Disabled Individuals

[x] Same as SSI resource levels.

[ ] More restrictive than SSI levels and are as follows:

Family Size	Resource Level
1	
2	
3	
4	
5	

[ ] Same as medically needy resource levels (applicable only if State has a medically needy program).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: INDIANA - N/A

RESOURCE LEVELS (Continued)

B. MEDICALLY NEEDY

Applicable to all groups -

/_/ Except those specified below under the provisions of section 1902(f) of the Act.

Family Size	Resource Level
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
For each additional person	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____

REASONABLE LIMITS ON AMOUNTS FOR NECESSARY MEDICAL
OR REMEDIAL CARE NOT COVERED UNDER MEDICAID

N/A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

METHODS FOR TREATMENT OF INCOME THAT DIFFER FROM THOSE OF THE SSI PROGRAM

(Section 1902(f) more restrictive methods and criteria and State supplement criteria in SSI criteria States without section 1634 agreements and in section 1902(f) States. Use to reflect more liberal methods only if you limit to State supplement recipients. DO NOT USE this supplement to reflect more liberal policies that you elect under the authority of section 1902(r)(2) of the Act. Use Supplement 8a for section 1902(r)(2) methods.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

MORE RESTRICTIVE METHODS OF TREATING RESOURCES THAN THOSE OF THE SSI PROGRAM- SECTION 1902(f) STATES ONLY

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: INDIANA

MORE RESTRICTIVE METHODS OF TREATING RESOURCES
THAN THOSE OF THE SSI PROGRAM - Section 1902(f) States only

5. For individuals who have been continuously institutionalized since before September 30, 1989 and who are married to community spouses, spousal resources are deemed to the applicant/recipient (including the initial month of institutionalization). The couple's countable resources are subject to the $2250 limitation listed in Supplement 8 to Attachment 2.6-A.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: INDIANA

METHODS FOR TREATMENT OF RESOURCES FOR INDIVIDUALS
WITH INCOMES RELATED TO FEDERAL POVERTY LEVELS

(Do not complete if you are electing more liberal methods under the authority of section 1902(r)(2) of the Act instead of the authority specific to Federal poverty levels. Use Supplement 8b for section 1902(r)(2) methods.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Standards for Optional State Supplementary Payments

Payment Category (Reasonable Classification)	Administered by Federal	Administered by State	Income Level Gross Individual	Income Level Gross Couple	Income Level Net Individual	Income Level Net Couple	Income Disregards Employed
(1) Aged, Blind and Disabled Individuals in Domiciliary Facilities	(2)	X	(3) 3 Times Maximum SSI/FBR	3 Times Maximum SSI/FBR	(4) $1,501.06* (Amount Set by FSSA each year)	$3,002.12* (Amount Set by FSSA each year)	(5) First $52 for personal needs allowance. A monthly maximum one-third the amount of state and local income tax liability until paid. For sheltered workshop participants & persons whose employment is part of a habilitation plan, disregard from gross income: 1) $16; and 2) transportation expenses; and 3) payroll taxes; and 4) ½ of the remainder after item 1,2,3 are subtracted.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Standards for Optional State Supplementary Payments

Payment Category (Reasonable Classification)	Administered by Federal	State	Income Level				Income Disregards Employed
			Gross		Net		
			Individual	Couple	Individual	Couple	
Supplemental Security Income cash recipients with $30 federal benefits rate		X	$22	$44	$22	$44	For sheltered workshop participants & persons whose employment is part of a habilitation plan, disregard from gross income: 1) $16; and 2) transportation expenses; and 3) payroll taxes; and 4) ½ of the remainder after item 1,2,3 are subtracted.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

INCOME LEVELS FOR 1902(f) STATES—CATEGORICALLY NEEDY WHO ARE COVERED UNDER REQUIREMENTS MORE RESTRICTIVE THAN SSI SECTION

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

RESOURCE STANDARDS FOR 1902(f) STATES—CATEGORICALLY NEEDY

Supplement 8 to Attachment 2.6-A
Addendum

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE INDIANA

Pursuant to a preliminary injunction issued in Cherry and Newkirk v. Magnant on June 7, 1990 by the U.S. District Court, Southern District of Indiana, Indianapolis Division, the eligibility of members of the certified plaintiff class as defined below is determined without consideration of the value of resources owned solely by the community spouse. Resources owned solely by the community spouse are exempt. The resource limitation for the institutionalized spouse is $1500. Class members are the categorically needy group described in 42 CFR 435.121. The court order is specific to the policy of deeming spousal resources in situations involving individuals institutionalized prior to September 30, 1989 who have spouses living in the community. Therefore, the $2250 resource limitation listed in Supplement 8 to Attachment 2.6-A is not applicable under the preliminary injunction in determining eligibility of members of the plaintiff class.

In the resource determination (including the initial month of institutionalization) SSI spousal deeming rules are used.

Certified Plaintiff Class

All married Medicaid applicants in the State of Indiana who have lived in a nursing home since before September 30, 1989 and who have been found ineligible for the Medicaid program because of resources owned by their spouses living at home.

(Eff. 4-1-90)

****

Beginning 11/1/94, the resources owned by the community spouse of individuals who have been continuously institutionalized since before September 30, 1989 are deemed available to the institutionalized spouse. The federal district court vacated the injunction and the Seventh Circuit Court of Appeals affirmed. (Cherry v. Sullivan, No. 93-3504, July 20, 1994.)

TN No. 94-033 Approval Date 1/19/95 Effective Date ~~11/1/94~~

Supercedes TN No. 91-22

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

MORE LIBERAL METHODS OF TREATING INCOME
UNDER SECTION 1902(r)(2) OF THE ACT*

____ Section 1902(f) State _X_ Non-section 1902(f) State

1. For the groups covered by Section 1902(a)(10)(E) of the Social Security Act:

   The value of in-kind support and maintenance is disregarded. [Effective 4/1/98]

   For Qualified Medicare Beneficiaries (QMB), 1902 (a) (10) (E) (i), disregard income in the amount of the difference between 100% of the Federal Poverty Level and 150% of the Federal Poverty Level. [Effective 6/1/14]

   For Specified Low-Income Beneficiaries (SLMB), 1902(a) (10) (E) (iii), disregard income in the amount of the difference between 150% of the Federal Poverty Level and 170% of the Federal Poverty Level. [Effective 6/1/14]

   For Qualifying Individuals (QI), 1902(a)(10) (E) (iv), disregard income in the amount of the difference between 170% of the Federal Poverty Level and 185% of the Federal Poverty Level. [Effective 6/1/14]

2. For the groups covered by Section 1902(a)(10)(A)(ii)(XXII) who are eligible for home and community-based services under the needs based criteria established 1915(i)(1)(A) and have income that does not exceed 150% of the FPL:

   Disregard income in the amount of the difference between 150% of the Federal Poverty Level and 300% of the Federal Poverty Level. [Effective 6/1/14]

3. For groups covered under 1902(a)(10)(A)(ii)(X) of the Act: [Effective 6/1/2014]

   A child allocation is deducted for each child of the applicant's or the applicant's spouse living in the household. The allocation is equal to the difference between the Supplement Security Income federal benefit rate for a couple and a single individual. For the unmarried applicant, an allocation is made for each child of the applicant's living in the applicant's household and is deducted first from the applicant's unearned income, and then, if there is a remainder, from the applicant's earned income.

   For the married applicant:

   An allocation is made for each child of the applicant's living in the applicant's household is deducted from the applicant's and applicant's spouses combined unearned income. If there is a remainder, it is deducted from the applicant's and applicant's spouse's earned income.

If a married applicant has stepchildren living in the home, the spouse's income must first be allocated to meet the needs of the spouse's own biological or adoptive dependent children and who are living with the couple and are not dependent children of the applicant. This is done before combining the applicant's spouse's income with the spouse's income, whether the applicant's spouse has unearned or earned income. This allocation for an applicant's step-child is done first from the applicant's spouse's unearned income if the spouse has both earned and unearned income.

For the applicant child:

An allocation is made from the parent(s)' income to any dependent children that is a sibling of the applicant child living in the household. The allocation is first made from combined unearned income of the each parent living with the applicant child. If there is a remainder, it is deducted from the combined earned income of each parent living with the applicant child.

4. For children covered under 1902(a)(10)(a)(i)(VI) and 1902(l)(1)(C):

   Disregard income in the amount of the difference between 133% and 150% of the Federal Poverty Level for the family size involved, as revised annually in the Federal Register.
   [Effective 7/1/98]

5. For children covered under 1902(a)(10)(A)(i)(VII) and 1902(l)(1)(D):

   Disregard income in the amount of the difference between 100% and 150% of the Federal Poverty Level for the family size involved, as revised annually in the Federal Register.
   [Effective 7/1/98]

6. For the groups covered by Section 1902(a)(10)(A)(ii)(XV) and 1902(a)(10)(A)(ii)(XVI):

   - Parental income is exempt.
   - The income of the spouse of the applicant/recipient is exempt in the eligibility determination.

   [Effective 7/1/02]

7. For pregnant women and infants covered under Section 1902(a)(10)(A)(i)(IV) and Section 1902(l)(1)(A) and 1902(1) (1) (B)::

   Disregard income in the amount of the difference between 150% and 200% of the Federal Poverty Level for the family size involved, as revised annually in the Federal Register.

*More liberal income methods may not result in exceeding gross income limitation under Section 1903(f).

8. All wages paid by the Census Bureau for temporary employment related to Census activities are excluded for the following groups:

_x_ Qualified children and pregnant women under 1902(a)(10)(A)(i)(III).

_x_ Poverty level pregnant women and infants under 1902(a)(10)(A)(i)(IV).

_x_ Poverty level children aged 1 up to age 6 under 1902 (a)(10)(A)(i)(VI).

_x_ Poverty level children aged 6 up to age 19 under 1902 (a)(10)(A)(i)(VII).

_x_ Optional categorically needy groups under 1902 (a) (10) (A) (ii) as listed below:

_x_ Optional aged and disabled poverty level category under 1902(a)(10)(A)(ii)(X)

_x_ Independent foster care adolescents under 1902(a)(10)(A)(ii)(XVII)
_x_ Certain classifications of children covered under 1902(a)(10)(A)(ii)(I) as approved in Supplement 1 to Attachment 2.2-A;
_x_ Disabled workers under 1902(a)(10)(A)(ii)(XV)

NOTE: The Special Income Level Group under 1902(a)(10)(A)(ii)(V), the Individuals Who Would be Eligible if In an Institution Group under 1902 (a) (10) (A) (ii) (VI) and the Hospice Group under 1902 (a) (10) (A) (ii) (VII) cannot be included in this disregard.

___ Medically Needy under 1902(a)(10)(C)(i)(III).

___ All aged, blind, or disabled groups in 209 (b) states under 1902(f).

_X_ QMBs, SLMBs, and QI's under 1905(p).

*More liberal methods may not result in exceeding gross income limitation under Section 1903(f)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

MORE LIBERAL METHODS OF TREATING RESOURCES UNDER SECTION 1902 (r) (2) of the Act

____ Section 1902(f) State

_X_ Non-section 1902(f) State

I. CONSIDERATION OF REAL PROPERTY AND LIFE INTEREST IN REAL PROPERTY

Eligibility groups covered:

[8-1-89, SPA 89-3]

Aged, Blind, and Disabled 1902(a)(10)(ii)(X) and 1902(m)(1) and (3) of the Act

Qualified Medicare Beneficiary—Section 1902 (A)(10)(E) of the Social Security Act.

Specified Low-Income Medicare Beneficiary—Section 1902 (a)(10)(E)(iii) and 1905 (p)(3)(A)(ii)

[SPA 02-003]

Workers with Disabilities—Sections 1902 (a)(10)(A)(ii)(XV) and 1902 (a)(10)(A)(ii)(XVI) of the Social Security Act.

A. Non-Exempt real property (including equity value) which would otherwise render an applicant/recipient ineligible is excluded from eligibility purposes if the applicant/recipient signs an agreement to sell or rent property and offers the property for sale or rent at current market value within 30 days of notification of eligibility in case of an applicant and 30 days from the signing of agreements by recipients.

B. Income-producing property is exempt if the income is greater than the expenses of ownership.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

II. Consideration of Resources Invested in Qualified Term Care Insurance

Eligibility Groups covered:

Aged, Blind, and Disabled 1902(a)(10)(ii)(X) and 1902(m)(1) and (3) of the Act

Qualified Medicare Beneficiary-Section 1902 (a) (10) (E) of the Social Security Act

A. A resource disregard in the amount specified in Item B below is given to an individual who has purchased a qualified long term care insurance policy as defined in Indiana Code 12-15-39.6, or a long term care insurance policy issued in another state including both original partnership states that have entered into a reciprocal agreement with Indiana pursuant to Indiana Code 12-15-39.6-13 and Section 1917(b)(1)(c) of the Social Security Act and New Partnership States authorized under Section 6021 of Public Law 109-171, is such long term Care insurance policy is covered under the reciprocity agreement and has used such policy to pay long term care services in a setting other than an acute wing of a hospital.

Effective April 1, 2009, Indiana shall accept all of the reciprocity standards promulgated pursuant to Section 6021(b) of Public Law 109-171 with respect to all other states agreeing to participate under such reciprocity standards.

If an individual is entitled to a resource disregard under this provision, the individual's resources that are subject to the disregard are also disregarded in determining the eligibility of the individual's spouse or minor child, if the individual's resources would otherwise be considered in determining eligibility for the spouse or child. In determining eligibility for the spouse or child, the disregard applies to the following:

(1) All resources in the sole name of the individual;
(2) All ownership interest in resources held jointly with someone other than the Medicaid applicant; and
(3) Fifty percent (50%) of all resources jointly held with the Medicaid applicant.

B. The amount of the disregard is equal to the following:
   (1) For individuals who purchase less than the State set dollar amount* of qualified insurance policy benefits, the amount of the disregard is equal to the amount of payments made under the insurance policy.
   (2) For individuals who purchase the State Set dollar amount* or more of qualified insurance policy benefits, the amount of the disregard is equal to all of the individual's resources once the insurance policy benefits have been exhausted.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

(3) For individuals who purchase a long term care insurance policy in another state and such policy is covered under a reciprocal agreement defined in Item A above, the amount of the disregard is equal to the amount of payments made under the insurance policy.

C. The phrase "State set dollar amount" used in Item B above is equal to $305,603 in calendar year 2014 and increases by 5% compounded each calendar year, rounded to the nearest one dollar (i.e. year 2015 = 320,883; year 2016 = $336,927; year 2017 = $353,773)

D. Such disregard is in effect for the lifetime of the individual who has purchased the long term care insurance policy and used the policy to pay for long term care services.

E. Resources disregarded under this provision are not subject to recovery of medical payments made on behalf of the individual.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER SECTION 1902 (r) (2) of the Act

____ Section 1902(f) State _X_ Non-section 1902(f) State

III. CONSIDERATION OF IRREVOCABLE TRUSTS, FUNERAL AGREEMENTS, AND LIFE INSURANCE POLICIES FOR FUNERAL AND BURIAL EXPENSES

[4/1/14; SPA 13-012] Eligibility groups covered:
Aged, Blind, and Disabled 1902(a)(10)(ii)(X) and 1902(m)(1) and (3) of the Act

A. One (1) irrevocable trust that has a value of not more than ten thousand dollars ($10,000), exclusive of interest, and is established for the sole purpose of providing money for the burial of the applicant or recipient is exempt.
    (1) The entire amount of an irrevocable funeral trust or escrow established under Indiana state law, Ind. Code § 30-2-13 is exempt.

B. An irrevocable prepaid funeral agreement having a value of not more than ten thousand dollars ($10,000) is exempt.

C. A life insurance policy with a face value of not more than ten thousand dollars ($10,000) to which provision is made to pay not more than ten thousand dollars ($10,000) toward the applicant or recipient's funeral expenses is exempt.

An applicant or recipient who owns resources described by A, B, or C and the total value of those resources is more than ten thousand dollars ($10,000), the value of those resources that is more than ten thousand dollars ($10,000) is not considered an exempt resource in determining the applicant's or recipient's eligibility for Medicaid.

IV. WORK INCENTIVE METHODOLOGIES

Eligibility groups covered:
Workers with Disabilities- Sections 1902 (a) (10) (A) (ii) (XV) and 1902 (a)(10)(A)(ii)(XVI) of the Social Security Act.

A. Resources of the parents of applicants/recipients are exempt.

B. Up to $20,000 of funds owned by the applicant/recipient that are approved by the central office of the Division of Family and Children as an "independence and self-sufficiency account" are exempt. Funds set aside for this purpose must be for the intention of purchasing goods or services that will increase or maintain the individual's employability.

C. All retirement accounts owned by the applicant/recipient and spouse are exempt.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: INDIANA

TRANSFER OF RESOURCES

1902(f) and 1917 of the Act

The agency provides for the denial of eligibility by reason of disposal of resources for less than fair market value.

A. Except as noted below, the criteria for determining the period of ineligibility are the same as criteria specified in section 1613(c) of the Social Security Act (Act).

1. Transfer of resources other than the home of an individual who is an inpatient in a medical institution.

a. /XX for transfers occuring prior to 7-1-88

The agency uses a procedure which provides for a total period of ineligibility greater than 24 months for individuals who have transferred resources for less than fair market value when the uncompensated value of disposed of resources exceeds $12,000. This period bears a reasonable relationship to the uncompensated value of the transfer. The computation of the period and the reasonable relationship of this period to the uncompensated value is described as follows:

If the uncompensated value exceeds $12,000, the period of ineligibility begins on the date of the transfer and extends until the individual incurs medical expenses, not subject to payment by a third party, equaling the uncompensated value, not to exceed 5 years.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: INDIANA

b. /XX/ The period of ineligibility is less than 24 months, as specified below:

If the uncompensated value is $12,000 or less, the period of ineligibility begins on the date of the transfer and extends until the individual incurs medical expenses, not subject to payment by a third party, equaling the uncompensated value, not to exceed 24 months.

c. /__/ The agency has provisions for waiver of denial of eligibility in any instance where the State determines that a denial would work an undue hardship.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: INDIANA

2. Transfer of the home of an individual who is an inpatient in a medical institution.

/XX A period of ineligibility applies to inpatients in an SNF, ICF or other medical institution as permitted under section 1917(c)(2)(B)(i).

Subject to the exceptions on page 2 of this supplement, an individual is ineligible for 24 months after the date on which he disposed of the home. However, if the uncompensated value of the home is less than the average amount payable under this plan for 24 months of care in an SNF, the period of ineligibility is a shorter time, bearing a reasonable relationship (based on the average amount payable under this plan as medical assistance for care in an SNF) to the uncompensated value of the home as follows:

See Addendum 1 to Supplement 9 to Attachment 2.6-A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: INDIANA

b. /7 Subject to the exceptions on page 2 of this supplement, if the uncompensated value of the home is more than the average amount payable under this plan as medical assistance for 24 months of care in an SNF, the period of ineligibility is more than 24 months after the date on which he disposed of the home. The period of ineligibility bears a reasonable relationship (based upon the average amount payable under this plan as medical assistance for care in an SNF) to the uncompensated value of the home as follows:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: INDIANA

No individual is ineligible by reason of item A.2 if--

(i) A satisfactory showing is made to the agency (in accordance with any regulations of the Secretary of Health and Human Services) that the individual can reasonably be expected to be discharged from the medical institution and to return to that home;

(ii) Title to the home was transferred to the individual's spouse or child who is under age 21, or (for States eligible to participate in the State program under title XVI of the Social Security Act) is blind or permanently and totally disabled or (for States not eligible to participate in the State program under title XVI of the Social Security Act) is blind or disabled as defined in section 1614 of the Act;

(iii) A satisfactory showing is made to the agency (in accordance with any regulations of the Secretary of Health and Human Services) that the individual intended to dispose of the home either at fair market value or for other valuable consideration; or

(iv) The agency determines that denial of eligibility would work an undue hardship.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: INDIANA

3. 1902(f) States

☑ Under the provisions of section 1902(f) of the Social Security Act, the following transfer of resource criteria more restrictive than those established under section 1917(c) of the Act, apply:

B. Other than those procedures specified elsewhere in the supplement, the procedures for implementing denial of eligibility by reason of disposal of resources for less than fair market value are as follows:

1. If the uncompensated value of the transfer is $12,000 or less:

2. If the uncompensated value of the transfer is more than $12,000:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: INDIANA

3. If the agency sets a period of ineligibility of less than 24 months and applies it to all transfers of resources (regardless of uncompensated value):

4. Other procedures:

B. For transfers occuring on or after 7-1-88 the State applies the provisions of Section 1917(c) of the Social Security Act.

An institutionalized spouse who (or whose spouse) transferred resources for less than fair market value shall not be found ineligible for nursing facility services, for a level of care in a medical institution equivalent to that of nursing facility services, or for home and community-based services where the State determines that denial of eligibility would work an undue hardship under the provision of section 1917(c)(2)(D) of the Social Security Act.

Addendum 1
to Supplement 9 to Attachment 2.6-A

Indiana

A period of ineligibility is not applied if the applicant transfers property which meets the definition of the home as outlined below. If the transferred property does not meet the definition of the home, a period of ineligibility is applied as in Item A. 1. a. of Supplement 9 to Attachment 2.6-A, Page 1, or Item b. of Supplement 9 to Attachment 2.6-A, Page 2.

The "home" is defined as the principal place of residence of:

The applicant/recipient;

The spouse of the applicant/recipient;

The parents of an applicant/recipient under age 18;

The biological or adoptive child(ren) under age 18 of the applicant/recipient; or

The biological or adoptive, disabled or blind child(ren) age 18 or older of the applicant/recipient.

The property is considered as "the home" until it is verified than none of the persons listed above intends to reside there or is physically able to reside there.

TM No. 85-8

Approval Date 5-6-85 **Effective Date** 4-1-85

Supercedes
TM No. _____

HCFA ID: E/0002P

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Indiana

TRANSFER OF ASSETS

1917(c) The agency provides for the denial of certain Medicaid services by reason of disposal of assets for less than fair market value.

1. Institutionalized individuals may be denied certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date.

The agency withholds payment to institutionalized individuals for the following services:

Payments based on a level of care in a nursing facility;

Payments based on a nursing facility level of care in a medical institution;

Home and community-based services under a 1915 waiver.

2. Non-institutionalized individuals:

___ The agency applies these provisions to the following non-institutionalized eligibility groups. These groups can be no more restrictive than those set forth in section 1905(a) of the Social Security Act:

The agency withholds payment to non-institutionalized individuals for the following services:

Home health services (section 1905(a)(7));

Home and community care for functionally disabled and elderly adults (section 1905(a)(22));

Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section 1905(a)(24).

___ The following other long-term care services for which medical assistance is otherwise under the agency plan:

State: Indiana

TRANSFER OF ASSETS

3. Penalty Date--The beginning date of each penalty period imposed for an uncompensated transfer of assets is:

   _____ the first day of the month in which the asset was transferred;

   __X__ the first day of the month following the month of transfer.

4. Penalty Period - Institutionalized Individuals--
   In determining the penalty for an institutionalized individual, the agency uses:

   __X__ the average monthly cost to a private patient of nursing facility services in the agency;

   _____ the average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized.

5. Penalty Period - Non-institutionalized Individuals--
   The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services;

   _____ imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

State: Indiana

TRANSFER OF ASSETS

6. Penalty period for amounts of transfer less than cost of nursing facility care--

a. Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency:

_X__ does not impose a penalty;

_____ imposes a penalty for less than a full month, based on the proportion of the agency's private nursing facility rate that was transferred.

7. Transfers made so that penalty periods would overlap--
The agency:

____ totals the value of all assets transferred to produce a single penalty period;

_X_ calculates the individual penalty periods and imposes them sequentially.

8. Transfers made so that penalty periods would not overlap--
The agency:

____ assigns each transfer its own penalty period

_X_ uses the method outlined below:

For transfers made in consecutive months, the agency totals the uncompensated value of the transfers and establishes a penalty period, based on the cumulative transfer value, which begins in the month following the month of the first transfer, if that month does not occur in another transfer penalty period.

State: Indiana

TRANSFER OF ASSETS

9. Penalty periods - transfer by a spouse that results in a penalty period for the individual--

(a) The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.

The period of ineligibility, or any portion of that period, is apportioned between the applicant or recipient and the applicant's or recipient's spouse, if the spouse otherwise becomes eligible for medical assistance as specified in regulations promulgated under 42 U.S.C. 1396p(c)(4) by the Secretary of Health and Human Services.

(b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

10. Treatment of income as an asset--
When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

___ The agency will impose partial month penalty periods.

When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

___ For transfers of individual income payments, the agency will impose partial month penalty periods.

_X_ For transfers of the right to an income stream, the agency will use the actuarial value of all payments transferred.

___ The agency uses an alternate method to calculate penalty periods, as described below:

State: Indiana

TRANSFER OF ASSETS

11. Imposition of a penalty would work an undue hardship--
The agency does not apply the transfer of assets provisions in any case in which the agency determines that such an application would work an undue hardship. The agency will use the following procedures in making undue hardship determinations:

The following criteria will be used to determine whether the agency will not count assets transferred because the penalty would work an undue hardship:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **INDIANA**

TRANSFER OF ASSETS

1917(c) For transfers of assets for less than fair market value made on or after November 9, 2009, the agency provides for the denial of certain Medicaid services.

1. Institutionalized individuals are denied coverage of certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date.

   The agency does not provide medical assistance coverage for institutionalized individuals for the following services:

   Nursing facility services;

   Nursing facility level of care provided in a medical institution;

   Home and community-based services under a 1915(c) or (d) waiver.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **INDIANA**

TRANSFER OF ASSETS

2. Non-institutionalized individuals:

___ The agency applies these provisions to the following non-institutionalized eligibility groups. These groups can be no more restrictive than those set forth in section 1905(a) of the Social Security Act:

The agency withholds payment to non-institutionalized individuals for the following services:

Home health services (section 1905(a)(7));

Home and community care for functionally disabled elderly adults (section 1905(a)(22));

Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section 1905(a)(24).

___ The following other long-term care services for which payment for medical assistance is otherwise made under the agency plan:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **INDIANA**

TRANSFER OF ASSETS

3. Penalty Date--The beginning date of each penalty period imposed for an uncompensated transfer of assets is the later of:

- the first day of a month during or after which assets have been transferred for less than fair market value;

_X_ The State uses the first day of the month in which the assets were transferred

___ The State uses the first day of the month after the month in which the assets were transferred

or

- the date on which the individual is eligible for medical assistance under the State plan and is receiving institutional level care services described in paragraphs 1 and 2 that, were it not for the imposition of the penalty period, would be covered by Medicaid;

  AND

  which does not occur during any other period of ineligibility for services by reason of a transfer of assets penalty.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **INDIANA**

TRANSFER OF ASSETS

4. Penalty Period - Institutionalized Individuals--
In determining the penalty for an institutionalized individual, the agency uses:

_X_ the average monthly cost to a private patient of nursing facility services in the State at the time of application;

___ the average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized at the time of application.

In determining the penalty for an institutionalized individual, the agency does not consider a total amount of $1,200 per year of assets transferred to a family member or nonprofit organization.

5. Penalty Period - Non-institutionalized Individuals--
The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services;

___ imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

6. Penalty period for amounts of transfer less than cost of nursing facility care--

- Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency imposes a penalty for less than a full month, based on the option selected in item 4.

_X_ The state adds together all transfers for less than fair market value made during the look-back period in more than one month and calculates a single period of ineligibility, that begins on the earliest date that would otherwise apply if the transfer had been made in a single lump sum.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **INDIANA**

TRANSFER OF ASSETS

7. Penalty periods - transfer by a spouse that results in a penalty period for the individual--

(a) The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.

(b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

8. Treatment of a transfer of income

When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

- For transfers of individual income payments, the agency will impose partial month penalty periods using the methodology selected in 6. above.

_X_ For transfers of the right to an income stream, the agency will base the penalty period on the combined actuarial value of all payments transferred.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **INDIANA**

TRANSFER OF ASSETS

9. Imposition of a penalty would work an undue hardship--

The agency does not impose a penalty for transferring assets for less than fair market value in any case in which the agency determines that such imposition would work an undue hardship. The agency will use the following criteria in making undue hardship determinations:

Application of a transfer of assets penalty would deprive the individual:

(a) Of medical care such that the individual's health or life would be endangered; or

(b) Of food, clothing, shelter, or other necessities of life.

10. Procedures for Undue Hardship Waivers

The agency has established a process under which hardship waivers may be requested that provides for:

(a) Notice to a recipient subject to a penalty that an undue hardship exception exists;

(b) A timely process for determining whether an undue hardship waiver will be granted; and

(c) A process, which is described in the notice, under which an adverse determination can be appealed.

These procedures shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the individual's personal representative.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **INDIANA**

TRANSFER OF ASSETS

11. Bed Hold Waivers For Hardship Applicants

The agency provides that while an application for an undue hardship waiver is pending in the case of an individual who is a resident of a nursing facility:

____ Payments to the nursing facility to hold the bed for the individual will be made for a period not to exceed_____ days (may not be greater than 30).

__X__ The Agency does not provide for payment to the nursing facility to hold the bed for the individual while an application for undue hardship waiver is pending.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Indiana

The agency does not apply the trust provisions in any case in which the agency determines that such application would work an undue hardship.

The following criteria will be used to determine whether the agency will not count assets transferred because doing so would work an undue hardship:

Under the agency's undue hardship provisions, the agency exempts the funds in an irrevocable burial trust.

The maximum value of the exemption for an irrevocable burial trust is $_____.

State/Territory: INDIANA

Citation	Condition or Requirement
	COST EFFECTIVENESS METHODOLOGY FOR COBRA CONTINUATION BENEFICIARIES N/A
1902(u) of the Act	Premium payments are made by the agency only if such payments are likely to be cost-effective. The agency specifies the guidelines used in determining cost effectiveness by selecting one of the following methods: ___ The methodology as described in SMM section 3598. ___ Another cost-effective methodology as described below.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Indiana

VARIATIONS FROM THE BASIC PERSONAL NEEDS ALLOWANCE

1-1-85 1. Sheltered workshop participants and persons whose employment is part of an individual habilitation plan - the personal needs allowance is the amount specified in item 2a on Page 4a of Attachment 2.6-A, plus all payroll taxes, plus transportation expenses, plus the amount determined according to the following formula: ½ of the remainder of gross income minus the sum of $16, plus payroll taxes, plus transportation expenses.

1-1-87 2. For individuals who have legal guardians - the personal needs allowance is the amount specified in item 2a on Page 4a of Attachment 2.6-A, plus an amount not to exceed $35 per month, for court-ordered guardianship fees paid to the legal guardian.

3. For individuals required to pay federal, state, and local income taxes on unearned income - the personal needs allowance is the amount specified in item 2a on Page 4a of Attachment 2.6-A, plus the amount owed and paid for taxes.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Indiana

SECTION 1924 PROVISIONS

A. Income and resource eligibility policies to determine eligibility for institutionalized individuals who have spouses living in the community are consistent with Section 1924.

B. In the determination of resource eligibility the State resource standard is the minimum standard allowed by law.

C. The definition of undue hardship for purposes of determining if institutionalized spouses receive Medicaid in spite of having excess countable resources is described below:

An institutionalized spouse who (or whose spouse) has excess resources shall not be found ineligible under title XIX of the Social Security Act, per section 1924 (c) (3) (C), where the State determines that denial of eligibility on the basis of having excess resources would work an undue hardship.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: INDIANA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

INCOME AND RESOURCE REQUIREMENTS FOR TUBERCULOSIS (TB) INFECTED INDIVIDUALS

For TB infected individuals under §1902(z)(1) of the Act, the income and resource eligibility levels are as follows:

Not applicable. Indiana does not cover this group.

Attachment 2.6-A
Supplement 15

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Indiana

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

The State covers low-income families and children under section 1931 of the Act.

In determining eligibility for Medicaid, the agency uses the AFDC standards and methodologies in effect as of July 16, 1996*, with the following modifications.

The agency continues to apply the following waivers of provisions of Part A of Title IV in effect as of July 16, 1996, or submitted prior to August 22, 1996 and approved by the Secretary on or before July 1, 1997.

Section 402(a)(7)(B) of the Act and various provisions of 45 CFR 233.20(a)(3)(i) regarding resources.
The State's resource limit for Indiana Manpower Placement and Comprehensive Training Program (IMPACT) recipient families is $1500.

Section 402(a)(18) of the Act and various provisions of 45 CFR 233.20(a)(3)(xiii) regarding the gross income test. The State substitutes the Federal Poverty Guidelines for the 185%-of-need standard for IMPACT recipient families.

Section 402(a)(41) of the Act regarding deprivation. Deprivation Requirements are not applied to anyone in the 1931 group.

Section 402(a)(1) and 402 (a)(19)(A) concerning statewideness. The State maintains a control group of TANF recipients to whom the more liberal waiver policies do not apply.

Section 402(a)(19)(G)(i), (ii), and (iii) of the Act concerning sanctions for non-compliance with TANF work requirements as set forth in Section 2.1(k) of the Waiver Terms and Conditions. The agency terminates medical assistance for IMPACT recipients (except for certain pregnant women and children) who fail to meet TANF work requirements.

* Eligibility under the TANF program is determined in the same manner as in the AFDC welfare reform demonstration project for which the Title IV-A waivers were originally approved.

State Plan under Title XIX of the Social Security Act
State: INDIANA

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

The State covers low-income families and children under section 1931 of the Act.

X The State uses less restrictive income and/or resource methodologies than those in effect as of July 16, 1996, as follows:

All wages paid by the Census Bureau for temporary employment related to Census 2000 activities are excluded. [TN No. 00-002 effective 04-01-00.]

All wages paid by the Census Bureau for temporary employment related to Census activities are excluded.

The income methodology being replaced is:
Wages are counted when determining eligibility.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: INDIANA

DISQUALIFICATION FOR LONG-TERM CARE ASSISTANCE FOR INDIVIDUALS WITH SUBSTANTIAL HOME EQUITY

1917(f) The State agency denies reimbursement for nursing facility services and other long-term care services covered under the State plan for an individual who does not have a spouse, child under 21 or adult disabled child residing in the individual's home, when the individual's equity interest in the home exceeds the following amount:

_X_ $500,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest $1,000).

_____ An amount that exceeds $500,000 but does not exceed $750,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest $1,000).

The amount chosen by the State is _____.

_____ This higher standard applies statewide.

_____ This higher standard does not apply statewide. It only applies in the following areas of the State:

_____ This higher standard applies to all eligibility groups.

_____ This higher standard only applies to the following eligibility groups:

The State has a process under which this limitation will be waived in cases of undue hardship.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Indiana

ASSSET VERIFICATION SYSTEM

1940 (a) of the Act

1. The agency will provide for the verification of the assets for purposes of determining or redetermining Medicaid eligibility for aged, blind and disabled Medicaid applicants and recipients using an Asset Verification System (AVS) that meets the following minimum requirements.

A. The request and response system must be electronic:

(1) Verification inquiries must be sent electronically via the internet or similar means from the agency to the financial institution (FI).
(2) The system cannot be based on mailing paper-based requests.
(3) The system must have the capability to accept responses electronically.

B. The system must be secure, based on a recognized industry standard of security (e.g., as defined by the U.S. Commerce Department's National Institute of Standards and Technology, or NIST).

C. The system must establish and maintain a database of FIs that participate in the agency's AVS.

D. Verification requests also must be sent to FIs other than those identified by applicants and recipients, based on some logic such as geographic proximity to the applicant's home address, or other reasonable factors whenever the agency determines that such requests are needed to determine or redetermine the individual's eligibility.

E. The verification requests must include a request for information on both open and closed accounts, going back up to 5 years as determined by the State.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Indiana

ASSET VERIFICATION SYSTEM

2. System Development

___ A. The agency itself will develop an AVS.

In 3 below, provide any additional information the agency wants to include.

_X_ B. The agency will hire a contractor to develop an AVS.

____ C. The agency will be joining a consortium to develop an AVS.

In 3 below, identify the States participating in the consortium. Also, provide any other information the agency wants to include pertaining to how the consortium will implement the AVS requirements.

_____ D. The agency already has a system in place that meets the requirements for an acceptable AVS.

_____ E. Other alternative not included in A. – D. above.

In 3 below, describe this alternative approach and how is will meet the requirements in Section 1.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Indiana

ASSET VERIFICATION SYSTEM

3. Provide the AVS implementation information requested for the implementation approach checked in Section 2, and any other information the agency may want to include.

Indiana will issue an RFI in January 2012 for the purpose of identifying qualified vendors and gaining an understanding of the cost and system changes that will be necessary to implement an AVS.

State Plan Under Title XIX of the Social Security Act

State: Indiana

METHODOLOGY FOR IDENTIFICATION OF APPLICABLE FMAP RATES

The State will determine the appropriate FMAP rate for expenditures for individuals enrolled in the adult group described in 42 CFR 435.119 and receiving benefits in accordance with 42 CFR Part 440 Subpart C. The adult group FMAP methodology consists of two parts: an individual-based determination related to enrolled individuals, and as applicable, appropriate population-based adjustments.

Part 1 – Adult Group Individual Income-Based Determinations

For individuals eligible in the adult group, the state will make an individual income-based determination for purposes of the adult group FMAP methodology by comparing individual income to the relevant converted income eligibility standards in effect on December 1, 2009, and included in the MAGI Conversion Plan (Part 2) approved by CMS on 02/05/2015. In general, and subject to any adjustments described in this SPA, under the adult group FMAP methodology, the expenditures of individuals with incomes below the relevant converted income standards for the applicable subgroup are considered as those for which the newly eligible FMAP is not available. The relevant MAGI-converted standards for each population group in the new adult group are described in Table 1.

Table 1: Adult Group Eligibility Standards and FMAP Methodology Features

Covered Populations Within New Adult Group		Applicable Population Adjustment			
Population Group	Relevant Population Group Income Standard For each population group, indicate the lower of: • The reference in the MAGI Conversion Plan (Part 2) to the relevant income standard and the appropriate cross-reference, or • 133% FPL. If a population group was not covered as of 12/1/09, enter "Not covered".	Resource Proxy	Enrollment Cap	Special Circumstances	Other Adjustments
		Enter "Y" (Yes), "N" (No), or "NA" in the appropriate column to indicate if the population adjustment will apply to each population group. Provide additional information in corresponding attachments.			
A	B	C	D	E	F
Parents/Caretaker Relatives	See Note #1 Below	N/A	N/A	N/A	N/A
Disabled Persons, non-institutionalized	See Note #2 Below	N/A	N/A	N/A	N/A
Disabled Persons, institutionalized	See Note #3 Below	N/A	N/A	N/A	N/A
Children Age 19 or 20	Not Covered	N/A	N/A	N/A	N/A
Childless Adults	Not Covered	N/A	N/A	N/A	N/A

Note #1: Attachment A, Column C, Line 1 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan.

Note #2: Attachment A, Column C, Line 2 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan.

Note #3: Attachment A, Column C, Line 3 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan.

Part 2 – Population-based Adjustments to the Newly Eligible Population Based on Resource Test, Enrollment Cap or Special Circumstances

A. Optional Resource Criteria Proxy Adjustment (42 CFR 433.206(d))

1. The state:

   ☐ Applies a resource proxy adjustment to a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

   ☒ Does NOT apply a resource proxy adjustment (Skip items 2 through 3 and go to Section B).

   Table 1 indicates the group or groups for which the state applies a resource proxy adjustment to the expenditures applicable for individuals eligible and enrolled under 42 CFR 435.119. A resource proxy adjustment is only permitted for a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

   The effective date(s) for application of the resource proxy adjustment is specified and described in Attachment B.

2. Data source used for resource proxy adjustments:

   The state:

   ☐ Applies existing state data from periods before January 1, 2014.

   ☐ Applies data obtained through a post-eligibility statistically valid sample of individuals.

   Data used in resource proxy adjustments is described in Attachment B.

3. Resource Proxy Methodology: Attachment B describes the sampling approach or other methodology used for calculating the adjustment.

B. Enrollment Cap Adjustment (42 CFR 433.206(e))

1. ☐ An enrollment cap adjustment is applied by the state (complete items 2 through 4).

   ☒ An enrollment cap adjustment is not applied by the state (skip items 2 through 4 and go to Section C).

2. Attachment C describes any enrollment caps authorized in section 1115 demonstrations as of December 1, 2009, that are applicable to populations that the state covers in the eligibility group described at 42 CFR 435.119 and received full benefits, benchmark benefits, or benchmark equivalent benefits as determined by CMS. The enrollment cap or caps are as specified in the applicable section 1115 demonstration special terms and conditions as confirmed by CMS, or in alternative authorized cap or caps as confirmed by CMS. Attach CMS correspondence confirming the applicable enrollment cap(s).

3. The state applies a combined enrollment cap adjustment for purposes of claiming FMAP in the adult group:

☐ Yes. The combined enrollment cap adjustment is described in Attachment C

☐ No.

4. Enrollment Cap Methodology: Attachment C describes the methodology for calculating the enrollment cap adjustment, including the use of combined enrollment caps, if applicable.

5. Special Circumstances (42 CFR 433.206(g)) and Other Adjustments to the Adult Group FMAP Methodology

1. The state:

☑ Applies a special circumstances adjustment(s).

☐ Does not apply a special circumstances adjustment.

2. The state:

☑ Applies additional adjustment(s) to the adult group FMAP methodology (complete item 3).

☐ Does not apply any additional adjustment(s) to the adult group FMAP methodology (skip item 3 and go to Part 3).

3. Attachment D describes the special circumstances and other proxy adjustment(s) that are applied, including the population groups to which the adjustments apply and the methodology for calculating the adjustments.

Part 3 – One-Time Transitions of Previously Covered Populations into the New Adult Group

A. Transitioning Previous Section 1115 and State Plan Populations to the New Adult Group

☒ Individuals previously eligible for Medicaid coverage through a section 1115 demonstration program or a mandatory or optional state plan eligibility category will be transitioned to the new adult group described in 42 CFR 435.119 in accordance with a CMS-approved transition plan and/or a section 1902(e)(14)(A) waiver. For purposes of claiming federal funding at the appropriate FMAP for the populations transitioned to new adult group, the adult group FMAP methodology is applied pursuant to and as described in Attachment E, and where applicable, is subject to any special circumstances or other adjustments described in Attachment D.

☐ The state does not have any relevant populations requiring such transitions.

Part 4 - Applicability of Special FMAP Rates

A. Expansion State Designation

The state:

☒ Does NOT meet the definition of expansion state in 42 CFR 433.204(b). (Skip section B and go to Part 5)

☐ Meets the definition of expansion state as defined in 42 CFR 433.204(b), determined in accordance with the CMS letter confirming expansion state status, dated _____.

B. Qualification for Temporary 2.2 Percentage Point Increase in FMAP.

The state:

☐ Does NOT qualify for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7).

☐ Qualifies for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7), determined in accordance with the CMS letter confirming eligibility for the temporary FMAP increase, dated _____. The state will not claim any federal funding for individuals determined eligible under 42 CFR 435.119 at the FMAP rate described in 42 CFR 433.10(c)(6).

Part 5 - State Attestations

The State attests to the following:

A. The application of the adult group FMAP methodology will not affect the timing or approval of any individual's eligibility for Medicaid.

B. The application of the adult group FMAP methodology will not be biased in such a manner as to inappropriately establish the numbers of, or medical assistance expenditures for, individuals determined to be newly or not newly eligible.

ATTACHMENTS

Not all of the attachments Indicated below will apply to all states; some attachments may describe methodologies for multiple population groups within the new adult group. Indicate those of the following attachments which are included with this SPA:

- ■ Attachment A – Conversion Plan Standards Referenced in Table 1
- ☐ Attachment B - Resource Criteria Proxy Methodology
- ☐ Attachment C- Enrollment Cap Methodology
- ■ Attachment D -Special Circumstances Adjustment and Other Adjustments to the Adult Group FMAP Methodology
- ■ Attachment E – Transition Methodologies

Most Recent Updated Summary Information for Part 2 of the Modified Adjusted Gross Income (MAGI) Conversion Plan*
INDIANA

	Population Group	Net standard as of 12/1/09	Converted standard for FMAP claiming	Same as converted eligibilty standard? (yes, no, or n/a)	Source of information in Column C (New SIPP conversion or Part 1 of approved state MAGI conversion plan)	Data source for Conversion (SIPP or state data)
	A	B	C	D	E	F
Conversions for FMAP Claiming Purposes						
1	**Parents/Caretaker Relatives** Dollar standards by family size 1 2 3 4 5 6 7 add-on	 $139.50 $229.50 $288.00 $346.50 $405.00 $463.50 $522.00 $58.50	 $152 $247 $310 $373 $435 $498 $561 $63	yes	Part 1 of approved state MAGI conversion plan	state data
2	**Noninstitutionalized Disabled Persons** SSI FBR%	100%	102%	n/a	new SIPP conversion	SIPP
3	**Institutionalized Disabled Persons** SSI FBR%	300%	300%	n/a	ABD Conversion Template	n/a
4	**Children Age 19-20**	n/a	n/a	n/a	n/a	n/a
5	**Childless Adults**	n/a	n/a	n/a	n/a	n/a

*The contents of this table will be updated automatically in the case of modifications in the CMS approved MAGI Conversion Plan.

Attachment D – Special Circumstances Adjustment and Other Adjustments to the Adult Group FMAP Methodology

Upon approval of the 12-month postpartum extension, Indiana will implement this proxy methodology to account for the proportion of individuals covered under the extended postpartum coverage option who would otherwise be eligible for coverage in the adult group and for the newly eligible FMAP under section 1905(y) of the Act. To calculate this proxy, historical member months used in the calculation met the following criteria:

- Aid categories MAMA - pregnant women under 138% FPL; and MAGP- pregnant women between 139% and 213% FPL
- All non-disabled adult and adolescent pregnant individuals are enrolled in one of these two categories. Non-citizens lacking satisfactory immigration status were excluded
- Member months between three and 12 months after the date of delivery (Date_Delivery) or end pregnancy date (Date_Exp) on the Recipient_Pregnancy table in the Enterprise Data Warehouse, using historical data in which the end of pregnancy event occurred from August 2018 through February 2019

The state selected the timeframe of August 2018 since it was after the state introduced the MAMA aid category and completed the transition. February 2019 was selected in order to allow for 12 postpartum months prior to the COVID-19 pandemic. From August 2018 through February 2019, 29,130 birth and miscarriage events were identified for individuals meeting the criteria listed above. The 29,130 events generated 242,550 member months corresponding to the months between 3 months and 12 months post-partum. (Please note that this is less than 10 months per event due to multiple events for some members. For example, if a member suffered a miscarriage, and then five months later suffered a second miscarriage, the postpartum period for the first event would be truncated.) Each of the postpartum period member months were individually evaluated to determine whether the member was 1) newly eligible, 2) not newly eligible, or 3) disenrolled from Medicaid during that month. Of the 242,550 member months, there were 58,850 member months during which the member was determined to be ”newly eligible”. This number was then divided by 242,550 to equal Indiana’s Proxy Percentage for claiming. Indiana’s Proxy Percentage for claiming is 24.3%. Therefore, approximately 24.3% of postpartum extension member months (months 3 through 12 postpartum) in the data period were classified as newly eligible.

Operationalizing the Methodology Process – this is used to track who we apply the proxy to, members who are in months 3-12 of the postpartum period.

A postpartum extension indicator (ZZ_POST_PARTUM_IND) will be added to the Standard Interface (SI) claim header and claim detail tables to identify expenditures that meet both requirements below:

- Aid categories MAMA and MAGP

- First date of service is 60 days after, and no later than one year after, the date of delivery (Date_Delivery) or end pregnancy date (Date_Exp) on the Recipient_Pregnancy table in the EDW.

Attachment E: Transition Methodologies

Prior to implementation of HIP 2.0, which will provide coverage to individuals eligible under 42 CFR §435.119, Indiana operated HIP 1.0 under 1115 waiver authority. HIP 1.0 provided eligibility to adults between the ages of 19 and 64 with a household income less than 100% FPL who are not otherwise eligible for Medicaid, with an enrollment cap for non-caretakers. Eligibility for HIP 1.0 was determined in accordance with Modified Adjusted Gross Income (MAGI) guidelines. Individuals eligible under HIP 1.0 will continue to be eligible for HIP 2.0 as the eligibility determination process is the same. With the implementation of HIP 2.0, HIP 1.0 enrollees will administratively become eligible under 42 CFR §435.119. These individuals will experience a seamless transition in coverage as of the effective date of HIP 2.0. As of 12/1/09 Indiana did not provide full, benchmark, or benchmark equivalent benefits to the HIP population. Therefore, upon the HIP 2.0 1115 waiver effective date the State will begin collecting enhanced FMAP for this population.

State/Territory: Indiana

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.

Provided: /_/ No limitations /X/ With limitations*

2.a. Outpatient hospital services.

Provided: /_/ No limitations /X/ With limitations*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

/X/ Provided: /_/ No limitations /X/ With limitations*

d. Ambulatory services offered by a health center receiving funds under section 329, 330, or 340 of the Public Health Service Act to a pregnant woman or individual under 18 years of age.

/_/ Provided: /_/ No limitations /_/ With limitations*

3. Other laboratory and x-ray services.

Provided: /_/ No limitations /X/ With limitations*

*Description provided on attachment.

State of Indiana

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES

FURNISHED TO THE CATEGORICALLY NEEDY

4.a Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided: ___ No limitations _X_ With limitations*

4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

4.c Family planning services and supplies for individuals of child-bearing age.

Provided: ___ No limitations _X_ With limitations*

4.c (i) Family planning services and supplies for individuals who are not pregnant and for individuals eligible pursuant to Attachment 2.2-A Page 23f.

Provided: ___ No limitations _X_ With limitations*

*Description provided on attachment.

4.d. 1) Face-to-Face Tobacco Dependence Counseling Services provided (by):

☒ (i) By or under supervision of a physician;

☒ (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services *other* than tobacco dependence services; * or

(iii) Any other health care professional legally authorized to provide tobacco dependence services under State law *and* who is specifically *designated* by the Secretary in regulations. (None are designated at this time; this item is reserved for future use.)

* Limitations to provider type and coverage listed in the Addendum to Attachment 3.1A.

2) Face-to-Face Tobacco Dependence Counseling Services Benefit Package for Pregnant Women

Provided: ☐ No limitations ☒ With limitations*

*Any benefit package that consists of *less* than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12 month period (eight (8) per year) should be explained below.

Please describe any limitations: Listed in the Addendum to Attachment 3.1A.

5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Provided With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: _____ No limitations __X___ With limitations*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services.

Provided: _____ No limitations __X___ With limitations*

* Description provided on attachment.

State/Territory: Indiana

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists' services.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

c. Chiropractors' services.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

d. Other practitioners' services.

/X/ Provided: Identified on attached sheet with description of limitations, if any.

/_/ Not provided.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided: /_/ No limitations /X/ With limitations*

b. Home health aide services provided by a home health agency.

Provided: /_/ No limitations /X/ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided: /_/ No limitations /X/ With limitations*

*Description provided on attachment 6.

State/Territory: Indiana

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

/X/ Provided: /_/ No limitations /X/With limitations*

/_/ Not provided.

8. Private duty nursing services.

/X/ Provided: /_/ No limitations /X/With limitations*

/_/ Not provided.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

9. Clinic services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

10. Dental services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

11. Physical therapy and related services.

a. Physical therapy.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

b. Occupational therapy.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

d. Respiratory therapy.

/X/ Provided with limitations.

*Description provided on attachment

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12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

b. Dentures.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

c. Prosthetic devices.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

d. Eyeglasses.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

*Description provided on attachments

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Supersedes
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b. Screening services.

/XX/ Provided: / / No limitations /XX/ With limitations*

/ / Not provided.

c. Preventive services.

/XX/ Provided: / / No limitations /XX/ With limitations*

/ / Not provided.

d. Rehabilitative services.

/XX/ Provided: / / No limitations /XX/ With limitations*

/ / Not provided.

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

/XX/ Provided: / / No limitations /XX/ With limitations*

/ / Not provided.

b. Skilled nursing facility services.

/ / Provided: / / No limitations / / With limitations*

/XX/ Not provided.

c. Intermediate care facility services.

/ / Provided: / / No limitations / / With limitations*

/XX/ Not provided.

*Description provided on attachment.

State/Territory_____

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED
TO THE CATEGORICALLY NEEDY

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

[X] Provided [ ] No limitations

[X] With limitations* [ ] Not Provided:

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

[X] Provided [ ] No limitations

[X] With limitations* [ ] Not Provided:

16. Inpatient psychiatric facility services for individuals under 22 years of age.

[X] Provided [ ] No limitations

[X] With limitations* [ ] Not Provided:

17. Nurse-midwife services

[X] Provided [ ] No limitations

[X] With limitations* [ ] Not Provided:

18. Hospice care (in accordance with section 1905(o) of the Act).

[X] Provided [ ] No limitations

[X] Provided in accordance with section 2302 of the Affordable Care Act

[X] With limitations* [ ] Not Provided:

*Description provided on attachment

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Indiana

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case management services & Tuberculosis related services.

a. Case management services as defined in, and according to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

____ Provided: _____ With limitations

__X__ Not provided.

b. Special tuberculosis (TB) related services under section 1902(z)(2) of the Act.

____ Provided: _____ With limitations *

__X__ Not provided.

20. Extended services for pregnant women

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

__X__ Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

_____ Additional coverage ++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

* Description provided on attachment.

State/Territory: Indiana

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider (in accordance with section 1920 of the Act).

/ / Provided: / / No limitations / / With limitations*

/X/ Not provided.

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

/X/ Provided: /X/ No limitations / /With limitations*

/ / Not provided.

23. Pediatric or family nurse practitioners' services.

Provided: / / No limitations /X/With limitations*

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: Indiana

SECTION 3 – SERVICES: GENERAL PROVISIONS

3.1 Amount, Duration, and Scope of Services

Medicaid is provided in accordance with the requirements of sections 1902(a), 1902(e), 1903(i), 1905(a), 1905(p), 1905(r), 1905(s), 1906, 1915, 1916, 1920, 1925, 1929, and 1933 of the Act; section 245(A)(h) of the Immigration and Nationality Act; and 42 CFR Parts 431, 440, 441, 442, and 483.

A. Categorically Needy

24. Any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary in accordance with section 1905(a)(28) of the Social Security Act and 42 CFR 440.170.

☒ Non-emergency transportation is provided in accordance with 42 CFR §431.53 as an administrative Service.

☐ Without limitations ☒ With limitations (Describe limitations in a Supplement to 3.1A either a Supplement or in Attachment 3.1D)

☐ Non-emergency transportation is provided without a broker in accordance with 42 CFR §440.170 as an optional medical service, excluding "school-based" transportation.

☐ Without limitations ☐ With limitations (Describe limitations in either a Supplement to 3.1A or in Attachment 3.1D)

(If non-emergency transportation is provided without a broker as an optional medical service or as an administrative service, **the state should describe in Attachment 3.1D how the transportation program operates** including types of transportation and transportation related services provided and any limitations. Describe emergency and non-emergency transportation services separately. Include any interagency or cooperative agreements with other Agencies or programs.)

☒ Non-emergency transportation is provided through a brokerage program as an optional medical service in accordance with 1902(a)(70) of the Social Security Act and 42 CFR 440.170(a)(4).

☒ The State assures it has established a non-emergency medical transportation program in accordance with 1902(a)(70) of the Social Security Act in order to more cost-effectively provide transportation, and can document, upon request from CMS, that the transportation broker was procured in compliance with the requirements of 45 CFR 92.36 (b)-(i).

(1) The State will operate the broker program without regard to the requirements of the following paragraphs of section 1902(a);

☐ (1) state-wideness (Please indicate the areas of State that are covered by the broker. If the State chooses to contract with more than one broker the State must provide a separate preprint for each broker)

☒ (10)(B) comparability

☒ (23) freedom of choice

(2) Transportation services provided will include:

☒ wheelchair van

☒ taxi

☒ stretcher car

☒ bus passes

☒ tickets

☒ secured transportation

☒ other transportation (if checked describe below other types of transportation provided.) - **Volunteers, gas reimbursement for family members and close associates**

☒ (3) The State assures that transportation services will be provided under a contract with a broker who:

(i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs:

(ii) has oversight procedures to monitor beneficiary access and complaints and ensures that transportation is timely and transport personnel are licensed qualified, competent and courteous:

(iii) is subject to regular auditing and oversight by the State in order to ensure the quality and timeliness of the transportation services provided and the adequacy of beneficiary access to medical care and services:

(iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on prohibitions on physician referrals under Section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate.) The broker shall not itself be a provider of transportation; however the state may require that the broker own/operate and have available vehicles referred to as "quick response vehicles" in the event the scheduled transportation provider is unavailable for transport or if there are no other qualified providers available to provide the transportation. The state acknowledges that the broker will use quick response vehicles only as a back-up measure to assure that beneficiaries are able to access medical service and not as a standard means of transportation. Usage of quick response vehicles are limited to selected counties. The State of Indiana discusses provider network weekly with SET to monitor the situation and to work on solutioning the gaps in the network. These meetings will continue until all QRVs would be retired.

(4) The broker contract will provide transportation to the following categorically needy mandatory populations:

☒ Low-income families with children (section 1931)
☒ Deemed AFDC-related eligibles
☒ Poverty-level related pregnant women
☒ Poverty-level infants
☒ Poverty-level children 1 through 5
☒ Poverty-level children 6 – 18
☒ Qualified pregnant women AFDC – related
☒ Qualified children AFDC – related

☐ IV-E foster care and adoption assistance children
☐ TMA recipients (due to employment) (section 1925)
☒ TMA recipients (due to child support)
☒ SSI recipients
☒ Individuals eligible under 1902(a)(10)(A)(i)- new eligibility group VIII (very-low income adults who are not otherwise eligible under any other mandatory eligibility group) – Becomes effective January 1, 2014, but states can elect to cover now as an early option.

(5) (A) The broker contract will provide transportation to the following categorically needy optional populations:

☒ Optional poverty-level - related pregnant women
☒ Optional poverty-level - related infants
☒ Optional targeted low income children
☒ Non IV-E children who are under State adoption assistance agreements
☒ Non IV-E independent foster care adolescents who were in foster care on their 18th birthday
☒ Individuals who meet income and resource requirements of AFDC or SSI
☒ Individuals who would meet the income & resource requirements of AFDC if child care costs were paid from earnings rather than by a State agency
☒ Individuals who would be eligible for AFDC if State plan had been as broad as allowed under Federal law
☒ Children aged 15-20 who meet AFDC income and resource requirements
☒ Individuals who would be eligible for AFDC or SSI if they were not in a medical institution
☒ Individuals infected with TB
☒ Individuals screened for breast or cervical cancer by CDC program
☐ Individuals receiving COBRA continuation benefits
☒ Individuals in special income level group, in a medical institution for at least 30 consecutive days, with gross income not exceeding 300% of SSI income standard
☒ Individuals receiving home and community based waiver services who would only be eligible under State plan if in a medical institution (please note that the broker may only provide transportation to and from 1905(a) services)
☒ Individuals terminally ill if in a medical institution and will receive hospice care
☒ Individuals aged or disabled with income not above 100% FPL
☒ Individuals receiving only an optional State supplement in a 209(b) State
☒ Individuals working disabled who buy into Medicaid (BBA working disabled group)
☒ Employed medically improved individuals who buy into Medicaid under TWWIIA Medical Improvement Group
☒ Individuals disabled age 18 or younger who would require an institutional level of care (TEFRA 134 kids).

(B) Any beneficiary enrolled in fee-for-service who is also eligible for transportation coverage will have his or her non-emergency transportation arranged through a broker.

i. Non-emergency transportation services for basic life support and advanced life support ambulance transportation.
ii. Non-emergency transportation services for members residing in nursing facilities.

(6) Payment Methodology

(A) Please describe the methodology used by the State to pay the broker:

The broker receives a fixed monthly risk-based capitated payment for all FFS members. This all-inclusive rate will cover all costs associated with the contract. The capitated rate may be adjusted on an annual basis.

(B) Please describe how the transportation provider will be paid:

The broker maintains a network of providers and is responsible for direct payments to providers.

(C) What is the source of the non-Federal share of the transportation payments?

Describe below the source of the non-Federal share of the transportation payments proposed under the State plan amendment. If more than one source exists to fund the non-Federal share of the transportation payment, please separately identify each source of non-Federal share funding.

State General Assembly funding

☒ (D) The State assures that no agreement (contractual or otherwise) exists between the State or any form of local government and the transportation broker to return or redirect any of the Medicaid payment to the State or form of local government (directly or indirectly). This assurance is not intended to interfere with the ability of a transportation broker to contract for transportation services at a lesser rate and credit any savings to the program.

☒ (E) The State assures that payments proposed under this State plan amendment will be made directly to transportation providers and that the transportation provider payments are fully retained by the transportation providers and no agreement (contractual or otherwise) exists between the State or local government and the transportation provider to return or redirect any of the Medicaid payment to the State or form of local government (directly or indirectly).

☐ (F) The State has included Federal Medicaid matching funds as State match when drawing down FTA SAFETEA–LU grants.

☒ (7) The broker is a non-governmental entity:

☐ The broker is not itself a provider of transportation nor does it refer to or subcontract with any entity with which it has a prohibited financial relationship as described at 42 CFR 440.170(4)(ii).

☒ The broker is itself a provider of transportation or subcontracts with or refers to an entity with which it has a prohibited financial relationship and:

☐ Transportation is provided in a rural area as defined at 42 CFR 412.62(f) and there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.

☐ Transportation is so specialized that there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-government broker

☒The availability of other non-governmental Medicaid participating providers or other Providers determined by the State to be qualified is insufficient to meet the need for transportation. QRVs will operate in the following counties: Allen, Bartholomew, Blackford, Boone, Clark, Clay, Dearborn, Decatur, Delaware, Elkhart, Fayette, Floyd, Franklin, Grant, Greene, Hamilton, Hancock, Harrison, Hendricks, Henry, Howard, Huntington, Jackson, Jefferson, Jennings, Johnson, Knox, Kosciusko, La Porte, LaGrange, Lake, Lawrence, Madison, Marion, Marshall, Monroe, Morgan, Noble, Ohio, Orange, Owen, Porter, Posey, Putnam, Ripley, Rush, Scott, Shelby, St. Joseph, Starke, Vanderburgh, Vermillion, Vigo, Wabash, Warrick, Washington, Wayne, Wells

☐ (8) The broker is a governmental entity and provides transportation itself or refers to or subcontracts with another governmental entity for transportation. The governmental broker will:

☐ Maintain an accounting system such that all funds allocated to the Medicaid brokerage program and all costs charged to the Medicaid brokerage will be completely separate from any other program.

☐ Document that with respect to each individual beneficiary's specific transportation needs, the government provider is the most appropriate and lowest cost alternative.

☐ Document that the Medicaid program is paying no more for fixed route public transportation than the rate charged to the general public and no more for public para-transit services than the amount charged to other human services agencies for the same service.

(9) Please provide a complete description of how the NEMT brokerage program operates. Include all services provided by the broker (call center, over-sight of providers, etc.). If applicable, describe any transportation services that will not be provided by the broker and how these services will be

The FSSA contracts with a single broker for the administration of the Non-Emergency Medical Transportation program for the FFS population. The broker is responsible for the following activities:

- **Ensuring that members seeking NEMT services are eligible for Indiana Medicaid services**
- **Ensuring that non-emergency transportation providers are first enrolled as Indiana Health Coverage Programs (IHCP) providers.**
- **Recruiting, maintaining, and continuously improving a network of local qualified transportation providers, which is available statewide. This network includes, but is not limited to, specialized motor vehicles, common vehicles, taxies, and public transit.**
- **Scheduling recurring trips, one-time trips, advance reservations, hospital and emergency room discharges, trip which require prior authorization, and requests for urgent trips.**
- **Determining the appropriate mode of transportation to meet a member's medical needs, including any special transport requirements for medically fragile or physically/mentally challenges members or long-distance travel requirements.**
- **Seeking and confirming any prior authorization requirements in accordance with state and federal requirements.**
- **Responding to telephone and written inquiries from members, their representatives, health care providers, non-emergency transportation providers, and other stakeholders.**
- **Assisting the state with ongoing program operations, policy and procedures development and review, monthly status meetings with FSSA and related contractors, and a monthly quality improvement committee.**
- **Tracking and resolving quality issues and any other issues as identified within the state's quality strategy, as appropriate.**
- **Reimbursing claims for services rendered.**

- **Determining payment based on the least expensive mode and the shortest, most efficient route.**
- **Monitoring and controlling fraud, waste, and abuse from transportation providers.**

The broker is not responsible for the following non-brokered services:

i. Non-emergency transportation services for basic life support and advanced life support ambulance transportation.
ii. Non-emergency transportation services for members residing in nursing facilities.

Nursing facility services for patients under 21 years of age

☒ Provided ☐ No Limitations ☒ With Limitations*☐ Not Provided

Services provided in Religious Nonmedical Health Care Institutions.

☒ Provided ☐ No Limitations ☒ With Limitations*☐ Not Provided

Emergency Hospital Services

☒ Provided ☒ No Limitations ☐ With Limitations*☐ Not Provided

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AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE ANO SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

_____provided __X__ not provided

26. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse

☐ Provided ☐ No Limitations ☐ With Limitations*☒ Not Provided

Electronic Visit Verification System. The state became compliant with the Electronic Visit Verification System (EVV) requirements for personal care services on January 1, 2021, in accordance with section 12006 of the 21st Century CURES Act.

State of: Indiana

Program of All-Inclusive Care for the Elderly State Plan Amendment

Amount, Duration and Scope of Medical and Remedial Care Services Provided To the Categorically Needy

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

X Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

____ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

State: Indiana

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE

AND SERVICES TO THE CATEGORICALLY NEEDY

Freestanding Birth Center Services (in accordance with section 1905(a)(28) and 1905(1)(3)(A)-(c) of the Act).

28. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers

Provided: ☐ No limitations X With limitations ☐ None licensed or approved

28. (ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

Provided: ☐ No limitations X With limitations

State: Indiana

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE

AND SERVICES TO THE CATEGORICALLY NEEDY

29. Psychosocial rehabilitation services

Provided: ☐ No limitations X With limitations

State/Territory: Indiana

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

CATEGORICALLY NEEDY GROUP(S)

30. Coverage of Routine Patient Cost in Qualifying Clinical Trials

*The state needs to check each assurance below.

Provided: __X__

I. General Assurances:

Routine Patient Cost – Section 1905(gg)(1)

__X__ Coverage of routine patient cost for items and services as defined in section 1905(gg)(1) that are furnished in connection with participation in a qualified clinical trial.

Qualifying Clinical Trial – Section 1905(gg)(2)

__X__ A qualified clinical trial is a clinical trial that meets the definition at section 1905(gg)(2).

Coverage Determination – Section 1905(gg)(3)

__X__ A determination with respect to coverage for an individual participating in a qualified clinical trial will be made in accordance with section 1905(gg)(3).

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 210 of the Consolidated Appropriations Act of 2021 amending section 1905(a) of the Social Security Act (the Act), by adding a new mandatory benefit at section 1905(a)(30). Section 210 mandates coverage of routine patient services and costs furnished in connection with participation by Medicaid beneficiaries in qualifying clinical trials effective January 1, 2022. Section 210 also amended sections 1902(a)(10)(A) and 1937(b)(5) of the Act to make coverage of this new benefit mandatory under the state plan and any benchmark or benchmark equivalent coverage (also referred to as alternative benefit plans, or ABPs). Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unlessit displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #74). Public burden for all of the collection of information requirements under this control number is estimated to take about 56 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 SecurityBoulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Inpatient Hospital services

Provided with limitations.
Inpatient hospital services are covered when provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the recipient's condition. Reimbursement shall not be made for any hospital services not covered under the Medicaid program.
The following require prior authorization:

(1) any procedure ordinarily rendered on an outpatient basis when rendered on an inpatient basis
(2) psychiatric inpatient admissions
(3) rehabilitation, including substance abuse, inpatient admissions
(4) burn inpatient admissions
(5) out of state hospitalization
(6) nonemergent inpatient admissions

The following are exempt form the prior authorization requirements:

(1) Inpatient hospital admissions when covered by Medicare.
(2) Routine vaginal and cesarean section deliveries.

If an inpatient procedure requires prior authorization and prior authorization is either not obtained or denied, reimbursement for the inpatient procedure and any associated services, including inpatient days, shall be denied.

2.a. Outpatient Hospital services

Provided with limitations.
Outpatient hospital services are covered when provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the recipient's condition. Reimbursement shall not be made for any hospital services not covered under the Medicaid program. For general anesthesia services, documentation in the patient's record must include specific reasons why such services are needed, if such services are to be provided on an outpatient basis.

2.b. Rural Health Clinic services

Provided with limitations.
Reimbursement is available to rural health clinics for medically necessary services provided by a physician, physician assistant, nurse practitioner, clinical psychologist, clinical social worker, dentist, dental hygienist, podiatrist, optometrist, chiropractor, licensed clinical addiction counselor, licensed marriage and family therapist, or licensed mental health counselor employed by the rural health clinic. Reimbursement shall not be made for any services not covered under the Medicaid program.

2.c.	Federally Qualified Health Center services	Provided with limitations. Reimbursement is available to FQHCs for medically necessary services provided by a physician, as defined in 42 C.F.R. 405.2412, physician assistant, nurse practitioner, clinical psychologist, clinical social worker, dentist, dental hygienist, podiatrist, optometrist, chiropractor, licensed clinical addiction counselor, licensed marriage and family therapist, or licensed mental health counselor. Reimbursement is also available for services and supplies incident to such services as would otherwise be covered if furnished by a physician or as an incident to a physician's services. Services to a homebound individual are only available in the case of those FQHCs that are located in an area that has a shortage of home health agencies as determined by Medicaid. Any other ambulatory service included in the Medicaid state plan is considered a covered FQHC service if the FQHC offers such a service. Reimbursement shall not be made for any service not covered under the Medicaid program.
3.	Other Laboratory and X-ray services	Provided with limitations. All laboratory and x-ray services must be ordered by a physician or other practitioner licensed to do so under state law. Covered when necessitated by a condition-related diagnosis. Only one (1) charge per day for each patient is allowed for venipuncture.

3.a.	Nursing Facility services	Provided with limitations.
	for individuals 21 years of age or older	Reimbursement is available for nursing facility services provided by a licensed and certified nursing facility in accordance with Attachment 4.19-D, when rendered to a recipient whose level of care has been approved by the Office of Medicaid Policy and Planning. Those services and products furnished by the nursing facility for the usual care and treatment of patients are reimbursed in the per diem rate in accordance with State law. The per diem rate for nursing facilities includes the following services: room and board, room accommodations, all dietary services, and laundry services; nursing care provided by a registered nurse, licensed practical nurse, or nurse's aide; all medical and nonmedical supplies and equipment; durable medical equipment (DME), and associated repair costs routinely required for the care of patients; medically necessary therapy services which include physical. occupational, respiratory, and speech pathology services; transportation to vocational/habilitation service programs; the cost of both legend and non-legend water products in all forms and for all uses.
4.b	Early **and** Periodic Screening, Diagnosis Treatment	Provided in excess of federal requirements, Treatment services are covered subject to prior authorization requirements and reimbursement limitations. Any treatment found necessary as a result of a diagnosis pursuant to an initial or periodic screening may be provided subject to any prior authorization requirements for the se1vices. However, if a service is not covered under the state plan, it is still available to EPSDT eligible recipients subject to prior authorization requirements in accordance with State law if it is necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services-. Medicaid reimbursement is available for medically necessary school nursing services rendered by a nurse who is employed by or under contract with a Medicaid participating school corporation provider when the services are: medically necessary; provided pursuant to a Medicaid enrolled student's educational program or plan as required by the Individuals with Disabilities Education Act (IDEA) or Section 504 of the Federal Rehabilitation Act of 1973. 29 U.S.C. 794.
4.c.	Family Planning services	Provided with limitations. Family planning services are those services provided to individuals of childbearing age, who are not pregnant, to temporarily or permanently prevent or delay pregnancy. Family planning services includes: diagnosis and treatment of sexually transmitted diseases, if medically indicated; follow-up care for complications associated with contraceptive methods issued by the family planning provider; health education and counseling necessary to make informed choices and understand contraceptive methods; laboratory tests, if medically indicated as part of the decision making process for choice of contraceptive methods; limited history and physical examination; pregnancy testing and counseling; provision of contraceptive pills, devices, and supplies; screening, testing, and counseling of members at risk for HIV and referral and treatment; tubal ligation or Essure device; and vasectomy.

4.d.1 Face-to-Face Tobacco Dependence Services

Provided with Limitations:
Reimbursement is available for tobacco dependence treatment.

Tobacco dependence treatment includes covered legend or nonlegend drugs intended to reduce an individual's dependence on tobacco products as well as tobacco dependence counseling. A member prescribed a legend or nonlegend drug intended to reduce an individual's dependence on tobacco products must engage in tobacco dependence counseling in conjunction with the receipt of said legend or nonlegend drug therapy.

Reimbursement is available for tobacco dependence counseling services rendered by licensed practitioners under applicable Indiana law participating in the Indiana Medicaid program.

The following may provide tobacco dependence counseling services when prescribed by a practitioner within the scope of his license under Indiana law and within the limitations set out in this state plan:

(1) A physician.
(2) A physician's assistant.
(3) A nurse practitioner.
(4) A registered nurse.
(5) A psychologist.
(6) A pharmacist.
(7) A dentist.
(8) An optometrist.
(9) A clinical social worker.
(10) A martial and family counselor.
(11) A mental health counselor.
(12) A licensed clinical addictions counselor.

5.a. Physicians' services

Provided with limitations.
Reimbursement is available for medically necessary services provided by a doctor of medicine or osteopathy for diagnostic, preventive, therapeutic, rehabilitative or palliative services provided within the scope of the practice of medicine, as defined by Indiana law, and subject to limitations.

Reimbursement is available for office visits limited to a maximum of office visits per rolling 12 months, per recipient, per provider without prior authorization. Additional office visits may be approved with prior authorization based on medical necessity. Office visits should be appropriate to the diagnosis and treatment given and properly coded. New patient office visits are limited to one per recipient, per provider within the last three (3) years. For purposes of this subsection, "new patient" means one who has not received any professional services from the provider or another provider of the same specialty who belongs to the same group practice within the last three (3) years.

A physician will not be reimbursed for the following: preparation of reports, missed appointments, writing or telephoning prescriptions to pharmacies, telephone calls to laboratories, any extra charge for after-hours services, mileage.

Reimbursement is available for a physician as an assistant surgeon and is limited to the procedures that generally require the skills and services of an assistant surgeon as set out in coding guidelines. When extenuating circumstances require an assistant surgeon when customarily one is not required, these circumstances must be well documented in the hospital record and documentation must be attached to the claim form. Reimbursement is not available for a surgical assistant who assists in diagnostic surgical procedures or for minor surgical procedures.

Reimbursement is not available to a physician for injecting medications that can be self-administered unless justified by the patient's condition. Possible noncompliance by a recipient to oral medication is insufficient justification to administer injections.

5.b. Medical and Surgical services furnished by a dentist	Provided with limitations. Reimbursement is available only for those services listed below subject to limitations. The following are covered medical and surgical services furnished by a dentist under the Indiana Medicaid program: oral biopsies, alveoplasty, excision of lesions, excision of benign tumor, nonodontogenic cyst removal, incise and drain abscess, fracture simple stabilize, compound fracture of the mandible, compound fracture of the maxilla, repair of wounds, suturing, , periodontal surgery limited to drug-induced periodontal hyperplasia, other medical and surgical services furnished by a dentist as medically necessary to treat recipients eligible for the EPSDT program, general anesthesia, intravenous (IV) sedation covered only for oral surgical services, and maxillofacial surgery
6.a. Podiatrists' Services	Provided with limitations. (1) Are provided by a podiatrist who is licensed by the State and meets standards issued by the Secretary of Health and Human Services; and (2) Consists of treatment that the podiatrist is legally authorized by the State to perform and services of a doctor of podiatric medicine, acting within the scope of his or her license, if the services would be covered as physicians' services when performed by a doctor of medicine or osteopathy. (3) Reimbursement is limited to 1 office visit and up to 6 routine foot care services per recipient with systemic disease of sufficient severity that unskilled performance of such procedure would be hazardous per 12 months. New patient office visits are limited to one (1) per recipient, per provider, within the last three (3) years. "New patient" is one who has not received professional services from the provider or another provider of the same specialty who belongs to the same group practice within the past three (3) years. Reimbursement is available within the scope of the practice of podiatry as defined by Indiana law. Covered services include diagnosis of foot disorders and mechanical, medical or surgical treatment of these disorders. Reimbursement is not available for any podiatric service provided outside the scope of state licensure or for any podiatric service for which federal financial participation is not available. Subject to prior authorization requirements, these limits do not apply to treatments found necessary for children under the age 21, after a diagnosis as a result an EPSDT service.

6.b. Optometrists' services

Optometrists' services are provided in accordance with 42 CFR 440.060.

Reimbursement is available for medically necessary services provided by an optometrist within the scope of practice as define by Indiana law and subject to procedure code limitations.

6.c. Chiropractors' services

Chiropractors' services include only services that—

(1) Are provided by chiropractor who is licensed by the State and meets standards issued by the Secretary of Health and Human Services under 42 CFR 420.21(a); and
(2) Consists of treatment by means of manual manipulation of the spine that the chiropractor is legally authorized by the State to perform
(3) Provided with limitations
Reimbursement is limited to 5 office visits and up to 50 therapeutic physical medicine treatments per recipient per year; however, the 5 office visits are included in the 50 visit/treatment maximum. DME and electromyography services are not covered. Reimbursement is subject to the scope of service limitations set out in 405 IAC 5. Reimbursement is not available for any chiropractic service provided outside the scope of IC 25-10-1-1, et seq., and 846 IAC 1-3-1, et seq., or for any chiropractic service for which federal financial participation is not available.

Subject to prior authorization requirements and 405 IAC 5-15-4 these limits do not apply to treatments found necessary for children under the age 21, after a diagnosis as a result an EPSDT service.

6.d. Other Practitioners' services

Nurse Practitioners' services

Provided with limitations.
Reimbursement is available for medically necessary, reasonable and preventive health care services provided by a licensed, certified nurse practitioner within the scope of the applicable license and certification.

Diabetes Self-Management
And Training Services

Reimbursement is limited to a total of sixteen units (15 minutes each) per recipient, per rolling calendar year. Additional units may be prior authorized. Services must be medically necessary; provided by health care professionals who are licensed, registered or certified under applicable Indiana law and who have specialized training in the management of diabetes; and ordered in writing by a physician, podiatrist, nurse practitioner, clinical nurse specialist, certified nurse midwife and physician assistant.

Pharmacist Services

Licensed Pharmacists may provide services and prescriptions for contraceptives as defined under State law.

6.d.	Other Practitioners' services (continued)	Provided with limitations.
	Physician Assistants' Services	Licensed Physician Assistants may provide medically necessary healthcare services within their scope of practice according to state law.
	Community Health Workers' Services	Reimbursement is available for medically necessary health care services provided by a certified community health worker within the scope of the applicable certification program. The services within the applicable certification program of a certified community health worker should be within the scope of practice for each of the following supervising licensed practitioners: health services provider in psychology, advanced practice nurse, physician assistant, podiatrist, and chiropractor. Supervision of the certified community health worker is included in the scope of practice for each supervising licensed practitioner. Each supervising licensed practitioner shall assume professional responsibility for the services provided by the certified community health worker. Each supervising licensed practitioner shall bill for the services of the certified community health worker
	Licensed Behavioral Health Practitioners Services	Licensed Clinical Social Workers may provide medically necessary healthcare services within their scope of practice according to state law. Licensed Marriage and Family Therapists may provide medically necessary healthcare services within their scope of practice according to state law. Licensed Mental Health Counselors may provide medically necessary healthcare services within their scope of practice according to state law. Licensed Clinical Addiction Counselors may provide medically necessary healthcare services within their scope of practice according to state law.

Psychologists' services

Psychologists' services include only services that are provided by licensed psychologists within the scope of practice as defined under state law.

Coverage is available for outpatient mental health and substance abuse treatment services provided by a licensed psychologist endorsed as a health services provider in psychology (HSPP), subject to the following limitations:

(1) Subject to prior authorization by the office or its designee, Medicaid will reimburse HSPP supervised outpatient mental health services for group, family, and individual outpatient psychotherapy when the services are provided by one (1) of the following practitioners:
- (A) A licensed psychologist.
- (B) A licensed independent practice school psychologist.
- (C) A licensed clinical social worker (LCSW).
- (D) A licensed marital and family therapist (LMFT).
- (E) A licensed mental health counselor (LMHC).
- (F) A licensed clinical addiction counselor (LCAC).
- (F) A person holding a master's degree in social work, marital and family therapy, or mental health counseling, except that partial hospitalization services provided by such person shall not be reimbursed by Medicaid.
- (G) An advanced practice nurse who is a licensed, registered nurse with a master's degree in nursing with a major in psychiatric or mental health nursing from an accredited school of nursing.

(2) A HSPP is responsible for certifying the diagnosis for the purpose of developing the plan of treatment and providing continuous supervision as follows:
- (A) The supervising practitioner is responsible for seeing the patient during the intake process or reviewing information submitted by the other licensed professionals, qualified behavioral health provider (QBHP), or other behavioral health provider (OBHP) and approving the plan of treatment within seven (7) days.
- (B) The supervising practitioner must provide face to face visits with the patient or review the plan of treatment submitted by the QBHP at intervals not to exceed ninety (90) days. These reviews must be documented and signed by the supervising practitioner assuming responsibility for the plan of treatment.

(3) Medicaid will reimburse for evaluation, psychological testing and group, family, and individual psychotherapy when provided by a licensed psychologist, licensed independent practice school psychologist, and a licensed psychologist endorsed as an HSPP.

(4) Medicaid will cover for school psychologist testing services provided by a licensed independent practice school psychologist or school psychologist who holds the national school psychologist certification or the Indiana Accomplished Practitioner license who is employed or contracted with a school corporation that participates in Medicaid when such services are medically necessary and required to determine the health related services a public school corporation shall provide per a Medicaid enrolled student's educational program or plan as required by the Individuals with Disabilities Education Act (IDEA) or Section 504 of the federal Rehabilitation Act of 1973. 29 U.S.C. 794.

(5) Subject to prior authorization by the office or its designee, Medicaid will reimburse for neuropsychological and psychological testing when the services are provided by an HSPP.

(6) Prior authorization is required for mental health service provided in an outpatient or office setting that exceed twenty (20) units per recipient, per provider, per rolling twelve (12) month period of time, except neuropsychological and psychological testing, which is subject to prior authorization.

(7) The following are services that are not coverable by the Medicaid program:
- (A) Daycare.
- (B) Hypnosis.
- (C) Biofeedback.
- (D) Missed appointments.

Telehealth

Coverage is available for health care services delivered via telehealth. Telehealth must be provided in accordance with Indiana state law.

The following services may not be delivered via telehealth:

(A) Ambulatory surgical services.
(B) Outpatient surgical services.
(C) Radiological services.
(D) Laboratory services.
(E) Anesthesia services or nurse anesthetist services.
(F) DME and HME services.
(G) Transportation services.

For more information on telehealth monitoring reimbursement for home health care services, please refer to Attachment 4.19-B, Page 3c.1.1

7. Home Health Services

Home Health Services are provided in accordance with 42 CFR 440.70 and include:

(1) Intermittent or part-time nursing services in accordance with 42 CFR 440.70(b)(1).
(2) Home health aide services in accordance with 42 CFR 440.70(b)(2).
(3) Medical supplies, equipment, and appliances suitable for use in any setting in which normal life activities take place in accordance with 42 CFR 440.70(b)(3).
(4) Physical Therapy, Occupational Therapy, or Speech Pathology and Audiology services provided by a home health agency or medical rehabilitation facility in accordance with 42 CFR 440.70(b)(4) and 42 CFR 440.110.

Coverage for Home Health Services provided by a home health agency that meets the Medicare Conditions of Participation (COP) requirements, and are ordered in accordance with 42 CFR 440.70(a) with prior authorization, for medically necessary care.

All medically necessary Home Health Services will be provided to children under the age of 21.

Medically necessary and reasonable service is defined as a covered service required for the care or well being of the patient and is provided in accordance with generally accepted standards of medical or professional practice.

Home Health Services require medical necessity review through the prior authorization process by the Office of Medicaid Policy & Planning (OMPP). However, prior authorization is not required for home health under the following circumstances which are determined to be medically necessary:

(1) Services are ordered in writing prior to inpatient hospital discharge provided by an RN, LPN, or home health aide, and the services do not exceed 120 units within 30 calendar days following hospital discharge. Services exceeding this amount must be reviewed for medical necessity through the prior authorization process.
(2) Intermittent nursing or part-time nursing services which are not provided as emergency services are added to the plan of care and provided for a recipient for whom other home health services have been currently authorized. New nursing services provided to recipients who do not have home health services outlined in their plan of care must be reviewed for medical necessity through the prior authorization process.

Coverage is not available for:
(1) Homemaker, chore services, and sitter/companion service.
(2) Educational activities.
(3) Out of state home health agency services except as required by 42 CFR § 431.52.
(4) Therapy rendered for diversional, vocational, recreational, or avocational purposes.
(5) Activities that can be conducted by non-medical personnel.
(6) Community-base palliative care which does not meet the definition of home health services as defined above and provided in accordance with 42 CFR 440.70.
(7) Medical social services which does not meet the definition of home health services as defined above and provided in accordance with 42 CFR 440.70.

All incontinence supplies must be provided by the one provider under contract with the Indiana Medicaid program to provide incontinence supplies.

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7.d.	Physical Therapy, Occupational Therapy, or Speech Pathology and Audiology services provided by a home health agency or medical rehabilitation facility	Reimbursement is available only for medically necessary and reasonable therapy and is provided with limitations. Physical Therapy, Occupational Therapy, Speech Pathology, and Audiology services provided by a home health agency in accordance with 42 CFR 440.70 (b) (4) and 42 CFR 440.110. Prior authorization is required by the OMPP for all therapy services except the following; (1) Initial evaluations. (2) Any combination of therapy services ordered in writing prior to inpatient hospital discharge, if the services do not exceed 30 units in thirty 30 calendar days following hospital discharge. (3) Oxygen equipment and supplies necessary for the delivery of oxygen with the exception of concentrators. (4) Therapy services provided by a nursing facility or large private or small intermediate care facility for the mentally retarded (ICF/MR), which are included in the facility's per diem rate. (5) Physical therapy and occupational therapy ordered in writing by a physician to treat an acute medical condition. Prior authorization is required by the OMPP for all audiology services except the following; (1) The initial assessment of hearing. (2) Determination of suitability of amplification and the recommendation regarding a hearing aid. (3) The determination of functional benefit to be gained by the use of a hearing aid. (4) Audiology services provided by a nursing facility or large private or small ICF/MR, which are included in the facility's established per diem rate.
8.	Private Duty Nursing	Private Duty Nursing services provided by a home health agency in accordance with 42 CFR 440.80. Reimbursement is available for medically necessary and reasonable services rendered by registered nurses, licensed practical nurses and home health agencies who are Medicaid providers, subject to prior authorization requirements applicable to home health agencies.

9.	Clinic services	Covered for medically necessary clinic services..
10.	Dental services	Covered subject to a $1,000 cap per recipient per 12 month period for all Dental services. Coverage limits based on diagnostic and treatment services..
11.	Physical Therapy and Related services	Covered for medically necessary therapy services. Therapy provided for diversional, recreational, vocational, or avocational purpose, or for the remediation of learning disabilities or for developmental activities which can be conducted by nonmedical personnel, is not covered.
11.a.	Physical Therapy	Provided in accordance with the requirements of 42 CFR 440.110. Therapy services will not be approved for more than one (1) hour per day per type of therapy. Evaluations and reevaluations are limited to three (3) hours of service per evaluation A certified physical therapist's assistant may provide services within scope of practice as defined by Indiana State law.
11.b.	Occupational Therapy	Provided in accordance with the requirements of 42 CFR 440.110. Therapy services will not be approved for more than one (1) hour per type of therapy. Evaluations and reevaluations are limited to three (3) hours of service per evaluation. A certified occupational therapy assistant may provide services within scope of practice as defined by Indiana State law.
11.c.	Services for individuals with speech, hearing and language disorders (provided by a speech pathologist or audiologist)	Provided in accordance with the requirements of 42 CFR 440.110. Therapy services will not be approved for more than one (1) hour per day per type of therapy. Speech therapy evaluations and reevaluations are limited to three (3) hours of service per evaluation. A registered speech-language pathology aide may provide services within scope of practice as defined by Indiana State law.
11.d.	Respiratory Therapy services	Provided in accordance with the requirements of 42 CFR 440.185. Coverage is limited by diagnosis and medical necessity. A certified respiratory therapy technician may provide services within scope of practice as defined by Indiana State law.

12.a. Prescribed Drugs Provided with limitations.

Reimbursement is available for prescribed drugs subject to the limitations set out in 405 lAC 5. The following are not covered: anorectics or any agent used to promote weight loss; topical minoxidil preparations; fertility enhancement drugs; drugs used to treat sexual or erectile dysfunction, as set forth in section 1927(d)(2)(K) of the Act, unless such drugs are used to treat conditions other than sexual or erectile dysfunction and such uses have been approved by the Food and Drug Administration; drugs prescribed solely or primarily for cosmetic purposes. All over-the-counter and non-legend items are subject to the limitations set out in 405 lAC 5-24.

Effective July 1st, 2023, the Medicaid Managed Care Plans contracted with the State of Indiana, will follow the statewide uniform preferred drug list (SUPDL) for covered outpatient drugs listed in the classes on the fee-for-service (FFS) preferred drug list (PDL). In accordance with Section 4401 of P.L. 101-508 (Omnibus Budget Reconciliation Act of 1990), Indiana Medicaid will fully participate in the manufacturer rebate program. In doing so, all applicable provisions and restrictions of the legislation, as well as that of any subsequent rules and/or regulations, will be strictly adhered to. Specifically, Indiana Medicaid will reimburse for all rebating manufacturers' (as identified to the agency by CMS) products fully in accordance with the specifications of the legislation. The program will also adhere to all reporting requirements of the legislation.

Supplemental Rebates--The State is in compliance with section 1927 of the Social Security Act. The state will cover drugs of federal rebate participating manufacturers. The state is in compliance with reporting requirements for utilization and restrictions to coverage. Pharmaceutical manufacturers can audit utilization data. The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification.

The state will be negotiating supplemental rebates in addition to the federal rebates provided for in Title XIX. Rebate agreements between the state and a pharmaceutical manufacturer will be separate from the federal rebates. A rebate agreement between the State and a drug manufacturer for drugs provided to the Medicaid program, submitted to CMS on June 28th, 2023 and entitled, State of Indiana Supplemental Rebate agreement, has been authorized by CMS, superseding the State of Indiana Supplemental Rebate agreement approved under IN SPA TN 20-018.

Effective July 1st, 2023, all supplemental rebates received for covered outpatient drug claims, pursuant to these agreements, are collected from manufacturers based on drug utilization for fee-for-service Medicaid beneficiaries and managed care Medicaid beneficiaries.

Supplemental rebates received by the State in excess of those required under the national drug rebate agreement will be shared with the federal government on the same percentage basis as applied under the national rebate agreement. All drugs covered by the program, irrespective of prior authorization requirement, will comply with the provisions of the national rebate agreement.

Effective July 1st, 2023, the State may enter into value/outcomes-based contracts with manufacturers on a voluntary basis. The Value-Based Supplemental Rebate Agreement will

apply to the Medicaid drug benefit for both the fee-for-service and managed care entity (MCE) drugs in accordance with the Statewide Uniform Preferred Drug List for all covered outpatient drugs.

12.b. Dentures

Provided with limitations.
Prior review and authorization by the agency is required for all dentures, partials and repairs.

12.c. Prosthetic devices

Prior authorization by the Office of Medicaid Policy and Planning is required for all prosthetic devices, except for all customizing features once the basic prosthesis is approved.

Coverage is not available for prosthetic devices dispensed for purely cosmetic reasons.

12.d. Eyeglasses

Covered for medically reasonable and necessary eyeglasses, with the following limitations:

(1) Eyeglasses provided to a recipient under 21 years of age will be limited to a maximum of 1 pair per year. Limits can be exceeded based on medical necessity.
(2) Eyeglasses provided to a recipient 21 years of age or over will be limited to a maximum of 1 pair every 5 years.

Medically necessary and reasonable is defined as a covered service required for the care or well being of the patient and is provided in accordance with generally accepted standards of medical or professional practice.

Coverage is not available for:

(I) Lenses with decorative designs.
(2) Fashion tints, gradient tints, sunglasses and photochromatic lenses.
(3) Oversized lenses larger than 61 mm, except when medically necessary.

13. Other diagnostic, screening preventive and rehabilitative services

Covered for medically necessary diagnostic preventative, therapeutic, and rehabilitative services

Medically necessary is defined as a covered service required for the care or well being of the patient and is provided in accordance with generally accepted standards of medical or professional practice

13.a. Diagnostic services

Covered for medically necessary diagnostic preventative, therapeutic, and rehabilitative services.

Coverage for environmental lead investigations is available for a one-time, on-site environmental lead investigation of a child's home or primary residence for a child with an elevated blood lead level. This environmental lead investigation will be provided by a licensed risk assessor or licensed lead inspector.

Medically necessary is defined as a covered service required for the care or well-being of the patient and is provided in accordance with generally accepted standards of medical or professional practice.

13.a.1 Face-to-Face Tobacco Dependence Services

Provided with Limitations:
Reimbursement is available for tobacco dependence treatment.

Tobacco dependence treatment includes covered legend or nonlegend drugs intended to reduce an individual's dependence on tobacco products as well as tobacco dependence counseling. A member prescribed a legend or nonlegend drug intended to reduce an individual's dependence on tobacco products must engage in tobacco dependence counseling in conjunction with the receipt of said legend or nonlegend drug therapy.

Reimbursement is available for tobacco dependence counseling services rendered by licensed practitioners under applicable Indiana law participating in the Indiana Medicaid program.

The following may provide tobacco dependence counseling services when prescribed by a practitioner within the scope of his license under Indiana law and within the limitations set out in this state plan:

(1) A physician.
(2) A physician's assistant.
(3) A nurse practitioner.
(4) A registered nurse.
(5) A psychologist.
(6) A pharmacist.
(7) A dentist.
(8) An optometrist.
(9) A clinical social worker.
(10) A martial and family counselor.
(11) A mental health counselor.
(12) A licensed clinical addictions counselor.

13.b. Screening Services

"Screening services" means the use of standardized tests given under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations.

Reimbursement is available for medically reasonable and necessary screening services. Medically reasonable and necessary service is defined as a covered service required for the care or well being of the patient and is provided in accordance with generally accepted standards of medical or professional practice.

13.c. Preventive Services

"Preventive services" means services recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized practice under State law to—
(1) Prevent disease, disability, and other health conditions or their progression;
(2) Prolong life; and
(3) Promote physical and mental health and efficiency.

Reimbursement is available for medically reasonable and necessary preventative services. Medically reasonable and necessary service is defined as a covered service required for the care or well being of the patient and is provided in accordance with generally accepted standards of medical or professional practice.

Indiana covers and reimburses all approved grade A and B preventive services and approved adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), and their administration, without cost-sharing. Changes to ACIP recommendations are incorporated into coverage and billing codes as necessary to comply with revisions.

13.d. Rehabilitative Services

"Rehabilitative services," includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level.

Reimbursement is available for medically reasonable and necessary rehabilitative services. Medically reasonable and necessary service is defined as a covered service required for the care or well being of the patient and is provided in accordance with generally accepted standards of medical or professional practice.

The intensity of service criteria shall be as follows:
(1) Multidisciplinary team evaluations should occur at minimum every two (2) weeks.
(2) Physical therapy and at least one (1) of the following therapies (totaling a minimum of three (3) hours daily):
(A) Occupational therapy.
(B) Speech therapy.
(3) Participation in a rehabilitation program under the direction of a qualified physician.
(4) Skilled rehabilitative nursing care or supervision required at least daily.

Discharge criteria may include, at minimum, the following:
(1) Evidence in the medical record indicating the patient has achieved stated goals.
(2) Medical complications precluding intensive rehabilitative effort.
(3) Multidisciplinary therapy is no longer needed.
(4) Additional functional improvement is not anticipated.
(5) Patient's functional status has remained unchanged for fourteen (14) days.

Educational services are not covered.

13.d.1. Medicaid Rehabilitation Option

Reimbursement is available for Medicaid Rehabilitation Option (MRO) services, which are defined as:

(1) Behavioral Health Counseling and Therapy services. Refers to a series of time-limited, structured, face-to-face sessions that work toward the goals identified in the individualized integrated care plan.

These services include the following:

- Individual counseling and therapy
- Family/Couple (Individual) with the consumer present counseling and therapy
- Family/Couple (Individual) without the consumer present counseling and therapy
- Group counseling and therapy
- Family/Couple (Group) with the consumer present counseling and therapy
- Family/Couple (Group) without the consumer present counseling and therapy

Services may be provided for persons who are living in the community and who need aid on an intermittent basis for emotional disturbances, mental illness, or addiction. Services may be provided in an individual or group setting, and with family members or other caretakers of the person in need of services. Services must be provided at home or at other locations outside the clinic setting.

The following providers are qualified to deliver this service:

- Licensed professional, except for a licensed clinical addiction counselor, defined as: Individuals wishing to be addiction counselors or clinical addiction counselors must meet the education, counseling experience, examination and exemptions, renewal of licensure, and temporary permit requirements of the State of Indiana.
- Qualified Behavioral Health Professional (QBHP)

Limitations: Service packages authorize the following units of service for 180 days based on a member's level of need (LON). Any additional medically necessary units of service may be prior authorized.

Adult		
Level of Need	Service Type	Units per 180 days (15 min.)
3	Individual Counseling and Therapy	32
4	Individual Counseling and Therapy	48
5	Individual Counseling and Therapy	48
5A	Individual Counseling and Therapy	48
3	Group Counseling and Therapy	48
4	Group Counseling and Therapy	60
5	Group Counseling and Therapy	60
5A	Group Counseling and Therapy	60

Child/Adolescent		
Level of Need	Service Type	Units per 180 days (15 min.)
3	Individual Counseling and Therapy	32
4	Individual Counseling and Therapy	48
5 /6	Individual Counseling and Therapy	48
3	Group Counseling and Therapy	48
4	Group Counseling and Therapy	60
5 /6	Group Counseling and Therapy	60

(2) Medication Training and Support services. Refers to monitoring medication compliance, providing education and training about medications, monitoring medication side effects, and providing other nursing/medical assessments. Services may be provided for persons who are living in the community and who need aid on an intermittent basis for emotional disturbances, mental illness, or addiction. Services may be provided in an individual or group setting, and with family members or other caretakers of the person in need of services. Services must be provided at home or at other locations outside the clinic setting.

The following providers are qualified to deliver this service:

- Licensed physician
- Authorized health care professional
- Licensed physician assistant (PA)
- Licensed registered nurse (RN)
- Licensed practical nurse (LPN)
- Medical Assistant (MA) who has graduated from a two (2) year clinical program

Limitations: Service packages authorize the following units of service for 180 days based on a member's level of need (LON). Any additional medically necessary units of service may be prior authorized.

Adult		
Level of Need	Service Type	Units per 180 days (15 min.)
3	Medication Training and Support	60
4	Medication Training and Support	104
5	Medication Training and Support	104
5A	Medication Training and Support	104

Child/Adolescent		
Level of Need	Service Type	Units per 180 days (15 min.)
3	Medication Training and Support	60
4	Medication Training and Support	104
5 /6	Medication Training and Support	104

(3) Skills Training and Development services. Refers to the development and/or restoration of skills (i.e., self-care, daily life management, or problem solving skills) directed toward restoring an individual to his best possible functional level, eliminating psychosocial barriers, and restoring a consumer's abilities that are essential to independent living. Development and/or restoration of skills is provided

through structured interventions for attaining recovery goals identified in the individualized integrated care plan and the monitoring of progress in achieving those skills. Services may be provided for persons who are living in the community, or who are residing in an ASAM 3.1 Substance Use Disorder Residential Treatment Facility, and who need aid on an intermittent basis for emotional disturbances, mental illness, or addiction. Services may be provided in an individual or group setting, and with family members or other caretakers of the person in need of services.

The following providers are qualified to deliver this service:

- Licensed professional
- QBHP
- OBHP

Limitations: Service packages authorize the following units of service for 180 days based on a member's level of need (LON). Any additional medically necessary units of service may be prior authorized.

Adult		
Level of Need	Service Type	Units per 180 days (15 min.)
3	Skills Training and Development	600
4	Skills Training and Development	750
5	Skills Training and Development	900
5A	Skills Training and Development	1000

Child/Adolescent		
Level of Need	Service Type	Units per 180 days (15 min.)
3	Skills Training and Development	600
4	Skills Training and Development	750
5/6	Skills Training and Development	900

(4) Behavioral Health Level of Need Redetermination. Refers to services required to assess an individual's functional needs and strengths, determine level of need, and make changes to the individualized integrated care plan. The assessment is used as a clinical guide and a treatment planning tool which assists providers in creating a person-centered plan of care. The redetermination includes face-to-face contact with the consumer and face-to-face or telephone collateral contacts with family members or non-professional caretakers, which results in a completed redetermination. Services may be provided for persons who are living in the community and who need aid on an intermittent basis for emotional disturbances, mental illness, or addiction.

The following providers are qualified to deliver this service:

- Individuals meeting the Division of Mental Health and Addiction's (DMHA) training competency standards for the performance of the DMHA approved assessment tool.

Limitations:

- Reimbursement is allowed for one redetermination per 180 days for Adults LON 3-5A and Children/Adolescents LON 3-6.

- Care Coordination services. Refers to the coordination of services to manage a mental health or substance use disorder. Care coordination services include the assessment of the eligible consumer to determine mental health and substance abuse treatment service needs, development of an individualized integrated care plan, referral and related activities to help the consumer obtain needed services, monitoring and follow-up, and evaluation. Care coordination is a service on behalf of the consumer, not to the consumer, and is management of the case, not the consumer.
  The following providers are qualified to deliver this service:
  - A licensed professional
  - A QBHP
  - An OBHP

  Limitations:
- Activities billed under behavioral health level of need redetermination.
- The actual or direct provision of medical services or medical treatment.

(5) [Crisis Intervention services has been moved to Attachment 3.1-A, Addendum Page 9c.2].

(6) Child and Adolescent Intensive Resiliency Services (CAIRS). Refers to a time-limited, non-residential service provided in a clinically supervised setting that provides an integrated system of individual, family and group interventions based on an individualized integrated care plan. CAIRS includes therapeutic services such as clinical therapies, psycho-educational groups, and rehabilitative services such as skills training and development and medication training and support. CAIRS is designed to alleviate emotional or behavioral problems with the goal of reintegrating the child into the community setting and restore a beneficiary to his best possible functional level. CAIRS is provided in close coordination with the educational program provided by the local school district. CAIRS is time-limited, curriculum-based, with goals that include reintegration into age appropriate community settings (e.g., school and activities with pro-social peers). Services may be provided for persons who are living in the community and who need aid on an intermittent basis for emotional disturbances, or addiction. Children who do not meet the medical necessity criteria for CAIRS will receive comparable treatment services under Early and Periodic Screening, Diagnostic and Treatment.
The following providers are qualified to deliver this service:

- Licensed professional
- QBHP
- OBHP

Limitations:

- The program is required to operate 2-4 hours per day and 3-5 days per week.
- Service packages authorize the following units of service for 180 days based on a member's level of need (LON). Any additional medically necessary units of service may be prior authorized.

Child/Adolescent		
Level of Need	Service Type	Units per 180 days (1 hour)
4	CAIRS	252-Limited to 90 consecutive days
5 /6	CAIRS	252-Limited to 90 consecutive days

(7) Adults Intensive Rehabilitative Services (AIRS). Refers to a time-limited, non-residential service provided in a clinically supervised setting for consumers who require structured rehabilitative services to maintain the consumer on an outpatient basis. AIRS is curriculum based and designed to alleviate emotional or behavior problems with the goal of reintegrating the consumer into the community, increasing social connectedness beyond a clinical setting, and/or employment. AIRS includes therapeutic services such as clinical therapies, psycho-educational groups, and rehabilitative services such as skills training and development and medication training and support. Services may be provided for persons who are living in the community and who need aid on an intermittent basis for mental illness, or addiction.

The following providers are qualified to deliver this service:

- Licensed professional
- QBHP
- OBHP

Limitations:

- The program is required to operate 2-6 hours per day and 3-5 days per week
- Service packages authorize the following units of service for 180 days based on a member's level of need (LON). Any additional medically necessary units of service may be prior authorized.

Adult		
Level of Need	Service Type	Units per 180 days (1 hour)
4	CAIRS	270-Limited to 90 consecutive days
5 /6	CAIRS	270-Limited to 90 consecutive days

(8) [Intensive Outpatient Treatment (IOT) has been moved to Attachment 3.1-A, Addendum Page 9c.2].

(9) Addiction Counseling services. Refers to a planned and organized service where addiction professionals and clinicians provide counseling intervention. Addiction counseling services to the beneficiary's family and caretakers is for the direct benefit of the beneficiary, in accordance with the beneficiary's needs and treatment goals identified in the beneficiary's treatment plan, and for the purpose of assisting in the beneficiary's recovery. In addition to individual, group, and family addiction counseling, other activities included are: education on addiction disorders and skills training in communication, anger management, stress management and relapse prevention. Services may be provided for persons who are living in the community and who need aid on an intermittent basis for emotional disturbances, mental illness, or addiction. Services may be provided in an individual or group setting, and with family members or other caretakers of the person in need of services.

The following providers are qualified to deliver this service:

- Licensed professional
- QBHP

Limitations: Service packages authorize the following units of service for 180 days based on a member's level of need (LON). Any additional medically necessary units of service may be prior authorized.

Adult		
Level of Need	Service Type	Units per 180 days (1 hour)
3	Addiction Counseling	32
4	Addiction Counseling	32
5	Addiction Counseling	32
5A	Addiction Counseling	50

Child/Adolescent		
Level of Need	Service Type	Units per 180 days (1 hour)
3	Addiction Counseling	32
4	Addiction Counseling	32
5 /6	Addiction Counseling	32

(10) [Peer Recovery Services has been moved to Attachment 3.1-A, Addendum Page 9c.3].

(11) Psychiatric Assessment and Intervention services. Refers to face-to-face and non-face-to-face activities that are designed to provide psychiatric assessment, consultation, and intervention services to consumers who are receiving services from an interdisciplinary team. Services may be provided for persons with a history of multiple hospitalizations and severe challenges in maintaining independent living within the community.

The following providers are qualified to deliver this service:

- Physician
- Authorized healthcare professional

Limitations: Service packages authorize the following units of service for 180 days based on a member's level of need (LON). Any additional medically necessary units of service may be prior authorized.

Adult		
Level of Need	Service Type	Units per 180 days (15 min.)
5	Psychiatric Assessment and Intervention	25
5A	Psychiatric Assessment and Intervention	100

MRO SERVICES WILL CONTINUE ON PAGE 9d

Opioid Treatment Services

Opioid treatment services refers to rehabilitative services for an individual to administer opioid treatment medication and to alleviate the adverse medical, psychological, or physical effects incident to opioid addiction. Opioid treatment services consist of the following Medicaid service components:

- U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medication
- Dispensing and administration of MAT medications
- Substance use disorder counseling
- Toxicology testing
- Individual and group therapy
- Intake Activities
- Periodic Assessments

Other services not defined as OTP services in this section may be covered by an opioid treatment program provider if deemed appropriate by the Office of Medicaid Policy and Planning (OMPP) and complying within coverage specifications listed in 3.1-A Addendum: Page 2.1, Item 5.a; Page 3, Item 6.d; and Page 7, Item 12.a. Any individual providing opioid treatment services that is not licensed by the State must instead be credentialed in addictions counseling by a nationally recognized credentialing body approved by the Division of Mental Health and Addiction. All opioid treatment services furnished by these credentialed individuals must be recommended by a physician or other licensed practitioner of the healing arts.

Counseling services provided by an OTP may be rendered via audio-visual and audio-only telehealth.

Limitations:

- Services must be rendered in an Opioid Treatment Program that has been certified under 42 C.F.R. 8 (regarding the process and standards by which SAMHSA determines that an opioid treatment program is qualified to provide opioid treatment under the Federal opioid treatment standards), and approved by the Family and Social Services Administration's Division of Mental Health and Addiction.

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Crisis Intervention Services

Refers to short-term emergency behavioral health services, available twenty-four (24) hours a day, seven (7) days a week. Crisis Intervention includes, but is not limited to crisis assessment planning and counseling specific to the crisis, intervention at the site of the crisis (when clinically appropriate), and pre-hospital assessment. The goal of Crisis Intervention is to resolve the crisis, and transition the consumer to routine care through stabilization of the acute crisis and linkage to necessary services. Crisis Intervention may be provided in an emergency room, clinic setting, or within the community. Services may be provided to any Medicaid eligible individual in need of crisis services.
The following providers are qualified to deliver this service:

- Licensed professional
- QBHP
- OBHP

There are no limitations on this service.

Intensive Outpatient Treatment (IOT)

Reimbursement is available for intensive outpatient treatment when provided to treat substance abuse or psychiatric disorders, subject to prior authorization. IOT must operate at least three (3) hours per day, at least three (3) days per week and must be based on an individualized integrated care plan.

The Medicaid covered service components are covered by the State through licensed professionals under 42 C.F.R. 440.60 and are as follows:

- Individual/Family Therapy (Attachment 3.1-A Addendum Page 3.1); and
- Group Therapy (Attachment 3.1-A Addendum Page 3.1).

The Medicaid covered service components and the practitioners who are qualified to provide them are as follows:

- Skills Training (Attachment 3.1A Addendum Page 8b and 8c);
- Medication Training and Support (Attachment 3.1A Addendum Page 8b);
- Peer Recovery Services (Attachment 3.1A Addendum Page 9c.3); and
- Care Coordination (Attachment 3.1A Addendum Page 9).

Services may be provided for persons who are living in the community and who need aid on an intermittent basis for emotional disturbances, mental illness, or addiction. Therapy services to the beneficiary's family and caretakers are for the direct benefit of the beneficiary, in accordance with the beneficiary's needs and treatment goals identified in the beneficiary's treatment plan, and for the purpose of assisting in the beneficiary's recovery.

The following providers are qualified to deliver Individual/Family Therapy; Group Therapy; Skills Training; Medication Training and Support; Peer Recovery Services; and Care Coordination.

- Licensed professional
- QBHP
- OBHP

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Peer Recovery Services	Refers to individual face-to-face services that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Services which may be provided include: • Assisting the consumer with developing self-care plans, and other formal mentoring activities aimed at increasing active participation in person-centered planning and delivery of individualized services. • Assisting the consumer in the development of psychiatric advanced directives. • Supporting day-to-day problem solving related to normalization and reintegration into the community. • Education and promotion of recovery and anti-stigma activities associated with mental illness and addiction. Peer Recovery Services must demonstrate progress toward and/or achievement of consumer treatment goals identified in the individualized integrated care plan (IICP). An IICP is developed with the consumer and must reflect the consumer's desires and choices. Services may be provided for persons who are living in the community and who need aid on an intermittent basis for mental illness or addiction. Services must be provided at home or at other locations outside the clinic setting. The following providers are qualified to deliver this service: • Individuals certified in Peer Recovery Services. Individuals providing Peer Recovery Services must be under the supervision of a Licensed professional or QBHP and must be self-identified consumers who are in recovery from mental illness and/or substance use disorders, are trained in a basic set of competencies necessary to perform the peer support function, have demonstrated the ability to support the recovery of others from mental illness and/or substance use disorders, and receive continuing and ongoing education as administered by agencies certified by the Department of Mental Health and Addiction (DMHA).

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Mobile Crisis Services

Mobile crisis services, authorized under 42 CFR 440.130(d), are mobile, face-to-face, home and community-based interventions that serve individuals experiencing a mental health or substance use-related crisis. Mobile crisis services must be recommended by a physician or other licensed practitioner and consist of a multidisciplinary team of trained providers who arrive and respond to mental health/substance use crises in the community operating 24-hours, 7 days per week. Services must be provided to individuals outside of a hospital or other facility settings including community mental health centers.

Mobile crisis services are tailored to meet the needs of the individual and may include:

- Triage/Screening: Screening to determine the level of risk faced by the individual in crisis and assessing the most appropriate response.
- Assessment: Collects information on the circumstances of the crisis event, safety and risk related to the individual and others involved, medication and substance use, strengths and resources of the individual, recent inpatient hospitalizations or mental health services, mental health conditions, medical history, and other pertinent information.
- De-escalation through brief counseling: Brief counseling techniques specific to the crisis that aims to lower risks and resolve the crisis so that a higher level of care is not needed.
- Care Coordination: Linkage of the individual in crisis to ongoing services to address the identified need(s). Services may include referrals for crisis stabilization, inpatient hospitalization, acute detoxification services, residential treatment services, recovery support services, medication services, home-based services, outpatient services, respite services, housing, and follow-up contacts.
- Crisis Intervention: Crisis assessment, crisis planning, and counseling specific to the crisis.
- Safety Planning: Engagement of the individual in a crisis planning process, resulting in the creation or update of planning tools, including an individualized safety plan. The safety plan aims to keep an individual in crisis and their environment safe and may include lethal means counseling, and other evidence-based interventions.
- Peer Recovery Support: Support provided by paraprofessional with lived experience with mental health and/or substance use disorder concerns.
- Medication Training and Support: Monitoring medication compliance, providing education and training about medications, monitoring medication side effects, and providing other

nursing/medical assessments. Allows for monitoring of medication-assisted treatment (MAT) and/or psychotropic medication services.

- Follow-up stabilization services: Follow up contacts in-person, via phone, or telehealth up to 14 days following initial crisis intervention. These services include coordination/warm hand-offs with identified resource needs (such as insurance navigation, housing, benefits and entitlements, physical health concerns, educational and/or vocational supports) which are intended to address precipitating mental health or substance use disorder factors leading to the crisis.

Mobile crisis teams are designated by the Division of Mental Health and Addiction (DMHA) and may include law enforcement-based co-responder behavioral health teams. Mobile crisis teams must include a minimum of two individuals with one individual able to perform an assessment within their scope of practice under Indiana state law. In accordance with Indiana state law mobile crisis teams must include:

- Individuals certified in Peer Recovery Services: Self-identified consumers who are in recovery from mental illness and/or substance use disorders, are trained in a basic set of competencies necessary to perform the peer support function, have demonstrated the ability to support the recovery of others from mental illness and/or substance use disorders, and receive continuing and ongoing education as approved by the DMHA; and
- At least one of the following:
    - Behavioral health professional licensed under Indiana state law, including marriage and family therapists, social workers, mental health counselors, addiction counselors and clinical addiction counselors
    - Other behavioral health professional (OBHP) as defined in Indiana Administrative Code working under a community mental health center (CMHC).
    - Emergency medical services personnel licensed in accordance with Indiana state law
    - Teams may include Community Health Workers certified by national certification programs that meet the state established Community Health Workers core competencies.

Mobile crisis services must be provided under the supervision of:

- Behavioral health professional licensed in accordance with Indiana state law;
- Licensed physician; or
- Licensed advanced practice nurse or clinical nurse specialist.

Supervision may be performed remotely.
All members of a mobile crisis team must complete state training on

person-centered care, trauma-informed care, de-escalation strategies, and harm reduction.

(12) Psychosocial rehabilitation services. Refers to Medicaid Rehabilitation Option (MRO) services provided in a community based Clubhouse setting in which the member, with staff assistance, is engaged in operating all aspects of the clubhouse, including food service, clerical, reception, janitorial and other member services such as employment training, housing assistance, and educational support. These activities are designed to alleviate emotional or behavior problems with the goal of transitioning to a less intense level of care, reintegrating the member into the community, and increasing social connectedness beyond a clinical or employment setting. The Clubhouse setting is tailored to address the social isolation and social stigma experienced by many persons suffering from mental illness. Psychosocial rehabilitation services are covered when provided under the authority of an approved Division of Mental Health and Addiction (DMHA) Medicaid Rehabilitation Option (MRO) provider as authorized by a physician or health service provider in psychology (HSPP). Psychosocial rehabilitation services consist of the following Medicaid covered service component:

- Skills Training and Development: Refers to the development and/or restorations of skills (i.e., self-care, daily life management, or problem solving skills) directed toward restoring an individual to his best possible functional level, eliminating psychosocial barriers, and restoring a consumer's abilities that are essential to independent living.

The following providers are qualified to provide these services:

- Licensed professional
- Qualified behavioral health professional (QBHP)
- Other behavioral health professional (OBHP)
- Authorized health care professional (AHCP)

Limitations:

- Services may only be rendered in an internationally accredited Clubhouse setting certified by DMHA.
- Services are available for individuals with an Adult Needs and Strengths Assessment (ANSA) level of need (LON) of 3, 4, 5 or 5A.
- Service packages authorize the following units of service for 180 days for any member with a level of need LON of 3 or above. Any additional medically necessary units of service may be prior authorized.

Level of Need	Service Type	Units per 180 days (15 min.)
3, 4, 5, 5A	Clubhouse psychosocial rehabilitation services	1,820

Adult		
Level of Need	Service Type	Units per 180 days (15 min.)
5	Psychiatric Assessment and Intervention	25
5A	Psychiatric Assessment and Intervention	100

Service Packages and Prior Authorization

MRO service packages are assigned to persons with a behavioral health need as demonstrated by a qualifying diagnosis and level of need. Services packages are designed to authorize a set of services and units of service necessary for the majority of persons with similar functional needs to achieve recovery. Service packages are assigned for 180 days based on the level of need assessment. Within the last 30 days of an assigned service package, a provider may reassess the person and a new service package will be assigned to start the day after the existing service package ends.

- Prior authorization is available under the following circumstances: A member depletes units within his or her MRO service package and requires additional units of a medically necessary MRO service.
- A member requires a medically necessary MRO service not authorized in his or her MRO service package.
- A member does not have one or more qualifying MRO diagnoses and/ or LON for the assignment of an MRO service package, and has a significant behavioral health need that requires a medically necessary MRO service.
- A member is newly eligible to the Medicaid program, or had a lapse in his or her Medicaid eligibility, and was determined Medicaid eligible for a retroactive period. In this case, a retroactive request for prior authorization is appropriate for MRO services provided during the retroactive period.

Providers must demonstrate that the service requested is medically necessary.

Individualized Integrated Care Plan Requirements

The following providers are able to certify a diagnosis for the purpose of developing an individualized integrated care plan (IICP) and approve the IICP for MRO services:

- A physician
- A licensed psychologist endorsed as a health service provider in psychology (HSPP)
- An advanced practice registered nurse (APRN)
- A licensed clinical social worker (LCSW)
- A licensed marriage and family therapist (LMFT)
- A licensed mental health counselor (LMHC)
- A licensed clinical addiction counselor (LCAC)

The supervising practitioner is responsible for seeing the patient during the intake process or reviewing information submitted by the other licensed professionals, qualified behavioral health provider (QBHP), or other behavioral health provider (OBHP) and approving the individualized integrated care plan within seven (7) days. Services included in an individualized plan of treatment must commence within two (2) weeks upon completion of a patient's intake assessment. The supervising practitioner must provide face to face visits with the patient or review the individualized integrated care plan submitted by the QBHP at intervals not to exceed ninety (90) days. These reviews must be documented and signed by the supervising practitioner assuming responsibility for the care plan

Provider Qualification Definitions
A licensed professional is defined as:
(1) A licensed psychiatrist.
(2) A licensed physician.
(3) A licensed independent practice school psychologist.
(4) A licensed psychologist or a psychologist endorsed as a health service provider in psychology (HSPP).
(5) A licensed clinical social worker (LCSW).
(6) A licensed mental health counselor (LMHC).
(7) A licensed marriage and family therapist (LMFT).
(8) A licensed clinical addiction counselor (LCAC), as defined under IC 25-23.6-10.5.

A "qualified behavioral health professional" (QBHP) means any of the following persons:
(1) An individual who has had at least two (2) years of clinical experience treating persons with mental illness under the supervision of a licensed professional, as defined above, with such experience occurring after the completion of a master's degree or doctoral degree, or both, in any of the following disciplines:

(a) In psychiatric or mental health nursing from an accredited university, plus a license as a registered nurse in Indiana.
(b) In pastoral counseling from an accredited university.
(c) In rehabilitation counseling from an accredited university.

(2) An individual who is under the supervision of a licensed professional, as defined above, is eligible for and working towards licensure, and has completed a master's or doctoral degree, or both, in any of the following disciplines:

(a) In social work from a university accredited by the Council on Social Work Education.
(b) In psychology from an accredited university.
(c) In mental health counseling from an accredited university.
(d) In marital and family therapy from an accredited university.

(3) An authorized healthcare provider (AHCP), defined as follows:

(a) a physician assistant with the authority to prescribe, dispense and administer drugs and medical devices or services under an agreement with a supervising physician and subject to the requirements of their scope of practice as defined by the Indiana Professional Licensing Agency (IPLA) (IC 25-27.5-5)/.
(b) a nurse practitioner or a clinical nurse specialist, with prescriptive authority and performing duties within the scope of that person's license and under the supervision of, or under a supervisory agreement with, a licensed physician as stated in the section of state law (IC 25-23-1) related to advanced practice nurse collaboration with a licensed practitioner.

Other behavioral health professional (OBHP) means any of the following persons:
(1) An individual with an associate or bachelor degree, or equivalent behavioral health experience, meeting minimum competency
standards set forth by a behavioral health service provider and supervised by either a licensed professional, as defined above, or a QBHP, as defined above.

may include: twenty-four (24) hour a day crisis intervention; care coordination to fulfill individual patient needs, including assertive care coordination when indicated; outpatient services, including intensive outpatient services, substance abuse services, counseling, and treatment; acute stabilization services, including detoxification services; residential services; day treatment; family support services; medication evaluation and monitoring; and services to prevent unnecessary and inappropriate treatment and hospitalization.

(c) Community Mental Health Centers wishing to provide MRO services must be certified to provide a continuum of care to Medicaid consumers. These providers may subcontract for services as appropriate.

(d) This MRO State Plan service is to run concurrently with the 1915(b)(4) fee-for-service selective contracting waiver (IN.03).

14. Services for individuals age 65 or older in institutions for mental diseases

Provided with limitations.

14.a.

Inpatient hospital services Reimbursement is available for medically reasonable and necessary inpatient psychiatric hospital services. Medically reasonable and necessary service is defined as a covered service required for the care or well being of the patient and is provided in accordance with generally accepted standards of medical or professional practice.

Prior authorization is required for all inpatient psychiatric admissions including admissions for substance abuse

Reimbursement is available for emergency admissions only in cases of a sudden onset of a psychiatric condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in one (1) of the following:

(1) Danger to the individual.
(2) Danger to others.
(3) Death of the individual.

Medicaid reimbursement will be denied for any days during which the inpatient psychiatric hospitalization or stay in a psychiatric residential treatment facility is found not to have been medically necessary.

15.a.	Intermediate Care Facility Services	Provided with limitations. Reimbursement is available for medically reasonable and necessary services provided by a certified intermediate care facility for the mentally retarded (ICF/MR), subject to prior authorization.
15.b.	Including such services in a public institution for the mentally retarded	Provided with limitations. Reimbursement is available for medically reasonable and necessary services provided by a certified intermediate care facility for the mentally retarded (ICF/MR), subject to prior authorization
16.	Inpatient Psychiatric Facility Services for Individuals under Age 21	Provided with limitations. Reimbursement is available for medically reasonable and necessary services for inpatient psychiatric hospital and psychiatric residential treatment facility services for individuals under age 21 years of age subject to prior authorization.
17.	Nurse-Midwife Services	Provided with limitations. Medicaid reimbursement is available for services rendered by a certified nurse-midwife. Coverage of certified nurse-midwife services is restricted to services the nurse-midwife is legally authorized to perform, including well-woman gynecological healthcare, family planning, and care to the normal and expanding family throughout pregnancy, labor, delivery, and post-delivery.
18.	Hospice Care	Provided with limitations. Medicaid reimbursement is available for hospice services subject to prior authorization. Hospice services consist of the following: (1) Palliative care for the physical, psychological, social, spiritual, and other special needs of a hospice program patient during the final stages of the patient's terminal illness. (2) Care for the psychological, social, spiritual, and other needs of the hospice program patient's family before and after the patient's death. In order for an individual to receive Medicaid-covered hospice services, a physician must certify in writing the individual is terminally ill and expected to die from that illness within six (6) months. For recipients twenty-one (21) years of age and older, In order to receive hospice services, a recipient must elect hospice services. Election of the hospice benefit requires the recipient to waive Medicaid coverage for other forms of health care for the treatment of the terminal illness for which hospice care was elected, or for treatment of a condition related to the terminal illness. For recipients less than twenty-one (21) years of age who elect hospice care, the recipient may receive concurrent curative treatment in conjunction with hospice services for the terminal illness. This allows the recipient or the recipient's representative to elect the hospice benefit, without forgoing any curative service the recipient is entitled to under Medicaid for treatment of the terminal condition.

19. Targeted Case Management for: Recipients with Elevated Blood Lead Levels	Reimbursement is available for targeted case management when provided in accordance with 42 CFR 440.169 and for individuals, who, through a blood lead screening conducted in accordance with the EPSDT periodicity schedule, are found with a confirmed elevated blood lead level, as defined by the Centers for Disease Control and Prevention. Reimbursement is limited to no more than 26, 15 minute units, per recipient, per twelve month period of time. Prior authorization is required for additional units of medically necessary targeted case management.
20. Extended Services for Pregnant Women	Reimbursement is available for extended services for pregnant women with limitations and include the following: - Pregnancy-related and postpartum services for 60 days after the pregnancy ends -Services for any other medical conditions that may complicate pregnancy Services must be medically necessary and reasonable and defined as a covered service required for the care or well being of the patient and provided in accordance with generally accepted standards of medical or professional practice.
20.a. Pregnancy-related and postpartum services for 60 days after the pregnancy ends	Coverage is limited to legend and non-legend drugs, prescribed for indications directly related to the pregnancy and routine prenatal, delivery and postpartum care, including family planning services. Additionally, transportation services, to and from the aforementioned services, will be provided. Payment for pregnancy-related services is subject to prior authorization.
20.b. Services for any other medical conditions that may complicate pregnancy	Reimbursement is available for services provided to a pregnant woman for the treatment of a chronic condition or other abnormal condition related to the pregnancy or complicates the medical management of the mother during pregnancy, childbirth and Puerperium including those conditions associated with fetal abnormalities and conditions. A condition that may complicate the pregnancy, is any condition manifesting itself by symptoms of sufficient severity that the absence of medical attention could reasonably be expected to result in a deterioration of the patient's condition or a need for a higher level of care. Reimbursement is available subject to prior authorization.

23. Pediatric or Family Nurse Practitioners' services

Provided with limitations.
Reimbursement is available for medically necessary and preventive health care services provided by a licensed, certified nurse practitioner within the scope of practice of the applicable license and certification.

24. Any other medical or remedial care recognized by state law

Provided as described in 24a – 24d.

24.a. Transportation services

Reimbursement is available for emergency and nonemergency transportation to or from a Medicaid covered service. Providers located within Indiana or in a designated out of state area may be reimbursed for up to twenty (20) one-way trips of less than fifty (50) miles each, per recipient, per twelve (12) month period, without prior authorization. Designated out-of-state areas are the following:

(A) Louisville, Kentucky
(B) Cincinnati, Ohio
(C) Harrison, Ohio
(D) Hamilton, Ohio
(E) Oxford, Ohio
(F) Sturgis, Michigan
(G) Watseka, Illinois
(H) Danville, Illinois
(I) Owensboro, Kentucky

Prior authorization is required for the following:

(1) More than 20 one-way trips, per recipient, per rolling 12-month period.
(2) Trips of 50 miles or more one way
(3) In-state train or bus transportation services, including out-of-state designated areas.
(4) Transportation services provided by a provider located in a non-designated, out-of-state area.
(5) Airline, air ambulance, and interstate transportation
(6) Family member transportation
(7) Medically necessary school-based specialized transportation

(a) School-based specialized transportation is defined as transportation to a medically necessary service (as outlined in the Individualized Education Plan (IEP)/Individualized Family Service Plan (IFSP) of an enrolled Medicaid beneficiary) provided in a specially adapted (e.g., specially adapted school bus or van) that has been physically adjusted or designed to meet the needs of the individual student under the Individuals with Disabilities Education Act (IDEA) (e.g., special harnesses, wheelchair lifts, ramps, specialized environmental controls, etc.,) to accommodate students with disabilities in the school-based setting.

(b) School-based specialized transportation is available to "Medicaid-eligible beneficiaries for whom the transportation services are medically necessary and documented in IEP/IFSP. School-based specialized transportation must be provided on the same date of service that a Medicaid covered service required by the student's IEP/IFSP is received

(c) The Medicaid enrolled student's IEP/IFSP as required by IDEA serves as the prior authorization for medically necessary school-based specialized transportation services when provided by a Medicaid participating school corporation. No additional prior authorization is required.

(d) School-based specialized transportation is provided by personnel who are employed by or under contract with a Medicaid-participating school corporation provider.

Trip limits can be exceeded based on prior authorization review and confirmation of a covered services associated with the trip.

		Except for trips over 50 miles, the following services are exempt from the numeric trip cap and prior authorization requirements: (1) Emergency ambulance services (2) Transportation to or from a hospital for an inpatient admission (3) Transportation for patients on renal dialysis or residing in a nursing home (4) Accompanying parent or recipient attendant (5) Return trip from emergency room in an ambulance
24.b.	Services provided in Religious Nonmedical Health Care Institutions	Provided within the limitations of 42 CFR 440.170(b).
24.c		Reserved
24.d.	Skilled Nursing Facility Services for Patients under 21 Years of Age	Reimbursement is available for skilled nursing services provided by a licensed and certified nursing facility when rendered to a Medicaid recipient whose level of care has been approved by the Medicaid agency.

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE

AND SERVICES TO THE CATEGORICALLY NEEDY

28. (i) Freestanding Birth Center services: Reimbursement is available for licensed or otherwise State-approved freestanding birthing centers

Provided: ___ No limitations _X_ With limitations ___ None licensed or approved

Provided with limitations:

1) Recipients must be considered low-risk, normal or having an uncomplicated pregnancy;
2) Delivery shall be performed by a:
   a. Certified nurse midwife; or
   b. Physician
3) Surgical services are limited to episiotomy and episiotomy repair; and shall not include operative obstetrics or cesarean sections;
4) Labor shall not be inhibited, stimulated or augmented with chemical agents during the first or second stage of labor;
5) Systemic analgesia may be administered and local anesthesia for prudential block and episiotomy repair may be performed;
6) General and conductive anesthesia shall not be administered at birthing centers;
7) Recipients shall not routinely remain in the facility in excess of twenty-four (24) hours.

28 (ii) Licensed or Otherwise recognized State-Recognized covered professionals providing services in the Freestanding Birth Center

Please check all that apply:

X (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

(b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
CASE MANAGEMENT SERVICES

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CASE MANAGEMENT SERVICES

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State Plan under Title XIX of the Social Security Act
State/Territory: Indiana

TARGETED CASE MANAGEMENT SERVICES
CHILDREN WITH ELEVATED BLOOD LEAD LEVELS

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):
Medicaid enrolled individuals who, through a blood lead screening conducted in accordance with the EPSDT periodicity schedule, are found with a confirmed elevated blood lead level (CEBLL) as defined by the Centers for Disease Control and Prevention (CDC).

___ Target group includes individuals transitioning to a community setting. Case management services will be made available for up to ____ consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in institutions for Mental Disease or individuals who are inmates of public institutions. (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):
_X_ Entire State
___ Only in the following geographic areas:

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1)):
___ Services are provided in accordance with §1902(a)(10)(B) of the Act.
_X_ Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Consistent with the Deficit Reduction Act (DRA) of 2005, the term "Targeted Case Management" means services which will assist individuals eligible under the plan in gaining access to needed medical, educational, social and other services relevant to elevated blood lead levels (EBLL) and other identified issues. Targeted Case management services are goal-oriented activities that provide, oversee, and coordinate services to lead poisoned individuals. This includes but is not limited to identifying resources, planning services, implementing and coordinating lead treatment and services, and monitoring the delivery of such services. Components of the service include: assessment of the impairment, treatment planning, and monitoring of the overall service delivery; provision of services in a setting accessible and appropriate to the recipient. Targeted Case Management for children with EBLL includes the following assistance:

- Assessment: Initiating a risk assessment of the individual's primary address to determine possible sources of lead exposure as well as identification of other risk factors (including, but not limited to, medical, educational, social, developmental, and behavioral); gathering information on the individual's history by interviewing the individual, his/her family, medical providers, social workers and other professionals; completing necessary documentation.

- Care Planning: Development of a care plan specific to the individual based on information gathered during the Assessment; through specific goals and objectives, the care plan will address the medical, social, educational and other service needs related to the individual's lead exposure and other identified issues; the care plan will also include objectives related to active participation from the individual and his/her family.

- Referral and Linkage: Referrals for necessary services, including but not limited to services to address medical, educational, social and nutritional needs, as appropriate; this includes activities that link the individual with needed services.

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TARGETED CASE MANAGEMENT SERVICES
CHILDREN WITH ELEVATED BLOOD LEAD LEVELS

- Monitoring: Follow-up activities and contacts with the individual and his/her family to ensure effective implementation of the care plan and that the care plan is addressing the individual's needs. Adjustments to the care plan will be made as necessary. Follow-up services must be provided as appropriate to the individual's case and not less frequently than one (1) contact every three (3) months.

- Case Closure: The case manager will terminate case management services in accordance with case closure guidelines set out in 410 IAC 29-2-2.

___ Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
Case managers have, at a minimum, either a bachelor's degree in social work (or a related field) or are a Registered Nurse (RN) and are authorized by a local health department (LHD) through a provider agreement. Case managers receive specialized training through the Indiana State Department of Health (ISDH) within six (6) months of hire. Case managers must provide services in accordance with 410 IAC 29-1 and §1915(g) of the Social Security Act. Case managers report to the County Health Officer, a Medical Doctor (MD) licensed by the State of Indiana.

Freedom of choice (42 CFR 441.18(a)(1)):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of §1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.
3. Individuals of the target population may choose whether or not to receive targeted case management services.
4. Any person or entity meeting the State's requirements who wishes to become a Medicaid provider of targeted case management services may be given the opportunity to do so.
5. Targeted case management will not be used to restrict the access to other services available under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
___ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):
The State assures the following:

1. Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
2. Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
3. Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

State Plan under Title XIX of the Social Security Act
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TARGETED CASE MANAGEMENT SERVICES
CHILDREN WITH ELEVATED BLOOD LEAD LEVELS

Payment [42 CFR 441.18(a)(4)]:
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records [42 CFR 441.18(a)(7)]:
Providers maintain case records that document for all individuals receiving case management as follows:

1. The name of the individual;
2. The dates of the case management services;
3. The name of the provider agency (if relevant) and the person providing the case management service;
4. The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved;
5. Whether the individual has declined services in the care plan;
6. The need for, and occurrences of, coordination with other case managers;
7. A timeline for obtaining needed services;
8. A timeline for reevaluation of the plan.

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

EPSDT Assurance:
Under the EPSDT benefit, TCM services will be provided to any individual determined to meet the medical necessity for the service.

State of: Indiana

Program of All-Inclusive Care for the Elderly State Plan Amendment

Name and address of State Administering Agency, if different from the State Medicaid Agency.

Division of Aging
402 W. Washington St., MS21 Room W-454
Indianapolis, IN 46204

I. Eligibility

The State determines eligibility for PACE enrollees under rules applying to community groups.

A. X The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the eligibility groups specified under these provisions in the statute and regulations. The applicable groups are:

A special income level equal to 300% of the SSI Federal benefit rate (FBR) (42 CFR 435.236). Spousal impoverishment eligibility rules apply.

(If this option is selected, please identify, by statutory and/or regulatory reference, the institutional eligibility group or groups under which the State determines eligibility for PACE enrollees. Please note that these groups must be covered under the State's Medicaid plan.)

B. _____ The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II — Compliance and State Monitoring of the PACE Program.

C. X The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State's approved HCBS waiver(s).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Regular Post Eligibility

1. x SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(A). Sec. 435.726-States which do not use more restrictive eligibility requirements than SSI.
1. Allowances for the needs of the:
(A.) Individual (check one)
1. x The following standard included under the State plan, (check one):
(a) __ SSI
(b) __ Medically Needy
(c) x The special income level for the institutionalized
(d) __ Percent of the Federal Poverty Level: %
(e) __ Other (specify): _____
2. __ The following dollar amount: $ _____
Note: If this amount changes, this item will be revised.
3. __ The following formula is used to determine the needs allowance:

_____
_____
_____

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B.) Spouse only (check one):
1. ___SST Standard
2. ___Optional State Supplement Standard
3. ___Medically Needy Income Standard
4. ___The following dollar amount: $ _____
Note: If this amount changes, this item will be revised.
5. ___ The following percentage of the following standard that is not greater than the standards above: __ % of ____ standard.
6. ___The amount is determined using the following formula:

_____
_____
_____

7. x Not applicable (N/A)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

(C.) Family (check one):
1. x AFDC need standard
2. __Medically needy income standard

The amount specified below cannot exceed the higher of the need standard fur a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3. __The following dollar amount: $ _____
Note: If this amount changes, this item will be revised.
4. __The following percentage of the following standard that is not greater than the standards above: ____% of _____ standard.
5. __The amount is determined using the following formula:
_____
6. __Other
7. __ Not applicable (N/ A)

(2). Medical and remedial care expenses in 42 CFR 435.726.

Regular Post Eligibility

2. __ 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a) 42 CFR 435.735--States using more restrictive requirements than SSI.

1. Allowances for the needs of the:
(A.) Individual (check one)
1. The following standard included under the State plan (check one):
(a) __ SSI
(b) __ Medically Needy
(c) __ The special income level for the institutionalized
(d) __ Percent of the Federal Poverty Level: %
(e) __ Other (specify): _____
2. __The following dollar amount: $ _____
Note: If this amount changes, this item will be revised.
3. __The following formula is used to determine the needs allowance.

_____

Note: If the amount protected for PACE enrollees in item 1 is **equal to, or greater than** the maximum amount of income a PACE enrollee may have and be eligible under PACE, **enter N/A.in items 2 and 3.**

(B.) Spouse only (check one):

1. __The following standard under 42 CFR435.121:

_____

2. __The Medically needy income standard:

_____

3. __Thee following dollar amount: $_____
Note: If this amount changes, this item will be revised.
4 .__The following percentage of the following standard that is not.greater than the standards above: ____% of ____standard.
5. ___The amount is determined using the following formula:

_____

6. __Not applicable (N/A)

(C.) Family (check one):

1. ___ AFDC need standard
2. ___Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3. __ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
4.__The following percentage of the following standard that is not greater than the standards above: ___ % of ___ standard.
5. __ The amount is determined using the following formula:
6. __ Other
7. __ Not applicable (N/A)

(b) Medical and remedial care expenses specified ill 42 CFR 435.735.

Spousal Post Eligibility

3. X State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a.) Allowances for the needs of the:

1. Individual (check one)

(A). X The following standard included under the State plan (check one):

1. _____SSI
2. _____Medically Needy
3. __X_The special income level for the institutionalized
4. _____Percent of the Federal Poverty Level: _____%
5. _____Other (specify):_____

(B)._____The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

(C)_____The following formula is used to determine the needs allowance:

_____
_____

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

_____
_____
_____
_____
_____
_____

II. Rates and Payments

A. The State assures CMS that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service.

1. X Rates are set at a percent of fee-for-service costs
2. ___ Experience-based (contractors/State's cost experience or encounter date)(please describe)
3. ___ Adjusted Community Rate (please describe)
4. ___ Other (please describe)

B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.

C. The State will submit all capitated rates to the CMS Regional Office for prior approval.

III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.

Program of All-Inclusive Care for the Elderly (PACE) Reimbursement Methodology

The PACE capitation rates are developed based on historical fee-for-service data for a total of two fiscal years and are developed using an Upper Payment Limit (UPL) methodology.

DEVELOPMENT OF THE UPL

The historical fee-for-service population data is extracted for claims and eligibility for a PACE eligible population and is summarized on a per member per month (PMPM) basis. Base data will be blended over the two-year period and trended to the appropriate fiscal year and adjusted to develop the UPL amount. The UPL will be reduced accordingly based on the anticipated reductions in health care service costs due to the implementation of the managed care PACE program. The reduction in health care costs is expected in the use of nursing home services with a portion of offsetting costs associated with non-institutional care. A percentage is factored into the rate for administrative expenses based on eligibility category – Medicaid-Medicare dual-eligible and Medicaid only.

DUAL ELIGIBILITY

The PACE capitation rates are developed for both the dual-eligible population and the Medicaid only eligible population. The Medicare eligible populations that are included reflect QMB-Plus and SLMB-Plus only populations.

ELIGIBILITY CATEGORIES

The eligible population base includes the nursing home and waiver level of care populations excluding those with developmental disabilities. The populations are further limited based on age (i.e., age 55 or greater) and include the fee-for-service eligible population only.

CATEGORIES OF SERVICE

All categories of service for the eligible population will be included in the development of the PACE capitation rate. The categories of service are limited to the categories provided in the fee-for-service data extract.

The base rates are developed on a state-wide basis. Geographic factors are developed by comparing the region specific areas to the state-wide expenditures on a PMPM basis. These factors are developed by reviewing nursing home, waiver and home health care expenditures.

RATE CATEGORY GROUPINGS

Rate categories are developed based on age – either pre-65 or post-65. Geographic factors will be reviewed and applied to the state-wide base capitation rates.

The State will submit all capitated rates to the CMS Regional Office for prior approval.

State of Indiana

1905(a)(29) Medication-Assisted Treatment (MAT)

Citation: 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1905(a)(29) _____MAT as described and limited in Supplement ____ to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy.

State of Indiana

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

i. General Assurance

a. MAT is covered under the Indiana Medicaid State Plan for all Medicaid beneficiaries who meet the medical necessity criteria for receipt of the service for the period beginning October 1, 2020 and ending September 30, 2025.

ii. Assurances

a. The state assures coverage of Naltrexone, Buprenorphine, and Methadone and all forms of these drugs for MAT that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

b. The state assures that Methadone for MAT is provided by Opioid Treatment Programs that meet the requirements in 42 C.F.R. Part 8.

c. The state assures coverage for all formulations of MAT drugs and biologicals for OUD that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

iii. Service Package

The state covers the following counseling services and behavioral health therapies as part of MAT.

a) Please set forth each service and components of each service (if applicable), along with a description of each service and component service.

From October 1, 2020, through September 30, 2025, the state assures that MAT to treat OUD as defined in section 1905(ee)(1) of the Social Security Act (the Act) is covered exclusively under section 1905(a)(29) of the Act.

- **Behavioral Health Individual/Group Counseling and Therapy:** The services covered as individual, or group behavioral health counseling and therapy consist of a series of time-limited, structured, face-to-face sessions that work toward the goals identified in the individualized integrated care plan.
- **Medication Training and Support:** The services covered as individual medication training and support involve face-to-face contact with the member for the purpose of monitoring medication compliance, providing education and training about medications, monitoring medication side effects, and providing other nursing or medical assessments.
- **Crisis Intervention:** The services covered as crisis intervention services are short-term emergency behavioral health services, available twenty-four (24) hours per day, seven (7) days per week. These services include crisis assessment, planning, and counseling specific to the crisis, intervention at the site of the crisis when clinically appropriate, and pre-hospital assessment. The goal of crisis services is to resolve the crisis and transition the member to routine care through stabilization of the acute crisis and linkage to necessary services.
- **Cognitive Behavioral Therapy:** The service covered as Cognitive Behavioral Therapy (CBT) is based on the individualized integrated care plan. CBT encourages patients to learn healthy coping mechanisms that are tailored to meet their needs. Services may be provided for members of all ages with a opioid-related disorder conditions that will not prevent the member from benefiting from this level of care.
- **Motivational Interviewing:** The service covered as Motivational Interviewing is based on the individualized integrated care plan. Motivational Interviewing focuses on using the motivational process to facilitate change within a patient. Services may be provided for members of all ages with an opioid-related disorder conditions that will not prevent the member from benefiting from this level of care.
- **Drug (opioid use disorder) Counseling:** The services covered as individual or group drug counseling are services where addiction professionals and clinicians provide counseling intervention that work toward goals identified in the individualized integrated care plan.
- **Peer Recovery Services:** Peer recovery services are individual, face-to-face services that provide structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Services must be provided by individuals who meet the training and competency standards for certified recovery specialists, as defined by the state.

Psychiatric Services: Psychiatric services such as assessments, diagnostic evaluations, psychotherapy, psychological and neuropsychological testing,

and other interventions are available to members of all ages with an opioid-related disorder. Services must be provided by individuals who meet the training and licensure requirements, as defined by the state.

b) Please include each practitioner and provider entity that furnishes each service and component service.

Behavioral Health Individual/Group Counseling and Therapy:

The following providers can render this service as defined under state law:

- Licensed Psychologist
- Licensed Physician (MD/DO)
- Licensed Independent Practice School Psychologist
- Health Service Provider in Psychology (HSPP)
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Clinical Addiction Counselor (LCAC)
- Licensed Mental Health Counselor (LMHC)
- *Providers who require supervision as defined under state Law:*
    - Qualified Behavioral Health Professional (QBHP)
    - Other Behavioral Health Professional (OBHP)

Medication Training & Support

The following providers can render this service as defined under state law:

- Licensed Psychologist
- Licensed Physician (MD/DO)
- Licensed Independent Practice School Psychologist
- Health Service Provider in Psychology (HSPP)
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Clinical Addiction Counselor (LCAC)
- Licensed Mental Health Counselor (LMHC)
- *Providers who require supervision as defined under state law:*
    - Qualified Behavioral Health Professional (QBHP)
    - Other Behavioral Health Professional (OBHP)

Crisis Intervention Services

The following providers can render this service as defined under state law:

- Licensed Psychologist
- Licensed Physician (MD/DO)
- Licensed Independent Practice School Psychologist

- Health Service Provider in Psychology (HSPP)
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Clinical Addiction Counselor (LCAC)
- Licensed Mental Health Counselor (LMHC)
- *Providers who require supervision as defined under state law:*
    - Qualified Behavioral Health Professional (QBHP)
    - Other Behavioral Health Professional (OBHP)

Cognitive Behavioral Therapy

The following providers can render this service as defined under state law:

- Licensed Psychologist
- Licensed Physician (MD/DO)
- Licensed Independent Practice School Psychologist
- Health Service Provider in Psychology (HSPP)
- *Providers who require supervision as defined under state law:*
    - Licensed Clinical Social Worker (LCSW)
    - Licensed Marriage and Family Therapist (LMFT)
    - Licensed Clinical Addiction Counselor (LCAC)
    - Licensed Mental Health Counselor (LMHC)
    - Qualified Behavioral Health Professional (QBHP)
    - Other Behavioral Health Professional (OBHP)

Motivational Interviewing

The following providers can render this service as defined under state law:

- Licensed Psychologist
- Licensed Physician (MD/DO)
- Licensed Independent Practice School Psychologist
- Health Service Provider in Psychology (HSPP)
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Clinical Addiction Counselor (LCAC)
- Licensed Mental Health Counselor (LMHC)
- *Providers who require supervision as defined under state law:*
    - Qualified Behavioral Health Professional (QBHP)
    - Other Behavioral Health Professional (OBHP)

Drug (opioid use disorder) Counseling

The following providers can render this service as defined under state law:

- Licensed Psychologist
- Licensed Physician (MD/DO)
- Licensed Independent Practice School Psychologist
- Health Service Provider in Psychology (HSPP)
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Clinical Addiction Counselor (LCAC)
- Licensed Mental Health Counselor (LMHC)
- *Providers who require supervision as defined under state law:*
    - Qualified Behavioral Health Professional (QBHP)
    - Other Behavioral Health Professional (OBHP)

Peer Recovery Services

The following providers can render this service as defined under state law:

- Licensed Psychologist
- Licensed Physician (MD/DO)
- Licensed Independent Practice School Psychologist
- Health Service Provider in Psychology (HSPP)
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Clinical Addiction Counselor (LCAC)
- Licensed Mental Health Counselor (LMHC)
- *Providers who require supervision as defined under state law:*
    - Qualified Behavioral Health Professional (QBHP)
    - Other Behavioral Health Professional (OBHP)

Psychiatric Services

The following providers can render this service as defined under state law:

- Licensed Psychologist
- Licensed Physician (MD/DO)
- Licensed Independent Practice School Psychologist
- Health Service Provider in Psychology (HSPP)
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Clinical Addiction Counselor (LCAC)
- Licensed Mental Health Counselor (LMHC)
- *Providers who require supervision as defined under state law:*
    - Qualified Behavioral Health Professional (QBHP)
    - Other Behavioral Health Professional (OBHP)

Provider Entities:

- Community Mental Health Center (CMHC)
- Opioid Treatment Program (OTP)
- Medicaid Rehabilitation Option (MRO) Clubhouse

c) Please include a brief summary of the qualifications for each practitioner or provider entity that the state requires. Include any licensure, certification, registration, education, experience, training and supervisory arrangements that the state requires.

Providers:

- Behavioral Health professionals who are Licensed Psychologists treating OUD must meet all necessary requirements as defined under state law.
- Behavioral Health professionals who are Licensed Physicians (MD/DO) treating OUD must meet all necessary requirements as defined under state law.
- Behavioral Health professionals who are Licensed Clinical Social Workers (LCSW) treating OUD must meet all necessary requirements as defined under state law.
- Behavioral Health professionals who are Licensed Marriage and Family Therapists (LMFT) treating OUD must meet all necessary requirements as defined under state law.
- Behavioral Health professionals who are Licensed Clinical Addiction Counselors (LCAC) treating OUD must meet all necessary requirements as defined under state law.

- Behavioral Health professionals who are Licensed Mental Health Counselors (LMHC) treating OUD must meet all necessary requirements as defined under state law.
- Behavioral Health professionals who are Qualified Behavioral Health Professionals (QBHP) treating OUD must meet all necessary requirements as defined under state law: A "qualified behavioral health professional" (QBHP) means any of the following persons:
    - (1) An individual who has had at least two (2) years of clinical experience treating persons with mental illness under the supervision of a licensed professional, as defined above, with such experience occurring after the completion of a master's degree or doctoral degree, or both, in any of the following disciplines:

        - (a) In psychiatric or mental health -nursing from an accredited university, plus a license as a registered nurse in Indiana
        - (b) In pastoral counseling from an accredited university.
        - (c) In rehabilitation counseling from an accredited university.
    - (2) An individual who is under the supervision of a licensed professional; as defined above, is eligible for and working towards licensure, and has completed a master's or doctoral degree, or both., in any of the following disciplines:
        - (a) In social work from a university accredited by the Council on Social Work Education.
        - (b) In psychology from an accredited university.
        - (c) In mental health counseling from an accredited university.
        - (d) 1n marital and family therapy from an accredited university.
    - (3) A licensed independent practice school psychologist under the supervision of a licensed professional, as defined under state law.
    - (4) An authorized healthcare provider (AHCP). defined as follows:
        - (a) a physician assistant with the authority to prescribe, dispense and administer drugs and medical devices or services under an agreement with a supervising physician and subject to the requirements defined under state law.
        - (b) a nurse practitioner or a clinical nurse specialist, with prescriptive authority and performing duties within the score of that. person's license and under the supervision or

          under a supervisory agreement with, a licensed physician pursuant to the definition under state law.
- Behavioral Health professionals who are <u>Other Behavioral Health Professionals (OBHP)</u> treating OUD must meet all necessary requirements as defined under state law: Other behavioral health professional (OBHP) means any of the following persons:
    - (1) An individual with an associate or bachelor's degree, or equivalent behavioral health experience, meeting minimum competency standards set forth by a behavioral health service provider and supervised by either a licensed professional or a QBHP.
    - (2) A licensed addiction counselor supervised by either a licensed professional as defined under state law, or a QBHP, as defined under state law.

Provider Entities:

- Community Mental Health Center (CMHC): (as defined under state law)
    - FSSA's Division of Mental Health and Addiction (DMHA) certified Community Mental Health Centers (CMHCs) are permitted by Indiana's state Medicaid agency (OMPP) to be approved to by DMHA provide opioid addiction treatment services according to the standards and expectations as defined under state law.
        - Provider agency has acquired a National Accreditation by an entity approved by DMHA.
        - Provider agency is an enrolled Medicaid provider that offers a full continuum of care.
        - Provider agency must maintain documentation in accordance with the Medicaid requirements defined under state Law.
        - Provider agency must meet all behavioral health provider agency criteria, as defined under state law."
- Opioid Treatment Program (OTP): 42 CFR 8.11-12
- Medicaid Rehabilitation Option (MRO) Clubhouse: (as defined under state Law)
    - The clubhouse certification will be issued by the Indiana Family and Social Services (FSSA) Division of Mental Health and Addiction (DMHA). The rendering clubhouse provider must be accredited by Clubhouse International and operate in conformity with the International Standards for Clubhouse Programs.

State of Indiana

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

iv. Utilization Controls

__**x**___ The state has drug utilization controls in place. (Check each of the following that apply)

__**x**___ Generic first policy
__**x**___ Preferred drug lists
__**x**___ Clinical criteria
__**x**___ Quantity limits

_____ The state does not have drug utilization controls in place.

v. Limitations

Describe the state's limitations on amount, duration, and scope of MAT drugs, biologicals, and counseling and behavioral therapies related to MAT.

MAT Drugs & Biologicals

The state has applied appropriate utilization management and day supply limits on MAT drugs. Limitations are dependent on drug product and vary based on formulation. All limitations are evidence based and certain class limitations are reviewed by the state's Drug Utilization Review Board.

Counseling & Behavioral Therapies

- **Behavioral Health Individual/Group Counseling and Therapy is limited to twenty (20) units per member, per provider, per calendar year. Additional units may be authorized with prior authorization and are based on medical necessity.**
- **Crisis Intervention Services are limited to interventions focused on an individual and must be rendered in the outpatient behavioral health setting.**
- **Drug (opioid use disorder) Counseling is limited to three (3) hours per day. Additional units may be authorized with prior authorization and are based on medical necessity.**

- **Peer Recovery Services are available without prior authorization for up to 365 hours (1,460 units) per calendar year. Additional units may be authorized with prior authorization and are based on medical necessity.**
- **Psychiatric interventions are available without prior authorization for an aggregated 20 units per beneficiary, per provider, per rolling 12-month period. Additional units for psychiatric interventions may be authorized with prior authorization based on medical necessity.**
- **Psychiatric diagnostic evaluations are available without prior authorization for one visit per beneficiary, per provider, per rolling 12-month period. Additional visits for psychiatric diagnostic evaluations may be authorized with prior authorization and are based on medical necessity.**
- **Prior authorization is required for all psychological and neuropsychological testing and is provided based on medical necessity.**
- **Psychiatric services are available without prior authorization for 30 visits per calendar year. Additional visits for psychiatric services may be authorized with prior authorization based on medical necessity.**

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section 1006(b) of the SUPPORT for Patients and Communities Act (P.L. 115-271) enacted on October 24, 2018. Section 1006(b) requires state Medicaid plans to provide coverage of Medication-Assisted Treatment (MAT) for all Medicaid enrollees as a mandatory Medicaid State Plan benefit for the period beginning October 1, 2020, and ending September 30, 2025. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 60). Public burden for all of the collection of information requirements under this control number is estimated to take about 80 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency Indiana

MEDICAID PROGRAM: REQUIREMENTS RELATING TO
COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Citation (s)	Provision (s)
1935(d)(1)	Effective January 1, 2006, the Medicaid agency will not cover any Part D covered drug for verified full-benefit dual eligible individuals who are enrolled in or entitled to receive Medicare benefits under Part A or Part B.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency Indiana

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Citation (s)		Provision (s)
1927(d)(2) and 1935(d)(2)	1.	The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit –Part D.

(1) Nonlegend (over-the-counter) drugs included on the Medicaid nonlegend drug formulary set out at:

http://www.indianapbm.com/Downloads/OTC%20Drug%20Formulary.xls

and

(2) Legend drugs that are:
(a) approved by the U.S. Food and Drug Administration;
(b) not designated by the Centers for Medicare and Medicaid Services as less than effective; or identical, related, or similar to a less than effective drug;
(c) subject to the terms of a rebate agreement between the drug's manufacturer and the CMS;
(d) prior authorized by Indiana Medicaid if subject to applicable prior authorization requirements for brand name drugs; and
(e) not specifically excluded from coverage by Indiana Medicaid. The following are specifically excluded from coverage by Indiana Medicaid:

- Anorectics or any agent used to promote weight loss;
- Topical minoxidil preparations;
- Fertility enhancement drugs;
- Drugs used to treat sexual or erectile dysfunction, as set forth in section 1927(d)(2)(K) of the Social Security Act, unless such drugs are used to treat conditions other than sexual or erectile dysfunction and such uses have been approved by the U.S. Food and Drug Administration;
- Drugs when prescribed solely or primarily for cosmetic purposes.

State of: Indiana

Program of All-Inclusive Care for the Elderly State Plan Amendment

Amount, Duration and Scope of Medical and Remedial Care Services Provided To the Medically Needy

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

____ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

____ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

STANDARDS ESTABLISHED AND METHODS USED
TO ASSURE HIGH QUALITY CARE

INDIVIDUAL PROVIDERS

Following are the criteria used and steps taken to assure high quality of care by individual providers of Medicaid:

1. Physicians and Dentists

   Requirement is licensing by the state. This is verified by the records of the State Board of Health or Dental.

2. Corporations, Partnership and Medical Clinics

   The group is required to submit a list of all providers who are associated with it. The license of each is verified as in paragraph 1.

3. Chiropractors, Osteopaths, Physical Therapists, Hearing Aid Dealers

   They must be licensed by the State Board of Health. License is verified.

4. Miscellaneous Suppliers

   Shoe companies, rental services, water softner services, oxygen, etc. - These providers are required to sign a Medicaid Agreement.

5. Nurses

   The Indiana State Board of Nurses Registration and Nursing Education must license them. The license is verfied.

6. Optometrists

   Optometry Registration and Examination Board must license them. The license is verified.

7. Audiologists

   Speech and Hearing Therapists must hold a Certificate of Clinical Competence in Audiology from the American Speech and Hearing Association, or have completed the academic and practicum requirements and be in the process of accumulating the necessary supervised work experience required for the certificate. The status is verified.

8. Pharmacists

   The pharmacist must be licensed by the Indiana State Pharmacy Board. License is verified.

9. Independent Laboratories

Laboratories must be certified by the State Board of Health. License is verified.

10. Doctors' Laboratories

Only a Medicaid agreement is required because of the physician's qualifications.

11. Psychologist

Must be licensed by the Psychology Board of the State Board of Medical Examiners. License status is verified.

12. Mental Health Clinic, Child Guidance Center, Rehabilitation Center, Family Planning Center, County Social Service Center, Speech and Hearing Center

These providers must provide the following information:

a. What service will be offered?

b. Name, position and qualifications of each staff member.

c. How many hours per week will each staff member be employed?

d. How is the facility funded?

e. How are recipients made aware of available services?

This data is reviewed and required credentials (licenses, etc.) are verified.

13. Out-of-State Providers

A Medicaid agreement is required of all out-of-state providers and suppliers and their licensure or certificate is checked with the boards of their respective states.

14. Nurse Practitioners

Must be licensed as a Registered Nurse by the Indiana Health Professions Bureau and must hold a certificate as a Nurse Practitioner from a certifying body that is nationally recognized.

CERTIFICATION REQUIREMENTS
FOR MEDICAID APPROVED FACILITIES
(Title XIX, Social Security Act)
AUGUST 19, 1972

I. General:

The Indiana State Department of Public Welfare is the single state agency designated by statute as responsible for administration of the Medical Assistance Program (Medicaid) as specified in Title XIX of the Social Security Act, as amended, and as such, may certify applying health facilities as providers of specified categories of health care after finding such applicants eligible to provide such care. Pursuant to an agreement between the State Department of Public Welfare and the Indiana State Board of Health, the State Board of Health will confirm that the standards outlined below, as required by Federal Legislation and Federal Regulations to be included in the state plan administered by the State Department of Public Welfare, have been met by a facility which has applied for such certification or certifications. Unless the applicable Federal Requirements have been met and current certification by the State Department of Public Welfare is in effect, vendor payments cannot be made to providers or suppliers of health care for recipients of public assistance.

II. Skilled Nursing Homes (Refs: Federal Social Security Act, Title XIX, as amended; 42 CFR 449; 42 CFR 450; 42 CFR 452; 42 CFR 405; Indiana's Welfare Act Code (1971) 12-1 and Health Facility Regulations, State of Indiana.

A. Certification as a Skilled Nursing Home under the provisions of Title XIX, Social Security Act. Health Facilities desiring to participate as Skilled Nursing Homes shall:

1. Meet the Indiana State licensure regulations for Comprehensive Care of the Indiana Health Facilities Council as revised or amended and current and subsequent regulations of the Department of Health, Education, and Welfare as specified by the state plan.

2. Meet the requirements established for extended care under Title XVIII, Social Security Act (Medicare).

3. Supply to the State Board of Health for the State Department of Public Welfare full and complete information, and promptly report any changes which would affect the current accuracy of such informtion, as to the identity:

a. Of each person having (directly or indirectly) an ownership interest of 10 percentum or more in such skilled nursing home.

b. In case a skilled nursing home is organized as a corportation, of each officer and director of the corportation, and

c. In case a skilled nursing home is organized as a partnership, of each partner.

d. All facilities which are certified as Skilled Nursing Homes under Title XIX of the Social Security Act must have present and available on the premises all pertinent records pertaining to the operation and management of the facility, including pay records, time cards, etc.

4. Have written agreements with one or more general hospital(s) participating in Title XIX (Medicaid) under which such hospital or hospitals will provide needed diagnostic and other services to patients of such skilled nursing homes and under which such hospitals agree to accept acutely ill patients of such skilled nursing homes who are in need of hospital care.

5. All facilities which are certified as Skilled Nursing Homes under Title XIX of the Social Security Act, and have less than 40 patients, must show one hour of Nursing Home Administrator's time per patient per week. All homes with 40 patients must have a full time (40 hours per week) Nursing Home Administrator.

6. All facilities which are certified as Skilled Nursing Homes shall have a full time (40 hours per week) Director of Nursing who shall be a Registered Nurse currently licensed in Indiana and whose duty shall be to supervise all nursing care within the facility. The Director of Nurses time shall not be included in direct patient care hours.

7. All facilities which are certified as Skilled Nursing Homes under Title XIX of the Social Security Act must document that they have a constructive and meaningful program of activities available for the psychological, social, and spiritual needs of their residents.

8. The direction and management of the facility or distinct part are such as to assure that the services required by

the residents are organized and administered in such manner that such services are, in fact, available within a financially accountable unit having assigned staff, to the residents on a regular basis and that such are provided efficiently and with consideration.

III. Intermediate Care Facilities (Ref: Federal Social Security Act, Title XIX, Section 1905, as amended; 42 CFR 442; Indiana's Welfare Act, Code 12-1 and Health Facility Regulations, State of Indiana). The requirements below have been arranged so that facilities presently lincensed as comprehensive nursing care health facilities or residential care facilities may identify those services and policies which each must establish or provide.

A. Comprehensive Nursing Care Health Facility to be certified as an Intermediate Care Facility shall:

1. Have licensure as a comprehensive nursing care health facility from the Indiana State Board of Health providing 1.5 hours of nursing care per patient per 24 hour period.

2. All facilities which are certified as Intermediate Care Facilities and have less than 40 patients shall show one hour of Administrator's time per patient per week. All facilities with 40 patients must have a full time (40 hours per week) Administrator.

** 3. All facilities, or distinct parts of facilities which are certified as Intermediate Care Facilities, shall have a full time (40 hours per week) Registered Nurse or a Licensed Practical Nurse working on the day shift. In such cases where full time personnel is not available, two qualified individuals may be employed to provide the forty (40) hours of coverage.

4. Provide individual storage facilities for the clothing and personal articles of each patient.

5. Have on file within the facility written policies providing for and/or pertaining to at least the following areas of operation:

** a. Provisions for the continuing supervision of each resident by his physician who sees him as needed and in no case, less often than sixty (60) days.

b. Assurance that arrangements exist for the services of a physician in the event of an emergency when a resident's own physician cannot be reached.

* c. Assurance that no more than four residents occupy the same room.

* This requirement will not be enforced at present, and not until such time as this Department announces that it is effective.

** Revised November, 1973

d. Assurance that the menus for medically prescribed diets are planned by a professionally qualified dietician or, are reviewed and approved by the attending physician.

e. Assurance that the types and amounts of protection and personal service needed by each resident are a matter of record and are known to all staff members who have personal contact with the resident.

f. Admission, transfer and discharge of residents:

1. Only those persons are accepted into the facility whose needs can be met within the accommodations and services the facility provides and who require more than mere room, board and laundry;

2. As changes occur in their physical or mental condition, necessitating service or care not regularly provided by the facility, residents are transferred promptly to hospitals, skilled nursing homes, or other appropriate facilities;

3. The resident, his next of kin, if any, and responsible agency are consulted in advance of the discharge of any resident, and case work services or other means are utilized to assure that adequate arrangements exist for meeting his needs through other resources.

g. Personal care and protection services.

1. See III A 4 e above.

2. There is, at all times, a responsible staff member actively on duty in the facility, and immediately accessible to all residents, to whom residents can report injuries, symptoms of illness, or emergencies, and who is immediately responsible for assuring that appropriate action is taken promptly.

3. Assistance is provided, as needed by individual residents, with routine activities of daily living including such services as help in bathing, dressing, grooming, and management of personal affairs such as shopping.

4. Continuous supervision is provided for residents whose mental condition is such that their personal safety requires such supervision.

h. Social Services. Services to assist residents in dealing with social and related problems are available to all residents through one or more caseworkers on the staff of the facility; and/or, in case of recipients of assistance, through caseworkers on the staff of the assistance agency; or through other arrangements.
All facilities which are certified as intermediate Care Facilities shall document that they have a constructive and meaningful program of activities avialable for the psychological, social and spiritual needs of the residents.

i. Activities. Activities are regularly available for all residents, including social recreational activities invólving active participation by the residents, entertainment of appropriate frequency and character, and opportunities for participation in community activities as possible and appropriate.

j. Food Services. At least three meals a day are served in one or more dining areas separate from sleeping quarters, and tray service is provided for residents temporarily unable to leave their rooms. The meals must constitute a nutritionally adequate diet, as established in the Health Facilities Council regulations HHF 33. See III A 4 d above.

k. Pharmaceutical services. An agreement with a registered pharmacist exists to the effect that at least every 30 days he will examine the facility's medicine procedures and storage facilities. Under no circumstances may bulk legend drugs be stored or maintained in the facility.

l. Nursing services. See III A 3 above and provide under the direction and general supervision of the registered professional nurse or licensed practical nurse in charge, guidance and assistance for each resident in carrying out his personal health program to assure that preventive measures, treatments, and medications prescribed by the physician are properly carried out and recorded.

m. Administration and management. The direction and management of the facility or distinct part are such as to assure that the services required by residents are organized and administered in such manner that such services are, in fact, available within a financially accountable unit having assigned staff, to the residents on a regular basis and that such services are provided efficiently and with consideration.

n. Clinical records. An individual health record for each resident including.

1. The name, address, and telephone number of his physician.

2. A record of the physician's findings and recommendations in the pre-admission evaluation of the individual's condition, subsequent reevaluation, and all orders and recommendations of the physician for care of the resident.

6. Supply to the State Board of Health for the State Department of Public Welfare full and complete information, and promptly report any changes which would effect the current accuracy of such information, as to the identity:

   a. Of each person having (directly or indirectly) an ownership interest of 10 percentum or more in such intermediate care home.

   b. In case an intermediate care facility is organized as a corporation, of each officer and director of the corporation, and

   c. In case an intermediate home is orgainzed as a partnership of each partner.

7. All facilities which are certified as Intermediate Care Facilities under Title XIX of the Social Security Act must have present and available on the premises all pertinent records pertaining to the operation and management of the facility, including pay records, time cards, etc.

B. Residential Care Health Facility to be certified as an Intermediate Care Facility must:

1. Meet the requirements outlined in Section III A. 2 through 7 above.

2. Have licensure as a residential care health facility from the Indiana State Board of Health.

3. Employ a nursing care staff to supply 1.5 hours of nursing care per patient per 24 hours.

4. Provide a well-lighted nurses' desk or station in a central location in the nursing area.

5. Provide a well lighted medicine cabinet located in or adjacent to the nurses' station. In addition, a refrigerator shall be

provided for pharmaceuticals requiring refrigeration.

6. Provide adequate soiled and clean utility areas. These areas may be in separate rooms or may be separated by a partition in the same room.

   a. The soiled utility area shall contain a clinical rim, flushing sink or other equipment suitable for cleaning bed pans if such facilities are not located in both rooms adjacent to each patient room.

   b. The clean utility room or area will contain a sink and work counter, a utensil sanitizer and storage cabinets. An autosterilizer may be placed in the clean utility room or area.

IV. Dual Certification - Skilled Nursing Home/Intermediate Care Facility. A facility may be certified as an eligible provider for both skilled nursing home care and for intermediate care.

A. Facilities with multiple Medicaid certification or certification of a single distinct part for Medicaid participation shall:

   1. Operate the Skilled Nursing Home section or unit as a distinct, indentifiable part of the facility. See IV C and iiA8.

   2. Operate the Intermediate Care section (s) or unit (s) as a distinct, indentifiable part (s) of its facility. See paragraph C below and iii5m.

   3. Each distinct part will contain only beds and related services for residents housed therein.

   4. Such distinct part will be staffed separately as set forth in sections III A3, IIIB3.

B. A facility with dual certification must function as two distinct parts except that the following services or facilities may be shared:

   1. Management

   2. Maintenance

   3. Laundry

   4. Recreation facilities

   5. Food services

   6. Administration including Director of Nursing.

7. Social services

8. A nursing station may be shared when it is centrally located with respect to both distinct parts and:

   a. Records are maintained for patients in a separate file with regard to their respective levels of care.

   b. Separate storage facilities for medicine are maintained for the two levels of care (refrigeration facilities may be shared).

9. Clean and soiled utility rooms may be shared when they are centrally located and determined to be adequate for both parts.

C. A distinct part is identified as an entire unit such as:

1. An entire ward

2. An entire wing

3. An entire floor

4. Any grouping of rooms or beds within a ward, wing, or floor which are contiguous, are at the same level of care, and are identifiable as such.

5. An entire building

PROVIDER ENROLLMENT REQUIREMENTS FOR PROVIDERS OF TRANSPORTATION

All providers must comply with applicable local, state and federal statutes, rules and regulations, and must complete and sign a provider agreement. The following additional requirements apply:

A. Professional Ambulance Service. In accordance with IC 16-1-39, vehicles and staff which provide emergency and stretcher services must be certified by the Emergency Medical Services (EMS) Commission and must maintain such certification throughout the period of participation.

B. Common transportation carriers except for taxicab and not-for-profit transportation entities. Each provider applicant or enrolled provider must submit proof of and maintain throughout its period of participation the following:

(1) Certification by the Indiana Motor Carrier Authority (I.M.C.A.).

(2) Insurance coverage as required by the I.M.C.A.

(3) Appropriate and valid drivers licenses for all drivers.

(C) Taxicab transportation entities. Each provider applicant or enrolled provider must submit proof of and maintain throughout its period of participation the following:

(1) Written acknowledgement by local or county officials of whether there are existing ordinances governing taxi services and written verification from local or county officials that taxicab services operating in the local vicinity are in compliance with those ordinances.

(2) Livery insurance as indicated by existing local ordinances, or in the absence of such ordinances a minimum of $25,000/50,000 public livery insurance covering all vehicles used in the business.

(3) Appropriate and valid drivers licenses for all drivers.

(D) Not-for-Profit transportation entities. Each provider applicant or enrolled provider must submit proof of and maintain throughout its period of participation the following:

(1) An acknowledgement from state or federal officials of their status as a not-for-profit entity.

(2) A minimum of $500,000 combined single limit commercial automobile liability insurance.

(3) Appropriate and valid drivers licenses for all drivers.

(E) Family Member Transportation. Each family member transportation provider must:

(1) Possess a valid drivers license as required by state law.

(2) Possess coverage of the minimum amount of automobile insurance as required by state law.

(3) Utilize as the vehicle for transporting family members, only a vehicle which has been duly licensed and registered.

(F) Providers of bus, train, airline or other air transport services. All providers must meet all certification and insurance requirements established by law.

STATE PLAN UNDER XIX OF THE SOCIAL SECURITY ACT

State of Indiana

METHODS OF PROVIDING TRANSPORTATION

Transportation to and from an Indiana Medicaid covered service is provided as an optional service under this State Plan by the following methods:

- When transportation is unavailable from a non-Medicaid reimbursed source, with the exception of Medicaid payments for family member mileage, Indiana Medicaid reimburses Medicaid-enrolled vendors for the least expensive type of emergency and non-emergency transportation available that meets the medical needs of the recipient.

- Transportation reimbursement includes the cost of meals and lodging en route to and from medical care and while receiving medical care, and the cost of an attendant to accompany the beneficiary, if necessary, and the cost of the attendant's transportation, meals, lodging, and, if the attendant is not a member of the beneficiary's family, a salary.

- Prior authorization is required for the following transportation services:
  - Interstate transportation or transportation services rendered by a provider located out- of-state in a non-designated area
  - All out of state pick up and destination locations, except in designated sister cities
  - Train services
  - Bus services for trips of 50 miles or more one-way
  - Airline or air ambulance services

- The following transportation services do not require prior authorization :
  - Emergency transportation services when destination is a hospital emergency department
  - Transportation for hospital admissions or discharges
  - Transportation for recipients on renal dialysis
  - Transportation for recipients residing in nursing homes

- An NEMT broker is responsible for the administration of non-emergency transportation for all fee-for-service members eligible for transportation services, except for the following non-brokered services:
  - Non-emergency transportation services for basic life support and advanced life support ambulance transportation.
  - Non-emergency transportation services for members residing in nursing facilities.

- Members enrolled in risk-based managed care receive non-emergency transportation through an NEMT broker contracted with the managed care entity.

- Family members enrolled as transportation providers are eligible for reimbursement for mileage only. Family members or close associates must be enrolled as an Indiana Medicaid provider. Trips are approved by the appropriate NEMT broker. This benefit is provided as an administrative service.

Any provider (including a transportation network company) or individual driver of non-emergency transportation to medically necessary services receiving payments under the State Plan must meet specified minimum requirements:

These minimum requirements include:

(A) Each provider and individual driver is not excluded from participation in any federal health care program (as defined in section 128B(f) of the Act) and is not listed on the exclusion list of the Inspector General of the Department of Health and Human Services;
(B) Each such individual driver has a valid driver's license;
(C) Each such provider has in place a process to address any violation of a state drug law; and
(D) Each such provider has in place a process to disclose to the state Medicaid program the driving history, including any traffic violations, of each such individual driver employed by such provider, including any traffic violations.

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

Indiana Medicaid reimbursement is not available for products, services or technologies that are experimental. Experimental, for purposes of the Indiana Medicaid Program, refers to those products, services, or technologies that do not have an established medical basis on which to predict a reasonable benefit. Prior authorization requests for transplant services are reviewed on a case-by-case basis for medical necessity. Commonly accepted medical conditions for which covered transplant services may be of benefit include, but are not limited to, those listed below:

Transplant Type	Medical Conditions
bone marrow	breast cancer; acute and chronic lymphocytic leukemia (ALL, CLL); acute and chronic myeloid leukemia (AML, CML); non-Hodgkin's lymphoma; Hodgkin's disease; hairy-cell leukemia; myelodysplastic syndromes; relapsed ALL or relapsed lymphomas; multiple myeloma; neuroblastoma; aplastic anemia; severe combined immunodeficiency diseases; congenital disorders of white blood cells; germ-cell cancer; ovarian cancer; mucopolysaccharide inborn errors of metabolism; soft tissue sarcomas; sickle cell anemia; thalassemia; congenital anemias; osteopetrosis; recurrent medulloblastoma without bulky, non-localized, residual tumor
corneal	corneal dystrophy; corneal degeneration; corneal infection; corneal injury; congenital corneal conditions
heart	end stage cardiac disease; refractory and life-threatening arrhythmias; refractory angina; refractory ischemia with inoperable coronary artery disease and left ventricular ejection fraction of less than 20%; Eisenmenger's syndrome; end stage cardiomyopathy; complex congenital defects
heart-lung	severe combined pulmonary and cardiac-vascular disease; end stage pulmonary disease with concurrent cardiac involvement/irreversible heart failure; primary pulmonary hypertension; congenital heart disease; cystic fibrosis; pulmonary/vascular disease

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES, continued

Transplant Type	Medical Conditions
liver	primary biliary cirrhosis; biliary atresia; primary sclerosing cholangitis; alpha one antitrypsin deficiency disease; Wilson's disease; primary hyperoxaluria; primary hypercholesterolemia; tyrosinosis; primary hemochromatosis; glycogen storage disease; familial cholestatic disease; fulminant hepatic failure due to acute infections, toxins, or environmental agents; non-resectable, primary, non-metastatic liver tumors confined to the liver; alcoholic cirrhosis in recipients (without history of recidivism) who have demonstrated abstinence for six months and who give every indication of having been rehabilitated; autoimmune chronic active hepatitis; cryptogenic cirrhosis; hepatitis B_eA_g negative chronic hepatitis B and Ag; chronic hepatitis B, surface antigen negative; hepatitis C; sarcoidosis; non-alcoholic steatohepatitis; Budd-Chiari syndrome; traumatic conditions other than metastatic cancer that resulted in the destruction of the liver or in the inability of the liver to function; non-cirrhotic portal hypertension with hepatic pulmonary disease
lung	severe pulmonary parenchymal or pulmonary vascular disease that is refractory to maximal medical therapy and is associated with a declining quality of life and limited life expectancy; emphysema; chronic obstructive pulmonary disease; alpha one antitrypsin deficiency; pulmonary fibrosis (primary or secondary); primary pulmonary vascular disease; primary pulmonary hypertension; cystic fibrosis; bronchopulmonary dysplasia; pulmonary berylliosis; atrioventricular canal; pulmonary alveolar proteinosis; pulmonary hemosiderosis; bronchiectasis; obliterative bronchiolitis; sarcoidosis; Eisenmenger's syndrome with repair of
pancreatic	type I diabetes mellitus; diabetic nephropathy with deteriorating and poor status; diabetic neuropathy; diabetic enteropathy; diabetic retinopathy such as proliferative retinitis; diabetics who fail aggressive medical management of their blood sugar; diabetics who demonstrate multiple episodes of ketoacidosis or hypoglycemia despite rigorous control and compliance; traumatic or inflammatory conditions, other than cancer, that have resulted in the destruction of the pancreas or the inability of the pancreas to function

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES, continued

Transplant Type	Medical Conditions
renal	severe renal disease that is refractory to maximal medical therapy and is associated with a declining quality of life and a limited life expectancy; end stage renal disease; near end stage renal disease with rapidly deteriorating status
small bowel	volvulus; necrotizing enterocolitis; gastroschisis; pseudo-obstruction; intestinal atresia; polyposis syndrome (if associated with small bowel disease); infarct; tumor (nonmalignant); Hirschsprung's disease (if associated with small bowel disease); congenital malformation; microvillus inclusion disease; trauma; Crohn's disease; desmoid; radiation enteritis; thrombosis

Indiana Medicaid reimbursement will be available for additional transplant services as they become accepted medical practice, in accordance with prevailing standards of medical care.

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.

1915(i) State Plan Home and Community-Based Services

Administration and Operation

The state implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit *for elderly and disabled individuals as set forth below.*

1. Services. *(Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):*

Indiana provides the following State Plan §1915(i) home and community-based services, which are referred to in this document as Child Mental Health Wraparound (CMHW) services:

1) Wraparound Facilitation
2) Habilitation
3) Respite Care
4) Training and Support for Unpaid Caregivers
5) Transportation

2. Concurrent Operation with Other Programs. (*Indicate whether this benefit will operate concurrently with another Medicaid authority)*:

***Select one*:**

☑	**Not applicable**
○	**Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act.** The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. *Specify:*
(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);
(b) the geographic areas served by these plans;
(c) the specific 1915(i) State plan HCBS furnished by these plans;
(d) how payments are made to the health plans; and
(e) whether the 1915(a) contract has been submitted or previously approved.

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates (*check each that applies*):

☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of

			providers)
☐	**A program operated under §1932(a) of the Act.** *Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:*		
☐	**A program authorized under §1115 of the Act.** *Specify the program*:		

3. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit. *(Select one)*:

☑	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:		
	○	The Medical Assistance Unit *(name of unit)*:	
	☑	Another division/unit within the SMA that is separate from the Medical Assistance Unit	
		(name of division/unit) This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.	The Division of Mental Health & Addiction (DMHA) is the operating agency under the umbrella of Indiana's SMA. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit.
	The State plan HCBS benefit is operated by *(name of agency)*		

4. Distribution of State plan HCBS Operational and Administrative Functions.

☑ *(By checking this box the state assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	☑	☑	☐	☐
2 Eligibility evaluation	☑	☑	☐	☐
3 Review of participant service plans	☑	☑	☐	☐
4 Prior authorization of State plan HCBS	☑	☑	☐	☐
5 Utilization management	☑	☑	☑	☐
6 Qualified provider enrollment	☑	☑	☑	☐
7 Execution of Medicaid provider agreement	☑	☑	☑	☐
8 Establishment of a consistent rate methodology for each State plan HCBS	☑	☑	☑	☐
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☑	☐	☐
10 Quality assurance and quality improvement activities	☑	☑	☐	☐

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

Functions 1-10 are performed/administered by DMHA or a State contracted entity. Office of Medicaid Policy and Planning (OMPP) is responsible for quality and program oversight for Functions 1-10. OMPP meets quarterly for trending and analysis of performance measure data for all functions. OMPP works with DMHA and/or contracted entities to develop and evaluate quality improvement strategies. Remediation can range from 24-48 hours for compliance issues that impact the imminent health, safety, or wellbeing of individual members and within thirty (30) business days for compliance issues that include missing a quarterly report deadline, missing a provider module update deadline, or quarterly data that appears to be trending near or below 86% compliance.

For utilization management, item 5 the contracted entity is the Medicaid Surveillance Utilization Review Contractors, for qualified provider enrollment, item 6 the contracted entity is DMHA and Medicaid Fiscal Agent, for the execution of Medicaid provider agreement, item 7 the contracted entity is the Medicaid Fiscal Agent, and for the establishment of a consistent rate methodology for each State plan HCBS, item 8 the contracted entity is an Actuarial Service.

Function #5- Utilization Management (Fraud & Abuse Detection System Contractor):

Surveillance & Utilization Review (SUR) is housed under Family and Social Services Administration's (FSSA) Program Integrity (PI) and is comprised of four (4) groups, one of which is SUR, which handles auditing functions. OMPP has expanded its program integrity activities by using a multi-pronged approach to SUR activity that includes provider self-audit, contractor desk audit and full on-site audit functions. The SUR sifts and analyzes claims data and identifies providers/claims that indicate aberrant billing patterns and/or other risk factors. PI contracts with Fraud & Abuse Detection System (FADS) contractors to help facilitate SUR activities. The FADS contractors assist PI through data analysis, audit services, and work to improve the integrity of the IHCP. The FADS contractor reviews claims data through the use of algorithms. All of the work conducted by the FADS contractors is approved and overseen by the PI team to ensure work is performed in compliance with State and Federal guidelines.

The audit process utilizes data mining, research, identification of outliers, problematic billing patterns, aberrant providers and issues that are referred by DMHA and OMPP. The SUR Unit meets with DMHA and OMPP at least quarterly to discuss audits and outstanding issues. The SUR unit is the Subject Matter Expert (SME) responsible for directly coordinating with the DMHA and OMPP. The unit analyzes data to identify potential areas of program risk and identify providers that appear to be outliers warranting review. Throughout the entire SUR process, oversight is maintained by OMPP through the PI team. The PI team offers education regarding key program initiatives and audit issues at provider meetings to promote ongoing compliance with Federal and State guidelines, including all Indiana Health Coverage Programs (IHCP) and SPA requirements.

Function #6 – Qualified Provider Enrollment

Providers interested in providing CMHW services must first apply for authorization through DMHA. Next, the provider must enroll as a Medicaid provider with Indiana Health Coverage Programs (IHCP). The OMPP contracts with a fiscal agent to process IHCP provider enrollments. The fiscal agent processes the applications, verifies licensure and authorization requirements are met, maintains the provider master file, assigns provider ID numbers, and stores National Provider Identifier and taxonomy information. Upon successful completion of the provider enrollment process an enrollment confirmation letter is mailed to the new provider.

Function #7- Execution of Medicaid Provider Agreement (Medicaid Fiscal Agent):

OMPP has a fiscal agent under contract, which is obligated to assist OMPP in processing approved Medicaid Provider Agreements to enroll approved eligible providers in the Medicaid Management Information System (MMIS) for claims processing. This includes the enrollment of DMHA approved 1915(i) providers. The expected processing time for new provider applications is 15 days for electronic applications and 20 days for paper applications. The fiscal agent also conducts provider training and provides technical assistance concerning claims processing. The Medicaid Fiscal Agent contract defines the roles and responsibilities of the Medicaid fiscal contractor.

DMHA and/or OMPP attend the MMIS Fiscal Agent's scheduled provider training sessions required in OMPP's contract with the Fiscal Agent. DMHA may also participate in the Fiscal Agent's individualized provider training for providers having problems.

Function #8 - Establishment of a consistent rate methodology for each State Plan HCBS (Medicaid Actuarial Contractor):

OMPP has an actuarial service under contract to develop and assess rate methodology as needed. The actuarial contractor completes the cost surveys and calculates rate adjustments. OMPP reviews and approves the fee schedule to ensure consistency, efficiency, economy, quality of care, and sufficient access to providers for CMHW services.

(By checking the following boxes the State assures that):

5. ☑ **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual, or any paid caregiver of the individual
- financially responsible for the individual
- empowered to make financial or health-related decisions on behalf of the individual
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*

To prevent conflict of interest, family choice of participation in the State's high-fidelity Wraparound CMHW services is a minimum expectation to meet the standard for quality care. Members are presented with all available treatment options at the point of assessment and plan of care development, including CMHW services; and must consent to participation in the CMHW services and choose the providers who will provide those services.

Additionally, the member and their family develop and lead the Child and Family Team with assistance from the Wraparound Facilitator. The individuals on the team consist of service providers, community supports and any natural supports. The wraparound team is committed to building an effective array of supports and interventions to ensure that the family vision is achieved. At the time of the initial evaluation, assessment, and Plan of Care (POC) development, the CMHW evaluator provides the individual with written documentation from DMHA and OMPP that explains the individual's right to exercise *freedom of choice* regarding the CMHW services selected on the plan of care, who will provide each of the CMHW services specified on the DMHA- approved plan of care, and in what setting. The participant selects CMHW service provider(s) from a pick list of DMHA- authorized CMHW service providers. Additionally, the Wraparound Facilitator is responsible to inform the member of their right to change their CMHW provider, including the Wraparound Facilitator, at any time during the CMHW benefit period.

To further prevent conflict of interest between evaluators, service providers, the member, and family, the following State processes are in place:

1) The Wraparound Facilitation Agency adheres to conflict-free standards including but not limited to not providing any other CMHW service except for facility- based respite care.
2) The Wraparound Facilitator is DMHA-authorized to provide only Wraparound Facilitation and is not authorized to provide any other CMHW service to the member for whom they are the Wraparound Facilitator.
3) DMHA, the independent state entity making the final eligibility determination and providing authorization for the plan of care, is not related by blood or marriage to the individual/participant; to any of the individual's paid caregivers; or to anyone financially responsible for the individual or empowered to make financial or health related decisions on the Individual/Participant's behalf. Additionally, DMHA is not a provider of CMHW services.
4) The quality improvement specialists provide oversight for CMHW providers and engage in quality management activities to promote adherence to Wraparound service delivery practices, including family choice and direction in the development of the plan of care, selection of service providers and preference for service delivery. Quality improvement specialists are responsible to provide training, education, site visits, record reviews and consultation to ensure provider compliance with CMHW requirements and standards.
5) Participants and families are educated regarding their rights and how to submit complaints or appeals regarding all aspects of CMHW service delivery, providers, inclusion in treatment planning, DMHA eligibility determinations or Plan of Care authorization.
6) The assessments, person-centered service plan and direct CMHW services are all based on a county level geographic region. Authorized providers are required to designate the geographical area of service by county as a part of the enrollment process. The providers may request to add or decrement counties as needs change.

6. ☑ **Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. ☑ **No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. ☑ **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. **Projected Number of Unduplicated Individuals To Be Served Annually.**
(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	7/1/2023	6/30/2024	1,100
Year 2			
Year 3			
Year 4			
Year 5			

2. ☑**Annual Reporting.** *(By checking this box the state agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

Financial Eligibility

1. ☑ **Medicaid Eligible.** *(By checking this box the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

2. **Medically Needy** (*Select one*):

☑ The State does not provide State plan HCBS to the medically needy.

☐ The State provides State plan HCBS to the medically needy. (*Select one*):

☐ The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services.

☐ The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

Evaluation/Reevaluation of Eligibility

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*Select one*):

☑	Directly by the Medicaid agency
	By Other (*specify State agency or entity under contract with the State Medicaid agency*):

2. Qualifications of Individuals Performing Evaluation/Reevaluation. The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

All determinations of eligibility, whether initial or renewal, are made by the State based upon the review of applications submitted by the access site (initials) or Wraparound Facilitators (renewals).

State employees making eligibility review decisions must meet the following qualifications:

1) Bachelor's degree in social services or related field
2) Experience working with children/youth identified as severely emotionally disturbed
3) Experience with the Child Adolescent Needs and Strengths (CANS) assessment tool and set algorithms established by the DMHA in partnership with the Praed Foundation and Indiana University.
4) Individuals performing evaluation/reevaluation must be employed with the State as a National Wraparound Implementation Center Local Coach candidate.

The individual administering the CANS assessment tool and collecting clinical information and data used to determine an individual's level of need for CMHW services must meet the following qualifications and standards:

5) Affiliated with a DMHA-authorized access site (Initial) or DMHA-authorized Wraparound facilitation agency (renewal).
6) One of the following clinical qualifications:
    a) A psychiatrist;
    b) A physician;
    c) A licensed psychologist or a psychologist endorsed as a health service provider in psychology (HSPP);
    d) A licensed clinical social worker;
    e) A licensed mental health counselor;
    f) A licensed marriage and family therapist;
    g) An advanced practice registered nurse under IC 25-23-1-1(b)(3) who is credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center;
    h) A licensed independent practice school psychologist; or
    i) The provider must have a bachelor's degree or a master's degree with two (2) or more years of one or a combination of the following experience:
        i. Clinical
        ii. Case management
        iii. Skills building
        iv. Child welfare
        v. Juvenile justice
        vi. Education in a K-12 school setting

Successful completion of DMHA/OMPP required training and certification (certification refers to the CANS assessment tool certification program).

3. Process for Performing Evaluation/Reevaluation. Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

The eligibility review process is the same for initial and annual reviews, with the exception that the initial is conducted by the access site, and the annual is conducted by the assigned Wraparound Facilitator.

All referrals for CMHW services must be received through the DMHA-authorized state-wide access site. An interested individual will receive education about Wraparound practice, available CMHW services, and the face-to-face evaluation. This face-to-face evaluation includes administration of the Child and Adolescent Needs and Strengths (CANS) assessment and completion of the CMHW application developed by OMPP and DMHA. The individual will determine whether to pursue application and assessment for 1915(i) services.

The assessment and supporting documentation identifies specific information about the individual's current strengths, needs, health status, living situation, family functioning, exposure to trauma, vocational status, social functioning, living skills, self-care skills, capacity for decision making, living situation, potential for self-injury or harm to others, substance use/abuse, and medication adherence. The access site also verifies the individual resides in a HCBS compliant setting, as defined by federal regulations.

The access site must submit the complete application packet to DMHA within ten (10) business days of receiving the parent/guardian's signature. DMHA notifies the access site regarding the eligibility determination on the eligibility determination form within five (5) working days of receiving the application packet. The eligibility determination form serves as the written notice documenting a DMHA determination regarding an individual's eligibility for participation in CMHW services. Information included on the Eligibility Determination form includes:

1) Approval or Denial of Individual's level of need/eligibility to participate in the CMHW services program;
2) The effective dates and reasons for the action(s) taken; and
3) The individual's appeal and fair hearing rights and procedural information.

The access site communicates DMHA's determination information on the eligibility determination form to the individual. Referrals to alternate services are made if the individual is not eligible for CMHW services.

At least annually, the Wraparound Facilitator conducts a review to ensure the participant continues to meet eligibility criteria. The Wraparound Facilitator will complete the face-to-face reevaluation with the participant, including the administration of the CANS assessment tool, to ensure all eligibility criteria for CMHW Wraparound participation are met. The high fidelity Wraparound process requires active investment by a wraparound team to meet the participant's needs. The Child and Family Team provides input regarding the participant's progress in moving towards achieving the vision.

The Wraparound Facilitator submits the results of the reevaluation to DMHA, which determines the participant's continued eligibility for the CMHW services. DMHA forwards the eligibility determination form to the Wraparound Facilitator, who communicates DMHA's eligibility

determination to the participant, family and to the Child and Family Team.

When it is anticipated that the participant may no longer be eligible for CMHW services, the Wraparound Facilitator and Child and Family Team will begin preparing the participant and family to transition to other more appropriate services (e.g., State plan services, community, and natural supports).

OMPP delegates the responsibility for accurate and timely eligibility reviews to DMHA. OMPP retains the authority and oversight of the 1915(i) benefit functions through regular monthly meetings to review quality assurance measures and to discuss issues, trends, and member appeals. OMPP reviews and approves policies, procedures, forms and standards for evaluation and re-evaluation of eligibility. OMPP may review and overrule the approval or disapproval of any specific eligibility determination by DMHA serving in its capacity as the operating agency for the 1915(i) HCBS State Plan Benefit.

4. ☑ Reevaluation **Schedule**. *(By checking this box the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

5. ☑ **Needs-based HCBS Eligibility Criteria.** *(By checking this box the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

The CANS assessment tool (developed for assessing youth ages 5 to 17) (Lyons, 1999) is used by the State to assist in assessing the youth and caregiver's strengths and needs (The assessment tool can be reviewed at: https://dmha.fssa.in.gov/DARMHA/mainDocuments). Patterns of CANS ratings derived from assessing six dimensions of the youth's life (e.g., life functioning, behavioral health symptoms, risk behaviors, youth strengths, caregiver strengths and needs and acculturation) have been used to develop a Behavioral Health Decision Model (algorithm). The recommendation is a result of an algorithm run on the CANS assessment ratings over multiple life domains. The CANS behavioral recommendation indicates the following levels of need for behavioral health services:

0-No treatment services indicated
1-Outpatient Services
2-Outpatient Services, with Limited Case Management
3- Supportive Community Services
4- Intensive Community Services: high-fidelity Wraparound
5- Intensive Community-Based Services
6- High-Intensity Services: Psychiatric Residential Treatment Facility (PRTF), State hospital, Intensive Community Based

Needs-Based Eligibility Criteria:

In addition to meeting the Target Group Eligibility criteria, individuals must also meet the following needs- based eligibility criteria:

1) The individual experiencing significant* emotional and/or functional impairments that impact his/her level of functioning at home or in the community, as a result of a mental illness. A minimum behavioral recommendation of a 4 is required.
2) The individual who meets a minimum 4 behavioral recommendation on the CANS, must also meet the following needs-based criteria and risk factors:
   a. Dysfunctional patterns of behavior due to one or more of the following behavioral/emotional need(s), as identified on the CANS assessment tool:
      1. Adjustment to Trauma.
      2. Psychosis.
      3. Debilitating anxiety.
      4. Conduct problems.
      5. Sexual aggression; and/or
      6. Fire-setting.
   b. The individual demonstrates significant* needs in at least one of the following family/caregiver area(s), as indicated on the CANS assessment tool, that results in a negative impact on the child's mental illness and may indicate a higher level of need:
      1. Mental Health.
      2. Supervision issues.
      3. Family Stress; and/or
      4. Substance abuse.

*"Significant" is determined by an assessed need for *immediate or intensive action due to a serious or disabling need in a variety of life domains* on the CANS assessment tool used by the State to assess an individual's Level of Need (LON).

Exclusionary Criteria:
The following exclusionary criteria are used to identify those youth the CMHW services program is not designed to serve:

1. An individual who is at imminent risk of harm to self or others. An individual who is identified as not able to feasibly receive intensive community-based services without compromising his/her safety, or the safety of others, will be referred to a facility capable of providing the level of intervention or care needed to keep the youth safe. Individuals residing in an institutional or otherwise HCBS non-compliant setting.

6. ☑ **Needs-based Institutional and Waiver Criteria.** *(By checking this box the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

State Plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)
In addition to meeting the Target Group Eligibility criteria, individuals must also meet the following needs-based eligibility criteria: 1) Youth is experiencing significant* emotional and/or functional impairments that impact his/her level of functioning at home or in the community, as a result of a mental illness. A minimum behavioral recommendation of a 4 is required, 2) The individual, who meets a minimum of 4 behavioral recommendation on the CANS, must also meet the following needs-based criteria: a) Dysfunctional patterns of behavior due to one or more of the following behavioral/emotional need(s), as identified on the CANS assessment tool: i. Adjustment to Trauma	Indiana Law allows reimbursement to NFs for eligible persons who require skilled or intermediate nursing care as defined in 405 Indiana Administrative Code 1-3-1 and 1-3-2. 405 IAC 1-3-1 (a) Skilled nursing services, as ordered by a physician, must be required and provided on a	Indiana Law allows reimbursement to ICF/IIDs for eligible persons as defined in 405 IAC 1-1-11. A person may be functionally eligible for an ICF/IID LOC waiver when documentation shows he individually meets the following conditions: 1) Has a diagnosis of intellectual disability, cerebral palsy,	Admission criteria for Psychiatric Residential Treatment Facilities (PRTFs), which include the following factors: 1) Individual's mental disorder is rated as severe or complex; 2) Multiple disruptive behaviors; 3) Serious family functioning impairments; 4) Prior failure of acute and/or emergency treatment to sufficiently ameliorate the condition;

ii. Psychosis; iii. Debilitating anxiety; iv. Conduct problems; v. Sexual aggression; and/or vi. Fire-setting. b) Demonstrates significant* needs in at least one of the following Family/caregiver area(s), as indicated on the CANS assessment tool: i. Mental Health; ii. Supervision issues; iii. Family Stress; and/or iv. Substance abuse. *"Significant" is determined by an assessed need for *immediate or intensive action due to a serious or disabling need in a variety of life domains* on the CANS assessment tool used by the State to assess an Individual's Level of Need (LON). **Exclusionary Criteria:** The following exclusionary criteria are used to identify those youth the CMHW services program is not designed to serve: 1) An individual who is at imminent risk of harm to self or others. 2) An individual who is identified as not able to feasibly receive intensive community-based services without compromising his/her safety, or the safety of others, will be referred to a facility capable of providing the level of intervention or care needed to keep the youth safe. 3) An individual residing in an institutional or otherwise HCBS non-compliant setting.	daily basis, essentially 7 days a week. 405 IAC 1-3-2 (a) Intermediate nursing care includes care for patients with long-term illnesses or disabilities which are relatively stable, or care for patients nearing recovery and discharge who continue to require some professional medical or nursing supervision and attention. A person is functionally eligible for either NF level of care or waiver if the need for medical or nursing supervision and attention is determined by any of the following findings from the functional screening: 1) Need for direct	2) epilepsy, autism, or condition similar to intellectual disability 3) Condition identified in #1 is expected to continue. 4) Condition identified in #1 had an age of onset prior to age 22. 4) Individual needs a combination or sequence of services, 5) Has 3 of 6 substantial functional limitations as defined in 42 CFR 435.1010 in areas of: Self-care; learning; self-direction; capacity for independent living; language; and mobility.	5) Symptom complexes showing a need for extended treatment in a residential setting due to a threat to self or others; 6) Impaired safety issues; and 7) Need for long-term treatment modalities. *The minimum eligibility rating for a child to qualify for institutional placement in a PRTF or state-operated facility (SOF) level of care is five (5) or higher, as determined by a behavioral recommendation from administration of the Child and Adolescent Needs and Strengths (CANS) Assessment Tool. While the algorithm that determines the CANS score is proprietary, the State has determined that a score of four (4) or higher meets the level of need criteria established for CMHW

	assistance at least 5 days per week due to unstable, complex medical conditions. Need for direct assistance for 3 or more substantial medical conditions including activities of daily living.		

*Long Term Care/Chronic Care Hospital **LOC= level of care

7. ☑ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5-year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

The State elects to target this 1915(i) State Plan HCBS benefit to the population defined below. With this election, the State will operate this program for a period of five years. At least 90 days prior to the end of this five-year period, the State may request that CMS renew this benefit for an additional five year term in accordance with 1915(i)(7)(C).

Target Groups:
Indiana's CMHW services program is designed to serve youth meeting the following targeted eligibility criteria:

1) The individual is age six through the age of 17 at the time of eligibility review;
2) The individual meets the criteria for two (2) or more DSM V diagnoses; and
3) The individual does not meet exclusionary criteria for CMHW services.

A participant who meets CMHW eligibility and began receiving CMHW 1915(i) services at or before the age of seventeen (17) shall remain eligible for up to one year of services beyond that participant's eighteenth birthday during the participant's benefit period as long as the remaining eligibility and needs-based criteria continue to be met.

Diagnostic Criteria:
The following diagnostic criteria are used to identify those youth the CMHW services program is designed to serve. A youth with any of the diagnoses below as primary is eligible for CMHW services:

Paranoid schizophrenia

Disorganized schizophrenia

Catatonic schizophrenia
Undifferentiated schizophrenia
Residual schizophrenia
Schizophreniform disorder
Other schizophrenia
Schizophrenia
Delusional Disorder
Shared psychotic disorder
Schizoaffective disorder, bipolar type
Schizoaffective disorder, depressive type
Other schizoaffective disorders
Schizoaffective disorder, unspecified
Other specified schizophrenia spectrum and other psychotic disorder
Unspecified schizophrenia spectrum and other psychotic disorder
Manic episode without psychotic symptoms, unspecified
Manic episode without psychotic symptoms, moderate
Manic episode, severe, without psychotic symptoms
Manic episode, severe with psychotic symptoms
Manic episode in partial remission
Manic episode, unspecified
Bipolar I disorder, current or most recent episode hypomanic
Bipolar disorder, current episode manic without psychotic features, unspecified
Bipolar I disorder, current or most recent episode manic, moderate
Bipolar I disorder, current or most recent episode manic, severe
Bipolar I disorder, current or most recent episode manic, with psychotic features
Bipolar disorder, current episode depressed, mild or moderate severity, unspecified
Bipolar I disorder, current or most recent episode depressed, moderate
Bipolar I disorder, current or most recent episode depressed, severe
Bipolar I disorder, current or most recent episode depressed, with psychotic features
Bipolar disorder, current episode mixed, unspecified
Bipolar disorder, Current episode mixed, moderate
Bipolar disorder, current episode mixed, severe, without psychotic features
Bipolar disorder, current episode mixed, severe, with psychotic features
Bipolar disorder, in partial remission, most recent episode hypomanic
Bipolar I disorder, current or most recent episode hypomanic, in partial remission
Bipolar I disorder, Current or most recent episode depressed, in partial remission
Bipolar disorder, in partial remission, most recent episode mixed
Bipolar II disorder
Other specified bipolar and related disorder
Bipolar I disorder, current or most recent episode depressed, hypomanic or manic, unspecified or Unspecified bipolar and related disorder
Major depressive disorder, single episode, moderate
Major depressive disorder, single episode, severe

Major depressive disorder, single episode, with psychotic features
Major depressive disorder, single episode, in partial remission
Major depressive disorder, recurrent episode, moderate
Major depressive disorder, recurrent episode, severe
Major depressive disorder, recurrent episode, with psychotic features
Major depressive disorder, recurrent episode, in partial remission
Major depressive disorder, recurrent episode, unspecified
Cyclothymic disorder
Persistent depressive disorder (dysthymia)
Disruptive mood dysregulation disorder
Agoraphobia
Agoraphobia with panic disorder
Agoraphobia without panic disorder
Social anxiety disorder (social phobia)
Panic disorder
Generalized anxiety disorder
Mixed obsessional thoughts and acts
Hoarding disorder
Posttraumatic stress disorder
Post-traumatic stress disorder, acute
Post-traumatic stress disorder, chronic
Dissociative identity disorder
Pain disorder exclusively related to psychological factors
Anorexia nervosa, unspecified
Anorexia nervosa, restricting type
Anorexia nervosa, binge eating/purging type
Bulimia nervosa
Binge eating disorder
Avoidant/restrictive food intake disorder
Pica in adults, avoidant/restrictive food intake disorder, other specified feeding or eating disorder
Unspecified feeding or eating disorder
Non-rapid eye movement sleep arousal disorders, Sleep terror type
Paranoid personality disorder
Borderline personality disorder
Conduct disorder confined to family context
Conduct disorder, Childhood-onset type
Conduct disorder, Adolescent-onset type
Other specified disruptive, impulse-control, and conduct disorder
Conduct disorder, Unspecified onset or Unspecified disruptive, impulse-control, and conduct disorder
Separation anxiety disorder
Reactive attachment disorder
Stereotypic movement disorder

Oppositional defiant disorder

The following diagnostic criteria are used to identify those youth the CMHW services program is designed to serve. A youth with any of the diagnoses below as secondary, but not primary, is eligible for CMHW services:

Alcohol use disorder, mild
Alcohol abuse with intoxication, uncomplicated
Alcohol abuse with alcohol-induced psychotic disorder with delusions
Alcohol abuse with alcohol-induced psychotic disorder with hallucinations
Alcohol abuse with other alcohol-induced disorder
Alcohol abuse with unspecified alcohol-induced disorder
Alcohol use disorder, moderate or severe
Alcohol dependence, in remission
Alcohol dependence with intoxication, uncomplicated
Alcohol dependence with withdrawal, uncomplicated
Alcohol dependence with alcohol-induced psychotic disorder with delusions
Alcohol dependence with alcohol-induced psychotic disorder with hallucinations
Alcohol dependence with unspecified alcohol-induced disorder
Opioid use disorder, mild
Opioid abuse with intoxication, uncomplicated
Opioid abuse with opioid-induced psychotic disorder with delusions
Opioid abuse with opioid-induced psychotic disorder with hallucinations
Opioid abuse with opioid-induced psychotic disorder, unspecified
Opioid abuse with unspecified opioid-induced disorder
Opioid use disorder, moderate or severe
Opioid dependence in remission
Opioid dependence with intoxication, uncomplicated
Opioid dependence with opioid-induced psychotic disorder with delusions
Opioid dependence with opioid-induced psychotic disorder with hallucinations
Opioid dependence with opioid-induced psychotic disorder, unspecified
Opioid dependence with unspecified opioid-induced disorder
Cannabis use disorder, mild
Cannabis abuse with intoxication, uncomplicated
Cannabis abuse with psychotic disorder with delusions
Cannabis abuse with psychotic disorder with hallucinations
Cannabis abuse with unspecified cannabis-induced disorder
Cannabis use disorder, moderate or severe
Cannabis dependence, in remission
Cannabis dependence with intoxication, uncomplicated
Cannabis dependence with psychotic disorder with delusions
Cannabis dependence with psychotic disorder with hallucinations
Cannabis dependence with unspecified cannabis-induced disorder
Sedative-, hypnotic-, or anxiolytic use disorder, mild

Sedative, hypnotic or anxiolytic abuse with intoxication, uncomplicated
Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions
Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations
Sedative, hypnotic or anxiolytic abuse with other sedative, hypnotic or anxiolytic-induced disorder
Sedative, hypnotic or anxiolytic abuse with unspecified sedative, hypnotic or anxiolytic-induced disorder
Sedative-, hypnotic-, or anxiolytic use disorder, moderate or severe
Sedative, hypnotic or anxiolytic dependence, in remission
Sedative, hypnotic or anxiolytic dependence with intoxication, uncomplicated
Sedative, hypnotic or anxiolytic dependence with withdrawal, uncomplicated
Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions
Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations
Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting amnestic disorder
Sedative, hypnotic or anxiolytic dependence with unspecified sedative, hypnotic or anxiolytic-induced disorder
Cocaine use disorder, mild
Cocaine abuse with intoxication, uncomplicated
Cocaine abuse with cocaine-induced psychotic disorder with delusions
Cocaine abuse with cocaine-induced psychotic disorder with hallucinations
Cocaine abuse with unspecified cocaine-induced disorder
Cocaine use disorder, moderate or severe
Cocaine dependence, in remission
Cocaine dependence with intoxication, uncomplicated
Cocaine dependence with cocaine-induced psychotic disorder with delusions
Cocaine dependence with cocaine-induced psychotic disorder with hallucinations
Cocaine dependence with unspecified cocaine-induced disorder
Amphetamine-type substance use disorder or Other or unspecified stimulant use disorder, mild
Other stimulant abuse with intoxication, uncomplicated
Other stimulant abuse with unspecified stimulant-induced disorder
Amphetamine-type substance use disorder or Other or unspecified stimulant use disorder, moderate or severe
Other stimulant dependence, in remission
Other stimulant dependence with intoxication, uncomplicated
Other stimulant dependence with unspecified stimulant-induced disorder
Other Hallucinogen or Phencyclidine use disorder, mild
Hallucinogen abuse with intoxication, uncomplicated
Hallucinogen abuse with hallucinogen persisting perception disorder (flashbacks)
Hallucinogen abuse with other hallucinogen-induced disorder
Hallucinogen abuse with unspecified hallucinogen-induced disorder
Other Hallucinogen or Phencyclidine use disorder, moderate or severe

Hallucinogen dependence, in remission
Hallucinogen dependence with intoxication, uncomplicated
Hallucinogen dependence with hallucinogen-induced psychotic disorder with delusions
Hallucinogen dependence with hallucinogen-induced psychotic disorder with hallucinations
Hallucinogen dependence with hallucinogen persisting perception disorder (flashbacks)
Hallucinogen dependence with other hallucinogen-induced disorder
Hallucinogen dependence with unspecified Hallucinogen-induced disorder
Inhalant use disorder, mild
Inhalant abuse with intoxication, uncomplicated
Inhalant abuse with inhalant-induced psychotic disorder with delusions
Inhalant abuse with inhalant-induced psychotic disorder with hallucinations
Inhalant abuse with unspecified inhalant-induced disorder
Inhalant use disorder, moderate or severe
Inhalant dependence, in remission
Inhalant dependence with intoxication, uncomplicated
Inhalant dependence with inhalant-induced psychotic disorder with delusions
Inhalant dependence with inhalant-induced psychotic disorder with hallucinations
Inhalant dependence with unspecified inhalant-induced disorder
Other (or unknown) substance use disorder, with mild use disorder
Other psychoactive substance abuse with intoxication, uncomplicated
Other psychoactive substance abuse with intoxication with perceptual disturbances
Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with delusions
Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with hallucinations
Other psychoactive substance abuse with psychoactive substance-induced persisting amnestic disorder
Other psychoactive substance abuse with unspecified psychoactive substance-induced disorder
Other (or unknown) substance use disorder, with moderate or severe use disorder
Other psychoactive substance dependence, in remission
Other psychoactive substance dependence with intoxication, uncomplicated
Other psychoactive substance dependence with intoxication with perceptual disturbance
Other psychoactive substance dependence with withdrawal, uncomplicated
Other psychoactive substance dependence with withdrawal with perceptual disturbance
Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with delusions
Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with hallucinations
Other psychoactive substance dependence with psychoactive substance-induced persisting amnestic disorder
Other psychoactive substance dependence with unspecified psychoactive substance-induced disorder
Attention-deficit/hyperactivity disorder, Predominantly inattentive presentation
Attention-deficit/hyperactivity disorder, Predominantly hyperactive/impulsive presentation

Attention-deficit/hyperactivity disorder, Combined presentation

☐ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe:
(1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. (Specify the phase-in plan):

(By checking the following box the State assures that):

8. ☑ **Adjustment Authority**. The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

9. Reasonable Indication of Need for Services. In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	**Minimum number of services**. The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is*:* One	
ii.	**Frequency of services**. The state requires (select one):	
	☑	**The provision of 1915(i) services at least monthly**
	○	**Monthly monitoring of the individual when services are furnished on a less than monthly basis** If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency:

Home and Community-Based Settings

(By checking the following box the State assures that):

1. ☑ **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (*Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive*

HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):

(Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)

The state assures that this SPA renewal will be subject to any provisions or requirements included in the State's most recent and/or approved home and community-based settings Statewide Transition Plan.

1915(i) CMHW services are provided in the member's home and community, based upon the member's preferences. Settings for service delivery are chosen by participant during the service planning process, identified in the participant's plan of care, reviewed, and approved by the State. During quality assurance reviews, service settings are reviewed for compliance as well. Settings found to be out of compliance are subject to remediation, including but not limited to corrective action and reclamation of funds.

Any type of institutional or institution-like residence (except approved respite facilities) as defined by federal regulations would be considered a non-complaint HCBS setting, and would be disallowed. For purposes of this document "home" includes any community-based residence that the participant lives in with the guardian/caregiver, including a foster home.

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Participants who reside with family members in homes or apartments in typical community neighborhoods where people who do not receive home and community-based services reside are presumed to be in compliance. If it is found that a participant living with family members who do not reside in typical community neighborhoods, but have relocated to an institution or institution-like setting will be considered as not fully complying with federal and state requirements. DMHA would require the participant and family to move to a compliant setting, and would work with the family on a month-by- month basis with demonstrated progress (such as the exploration of alternate residences) as is reasonable to accommodate any lease or other legal obligations, not to exceed one year from the date of formal notice. Progress toward this transition would have been monitored no less often than monthly as part of the required monthly Child and Family Team meetings, and would include assistance from the local System of Care and DMHA where appropriate.

Ongoing Compliance and Monitoring of Settings

In order to ensure ongoing compliance and monitoring of settings, DMHA will continue to train all providers on the setting requirements, including an assessment of the residential setting by access personnel as part of the initial application for eligibility process; requiring an annual confirmation of the compliance of the residential setting (attestation form); requiring Wraparound Facilitators to assess any changes in the residential setting during the program year, and reporting the assessment to the State; and the Child and Family Team, guided by the Wraparound Facilitator and other providers, determining the settings in which services will be delivered as part of plan development, to be reviewed and approved by the State.

All providers must participate in orientation and service specific training. This training includes information regarding the HCBS Settings Final Rule requirements. A description of the setting in which services are delivered is required in all service notes, as discussed in training. Demonstrated competency measures are included in DMHA trainings, and questions on this requirement have been included. Potential providers are required to pass the competency measure in order to be approvable as a provider. Ongoing support is available to providers who may have questions regarding allowable settings. All providers are given state contacts for technical assistance in any areas of need.

As part of the initial application for eligibility and again at the time of annual eligibility renewal, questions related to settings compliance will be addressed and included in the DMHA Youth and Family Rights Attestation form, which includes all of the rights offered to all participants. A field has been added to the Youth and Family Rights Attestation form that the family signs to validate the compliance of the participant's residential setting. Access personnel (who complete initial assessments for application for eligibility on behalf of the State) receive training on the setting requirements, understanding that it is a fundamental part of the initial assessment. A description of the participant's living situation has always been a requirement of the initial and annual application, which is then reviewed by the State as part of the eligibility process. The Wraparound Facilitators are in the participants' home at least once per month.+As part of the State's plan to ensure ongoing compliance, Wraparound Facilitators review any relocation of the participant to a new setting to ensure that the setting is compliant with the federal requirements, and communicate that to DMHA when updating the participant's demographic information.
If, during the eligibility period the participant is found to be in an institutional, institution-like, or otherwise non-compliant setting, the Wraparound Facilitator notifies DMHA to begin the remediation process.

Wraparound Facilitators guide the Child and Family Team meeting for plan of care development including determining services, strategies, responsible parties, and the setting in which services will take place. The plan of care is then reviewed and approved by DMHA quality assurance staff for compliance. DMHA quality assurance staff review 100% of service plans submitted before approval. There is currently an established process for the Wraparound Facilitator to notify DMHA if the participant will be out the identified setting for more than 24 hours. This includes but is not limited to camp, overnight with relatives or placement in an acute setting. This allows for DMHA to monitor changes in the living arrangement.

Upon enrollment in the program, youth and families are also given information regarding contacting DMHA for assistance with any concerns they may have. Anyone, provider, family member, or other, may submit a complaint to DMHA about any concern they may have including services provided in non-compliant or questionable settings. Access to the web-based complaint portal is provided on several DMHA webpages.

All issues involving HCBS settings compliance will be processed as complaints and accordingly will be tracked, monitored, and reported as a subsection of overall quality improvement activities. Review of settings issues will also be specifically included in overall trend analysis to determine any patterns requiring remediation.

Person-Centered Planning & Service Delivery

(By checking the following boxes the state assures that):

1. ☑ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

2. ☑ Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

3. ☑ The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

4. Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities. There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):*

The individual administering the CANS assessment tool and collecting clinical information and data used to determine an Individual's/Participant's level of need for CMHW services must meet the following qualifications and standards:

1) Affiliated with a DMHA-approved access site (initial) or DMHA-authorized Wraparound Facilitation agency (renewal).
2) One of the following clinical qualifications:
    a) A psychiatrist;
    b) A physician;
    c) A licensed psychologist or a psychologist endorsed as a health service provider in psychology (HSPP);
    d) A licensed clinical social worker;
    e) A licensed mental health counselor;
    f) A licensed marriage and family therapist;
    g) An advanced practice nurse under IC 25-23-1-1(b)(3) who is credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center;
    h) A licensed independent practice school psychologist; or
    i) An unlicensed individual who does not have a license to practice independently but practices under the supervision of one of the above mentioned persons; The provider must have a bachelor's degree or a master's degree with two (2) or more years of one or a combination of the following experience:
        a. Clinical
        b. Case management
        c. Skills building
        d. Child welfare
        e. Juvenile justice
        f. Education in a K-12 school setting

Successful completion of DMHA/OMPP required training and certification (certification refers to the CANS assessment tool certification program).

5. Responsibility for Development of Person-Centered Service Plan. There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*

The CMHW service provider developing the plan of care must meet the following criteria:

1. The provider must be employed by a DMHA-authorized accredited agency to be a provider of the service of Wraparound Facilitation.
2. The provider must have a bachelor's degree or a master's degree with two (2) or more years of one or a combination of the following experience:
    a. Clinical
    b. Case management
    c. Skills building
    d. Child welfare
    e. Juvenile justice
    f. Education in a K-12 school setting
3. The provider must complete the following office-required service provider training and certifications:
    a. CMHW services orientation
    b. Child and adolescent needs and strengths assessment tool SuperUser certification
    c. Wraparound practitioner training
    d. Cardiopulmonary resuscitation (CPR) certification

1. **Supporting the Participant in Development of Person-Centered Service Plan**. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

All CMHW services adhere to the Wraparound model of service delivery. Engagement and involvement of the family in the Plan of Care development is fundamental to the definition of Wraparound Facilitation, and to the Child and Family Wraparound Team paradigm. Wraparound Facilitation is a variety of specific tasks and activities designed to engage the family in the planning process that follows a series of steps and is provided through a Child and Family Wraparound Team (a treatment/support team developed by the CMHW- enrolled participant and family to assist them in developing and implementing the individualized plan of care).

During initial assessment at the access site, the family is offered a list of available Wraparound Facilitators and the agencies for the county in which the family lives. The family may choose any Wraparound Facilitation agency from this randomly generated list. The access site submits the family's choice of Wraparound Facilitator (via picklist) along with eligibility documents to the State for review and approval. If eligibility is approved, the State creates an initial plan of care authorizing two-to-three months of Wraparound Facilitation services. This is assigned to the chosen Wraparound Facilitator who begins the person-centered planning process to develop the comprehensive plan of care.

The Wraparound Facilitator will guide the family through the ongoing Wraparound process and development of the CMHW service plan. The Wraparound Facilitator is responsible for coordination of care and ensuring Participant's care/service delivery adheres to the high

fidelity Wraparound model.

The Wraparound Facilitator prepares the participant and family for the Child and Family Team meeting by discussing the individual's and family's rights; the high-fidelity Wraparound and team process; and assists the Participant/family to identify potential members of their Child and Family team (including friends and other advocates that are not providing services). The participant and family determine the members of the Child and Family Team.

All Plan of Care development takes place within the framework of the Child and Family Team meeting process. This process requires that the Child and Family Team meetings be only convened when the Participant/family is available, with their active participation at a location convenient to them.

The chosen providers and families sign the approved Person-Centered Plan. DMHA includes each person-centered-plan as part of the plan of care, which is then incorporated into the Care Plan that providers are required to sign.

The 10 Principles of Wraparound, intended to support the family in the treatment process, include:

- *Family Voice and Choice*: Wraparound Team specifically elicits and prioritizes the family and youth perspectives during all phases of the Wraparound Process. The Team strives to provide options and choices such that the Plan reflects family values and preferences.
- *Team Based*: The Team consists of individuals agreed upon by the family and committed to them through informal, formal and community support and service relationships.
- *Natural Supports*: The Team encourages the full participation of team members chosen from the family's networks of interpersonal and community relationships.
- *Collaboration*: Team members cooperate and share responsibility for developing, implementing, monitoring, and evaluating a single wraparound plan. The plan reflects a blending of team members' perspectives, mandates, and resources. The Plan guides and coordinates each team member's work towards meeting the Team's goals
- *Community-Based*: The Team implements services and supports that take place in the most inclusive, responsive, accessible, and least restrictive settings possible that safely promote youth and family integration into home and community life.
- *Culturally Competent*: The Wraparound Process respects and builds on the values, preferences, beliefs, culture, and identity of the youth and family and their community. Non-family Team members refrain from imposing personal values on the Plan.
- *Individualized*: The Team develops and implements customized strategies, supports and services to achieve the goals laid out in the Plan.
- *Strengths Based*: Both the Wraparound Process and Plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the youth and family, their community, and the other team members.
- *Persistence*: Regardless of challenges that may occur, the Team persists in working toward the goals included in the Plan until the Team agrees that a formal Wraparound Process is no longer required.
- *Outcome Based*: The goals and strategies of the Plan are tied directly to observable

or measurable indicators of success. The Team monitors progress in terms of these indicators and revises the Plan accordingly.

2. **Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

The participant and family determine who will provide services at all times while in the CMHW program. During the application process, the access site presents the participant and family with a pick list of DMHA-authorized providers of Wraparound Facilitation in their county for assignment if the application is approved. Once approved, the State creates the initial plan of care and assigns the participant and family to their selected Wraparound Facilitator. As part of the person-centered- planning process, the Wraparound Facilitator informs the participant and family, verbally and in writing, about their right to choose from among any DMHA-authorized provider of the chosen service in their county.

As a service is identified, the Wraparound Facilitator generates what is referred to as a pick list. Pick lists contain the names and contact information of all DMHA-authorized providers of a CMHW service in the county in which the participant resides. The providers are presented in random order each time the list is generated. Participants and family members may interview potential service providers and select the provider of each service on the Plan of Care. An image of the signed pick list is maintained in the State database, and the original maintained in the Participant's record managed by the Wraparound Facilitation providers.

The Wraparound Facilitator ensures the participant is aware of their option to change CMHW service providers at any time. This includes the option to change the Wraparound Facilitator. The participant can request a pick list at any time to select a different service provider.

At the time of authorization, the providers select the counties in which they will provide services. Families are provided a picklist which includes all providers who have elected to serve the member's county of residence.

A listing of approved/enrolled CMHW service providers is also posted on the Indiana Medicaid website at www.indianamedicaid.com.*

*When accessing indianamedicaid.com website, the individual has a choice of a "Member" tab and "Provider" tab. The Member tab notes: "If you are an Indiana Medicaid Member or are interested in applying to become a member, please click the member tab." Selection of the member tab provides an array of information to individuals applying for or eligible for Medicaid services, including a "Find a Provider" link. This link allows individuals to target their search by selecting types of providers by city, county or state. The resulting list includes the provider's name, address, telephone number and a link to the map for each provider location.

3. **Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency**. *(Describe the process by which the person-centered service plan is made subject to the approval of the Medicaid agency):*

OMPP delegates the responsibility for service plan approval to DMHA. OMPP retains the authority and oversight of the 1915(i) program delegated to DMHA through routine monthly meetings to discuss issues, trends, member appeals and provider issues related to program operations including service plan approvals.

In addition, OMPP reviews and approves the policies, processes, and standards for developing and approving the plan of care. Based on the terms and conditions of this State Plan Amendment, the Medicaid agency may review and overrule the approval or disapproval of any specific plan of care acted upon by the DMHA serving in its capacity as the operating agency for the 1915(i) HCBS benefit.

4. **Maintenance of Person-Centered Service Plan Forms**. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

☑	Medicaid agency	☑	Operating agency	☑	Case manager
☐	Other (*specify):*				

Services

1. **State plan HCBS.** *(Complete the following table for each service. Copy table as needed):*

1a. State plan HCBS.

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Wraparound Facilitation
Service Definition (Scope)*:*	

Wraparound Facilitation is a comprehensive service comprised of a variety of specific tasks and activities designed to facilitate high fidelity Wraparound and is a required component of the CMHW services. The Wraparound Facilitator ensures that care is delivered in a manner consistent with strength-based, family-driven, and culturally competent values. The Wraparound Facilitator manages the entire wraparound process and ensures that the participant and family's voice, preferences, and needs are central in the plan of care development, throughout service delivery and into the child and family transition into a less intensive level of service delivery, when appropriate.

The Child and Family Team is responsible for assuring that the participant's needs, and the entities responsible for addressing them, are identified in a written plan of care (POC). The Wraparound Facilitator is the individual who facilitates and supervises this process, including:

1) Completing a comprehensive assessment of the participant, including administration of the CANS assessment tool.
2) Guiding the family engagement process by exploring and assessing strengths and needs through documentation of the family timeline and story.
3) Facilitating, coordinating, and attending Child and Family Team meetings.
4) Developing the plan of care in full partnership with Child and Family Team member, while ensuring compliance with high fidelity Wraparound and Medicaid standards.
5) Assists participant in gaining access to a full continuum of services (i.e., medical, social, educational, and/or other needed services).
6) Guides the POC planning process by informing the team of the participant and family's vision and ensuring that the participant and family's vision is central to all service planning and delivery.
7) Ensuring that the services are delivered in a HCBS compliant setting of the participant's

choice.

8) Ensuring that participants are informed of their right to choose from among enrolled, office-authorized providers, and to change providers at any time in the process.
9) Develops, implements, and monitors the crisis plan; and intervenes during a crisis, if needed.
10) Assures that all work to be done to assist the participant in obtaining goals on the POC is identified and assigned to a Child and Family Team member.
11) Oversees implementation of the POC.
12) Reassess, amends, and secures on-going approval of the POC.
13) Monitors all services authorized for a participant's POC.
14) Assures care is delivered in a manner consistent with strength-based, family driven, and culturally competent values.
15) Offers consultation and education to all CMHW service providers regarding the values and principles of the wraparound model.
16) Monitors participant progress toward treatment goals.
17) Ensures that necessary data for evaluation is gathered and recorded.
18) Ensures that all CMHW assessment and service-related documentation is gathered and reported to DMHA, as mandated.
19) Completes the annual CMHW services level of need re-evaluation, with active involvement of the Participant and the Child and Family Wraparound Team.
18) Communicates and coordinates with local Division of Family Resources (DFR) regarding continued Medicaid eligibility status.
19) Guides the transition of the Participant and family from CMHW services to State plan, or other community-based services, when indicated.

The Wraparound model involves 4 stages (Miles, Brunes, Osher & Walker, 2006). The Wraparound Facilitator is responsible to guide the participant, family, and the Wraparound team through the 4 Stages of Wraparound:

1) *Engagement*: The family meets the Wraparound Facilitator. Together they explore the family's strengths, needs, and culture. They talk about what has worked in the past and what they expect from the Wraparound process. The WF engages other team members, identified by the Participant and family, and prepares for the first Child and Family Team meeting.
2) *Planning*: The WF informs the Child and Family Wraparound team members about the family's strengths, needs, and vision for the future. The Wraparound team does not meet unless the family is present. The team decides what to work on, how the work will be accomplished, and who is responsible for each task. POC development is facilitated by the WF, who is responsible to write the POC and obtain approval for the POC from DMHA. The WF also facilitates development of a crisis plan to manage crises that may occur.
3) *Implementation*: Child and Family and Team members meet monthly, or as needed. Meetings are facilitated by the WF, who ensures that the family guides the Child and Family Team meeting process. The team reviews accomplishments and progress toward goals and adjusts, as needed. Family and team members work together to implement the POC.
4) *Transition*: As the Participant nears reaching their POC goals, preparations are made for the youth to transition out of CMHW services to State plan services appropriate to meet the Participant's level of need for continued outpatient and/or home-based services, as needed. The family and team together decide how the Participant/family will continue to get support, when needed once the Participant has transitioned from CMHW services.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

None	
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*	
☑	Categorically needy *(specify limits):*
	No limits
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Accredited Agency	Individuals from Accredited Agencies must meet standards in the *Other Standard* section.	Accreditation Association for Ambulatory Health Care (AAHC), Council on Accreditation (COA), Utilization Review Accreditation Commission (URAC), Commission on Accreditation of Rehab Facilities (CARF), American	Individuals providing this service must be affiliated with a DMHA- authorized CMHW accredited agency that adheres to the following standards: 1) Agency participates in a local system of care, where available, that endorses the values and principles of Wraparound. 2) Agency adheres to conflict-free standards including but not limited to not providing any other CMHW service except for facility- based respite care. 3) Agency must maintain documentation that the individual providing the service meets the following standards: a. Hold a bachelor's or master's degree in one of the following specialties from an accredited college or university: i. Social work ii. Psychology iii. Sociology iv. Counseling v. Nursing vi. Education vii. Rehabilitation viii. Or related degree if approved by the FSSA/DMHA/OMPP representative b. Have two (2) or more years of one or a combination of the following experience:

		Council for Accredited Certification (ACAC), Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or National Committee for Quality Assurance Accreditation (NCQAA)	i. Clinical ii. Case management iii. Skills building

			iv. Child welfare v. Juvenile justice vi. Education in a K-12 school setting 3) The provider must complete the following office-required service provider training and certifications: a. CMHW services orientation b. Child and adolescent needs and strengths assessment tool SuperUser certification c. Wraparound practitioner training d. Cardiopulmonary resuscitation (CPR) certification 4) Individual has completed security screens including, but not limited to, the following: a. Fingerprint based national and state criminal history background screen b. Local law enforcement screen c. State and local Department of Child Services abuse registry screen d. Five-panel drug screen, or Agency meets same requirements specified under the Federal Drug Free Workplace Act 41 U.S.C. 10 Section 702(a)(1) 6) All approved providers must complete DMHA and OMPP approved training for CMHW services. Wraparound Facilitators and their supervisors must complete the Wraparound Practitioner Training Program. This training allows the state to ensure fidelity to the wraparound service delivery model.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Accredited Agency	DMHA	Verification documentation submitted to DMHA: Initially at point of DMHA

		authorization of the CMHW agency and at least every three years thereafter.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

1b. State plan HCBS.

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Habilitation

Service Definition (Scope)*:*

Habilitation services are provided with the goal of enhancing the participant's level of functioning, quality of life and use of social skills; as well as building the participant's strengths, resilience and positive outcomes. This is accomplished through development of the following skills:

1) Identification of feelings
2) Managing anger and emotions
3) Giving and receiving feedback, criticism, or praise
4) Problem-solving and decision making
5) Learning to resist negative peer pressure and develop pro-social peer interactions
6) Improve communication skills
7) Build and promote positive coping skills
8) Learn how to have positive interactions with peers and adults

Habilitation services are provided face-to-face and one-to-one in the participant's home or in a community-based setting. The setting is determined by the preferences of the participant and must be compliant with federal HCBS settings regulations.

While participating in this service, transportation to and from community-based activities can be requested under this 1915(i) benefit if required and based on an assessed need. Transportation services must not duplicate services offered under the state plan.

Service exclusions include:

1) Services provided to anyone other than the participant when the activity occurs in a group setting.
2) Service provided to participant's family members
3) Service provided in order to give the family/caregiver respite
4) Service provided that is strictly vocational/educational in nature, such as tutoring or any other activity available to the participant through the local educational agency under the Individuals with Disabilities Education Improvement Act of 2004; or covered under the Rehabilitation Act of 1973
5) Activities provided in the service provider's residence
6) Leisure activities that provide a diversion, rather than a therapeutic objective
7) Duplicative services covered under the Medicaid State Plan

Additional needs-based criteria for receiving the service, if applicable *(specify):*

None

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):	
☑	Categorically needy *(specify limits):*
	Habilitation services will be limited to up to three (3) hours daily and up to thirty (30) hours of services per participant/per month.
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Accredited Agency	None	AAAHC, COA, URAC, CARF, ACAC, JCAHO, or NCQA Accreditation	DMHA authorized accredited agencies must receive authorization from DMHA for an individual to provide this service based on the qualifications of the individual. Agencies must maintain documentation that the individual providing the service meets the following requirements and standards: 1) Individual is at least 21 years of age and possesses a high school diploma, or equivalent. 2) Demonstrate a minimum of two (2) years of qualifying experience, as defined by DMHA, working with or caring for youth with serious emotional disturbances (SED) 3) Individual has completed and submitted proof of the following screens: a) Finger-print based national and state criminal history background screen b) Local law enforcement screen c) State and local Department of Child Services abuse registry screen d) Five-panel drug screen, or Agency meets same requirements specified under the Federal Drug Free Workplace Act 41 U.S.C. 10 Section 702(a)(1) 4) Documentation of the following:

			a) Current Driver's License b) Proof of current vehicle registration c) Proof of motor vehicle insurance coverage 5) For every thirty (30) hours of habilitation services provided, the provider must obtain one (1) hour of face-to-face supervision with a DMHA authorized mental health service provider contracted with or employed by the agency that meets one (1) of the following licensure requirements: a) Licensure in psychology (HSPP) as defined in IC 25-33-1. b) Licensed marriage and family therapist (LMFT) under IC 25-23.6-8. c) Licensed clinical social worker (LCSW) under IC 25-23.6-5. d) Licensed mental health counselor (LMHC) under IC 25-23.6-8.5. e) Advanced practice nurse (APN) under IC 12-15-5-14(d) 6) Complete the DMHA required service provider training: a) CMHW services orientation b) CPR certification

Non-Accredited Agency	None	None	DMHA- authorized non-accredited agencies must receive approval from DMHA for an individual to provide this service, based on the qualifications of the individual. Agencies must maintain documentation that the individual providing the service meets the following requirements and standards: 1) Individual is at least 21 years of age and possesses a High school diploma, or equivalent. 2) Demonstrate a minimum of two (2) years of qualifying experience, as defined by DMHA, working with or caring for youth with

			serious emotional disturbances (SED) 3) Individual has completed and submitted proof of the following screens: a) Fingerprint based national and state criminal history background screen b) Local law enforcement screen c) State and local Department of Child Services abuse registry screen d) Five-panel drug screen, or Agency meets same requirements specified under the Federal Drug Free Workplace Act 41 U.S.C. 10 Section 702(a)(1) 4) Documentation of the following: a) Current Driver's License b) Proof of current vehicle registration c) Proof of motor vehicle insurance coverage 5) For every thirty (30) hours of habilitation services provided, the provider must obtain one (1) hour of face-to-face supervision with a DMHA authorized mental health service provider contracted with or employed by the agency that meets one (1) of the following licensure requirements: a) Licensure in psychology (HSPP) as defined in IC 25-33-1. b) Licensed marriage and family therapist (LMFT) under IC 25-23.6-8. c) Licensed clinical social worker (LCSW) under IC 25-23.6-5. d) Licensed mental health counselor (LMHC) under IC 25-23.6-8.5. e) Advanced practice nurse

			(APN) under IC 12-15-5-

			14(d) 6) Complete the DMHA required service provider training: a) CMHW services orientation b) CPR certification
Individual	None	None	The DMHA- authorized CMHW individual providing the service meets the following requirements and standards: 1) Individual is at least 21 years of age and possesses a high school diploma, or equivalent. 2) Demonstrate a minimum of two (2) years of qualifying experience, as defined by DMHA, working with or caring for youth with serious emotional disturbances (SED) 3) Individual has completed and submitted proof of the following screens: a) Fingerprint based national and state criminal history background screen b) Local law enforcement screen c) State and local Department of Child Services abuse registry screen d) Five-panel drug screen, or agency meets same requirements specified under the Federal Drug Free Workplace Act 41 U.S.C. 10 Section 702(a)(1) 4) Documentation of the following: a) Current Driver's License b) Proof of current vehicle registration c) Proof of motor vehicle insurance coverage 5) For every thirty (30) hours of habilitation services provided, the provider must obtain one (1) hour

			of face-to-face supervision with an approved mental health service provider that meets one (1) of the following licensure requirements: a) Licensure in psychology (HSPP) as defined in IC 25-33-1. b) Licensed marriage and family therapist (LMFT) under IC 25-23.6-8. c) Licensed clinical social worker (LCSW) under IC 25-23.6-5. d) Licensed mental health counselor (LMHC) under IC 25-23.6-8.5. e) Advanced practice nurse (APN) under IC 12-15-5-14(d) 6) Complete the DMHA required service provider training: a) CMHW services orientation b) CPR certification

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Accredited Agency	**DMHA**	Verification documentation submitted to DMHA: Initially at point of DMHA authorization of the CMHW agency and at least every three years thereafter. Must resubmit documentation for verification again at time of re-accreditation for agency.
Non-Accredited Agency	**DMHA**	Verification documentation submitted to DMHA: Initially at point of DMHA authorization of the CMHW agency and at least every two years thereafter.
Individual	**DMHA**	Verification documentation submitted to DMHA: Initially at point of DMHA

		authorization of the CMHW agency and at least every two years thereafter.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

1c. State plan HCBS.

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Respite Care

Service Definition (Scope):

Respite Care is a service provided to a participant unable to care for himself/herself. The service is furnished on a short-term basis to provide needed relief to or because of the absence of the caregiver. Respite Care services may be provided as planned (routine) and unplanned (unexpected).

Routine Respite Care may be provided in the following manner:

1) On an hourly basis, billed less than 8 hours in the same day.
2) On a daily basis, as follows:
   - Billed for service provided 8 to 24 hours in the same day.
   - Routine Respite Daily service cannot exceed fourteen (14) consecutive days.
   - A minimum of thirty (30) days must pass after a 14-consecutive-day stay before Daily Respite may be utilized again.
   - Routine Respite Daily service is limited to 40 days per service plan year.

Unexpected Respite Care may be provided on an unplanned basis when a caregiver has an unexpected or emergency situation, and requires assistance in caring for the participant:

1) Unexpected Respite is provided on a daily basis
2) Unexpected Respite cannot exceed fourteen (14) consecutive days.
3) A minimum of thirty (30) days must pass after a 14-consecutive-day stay before Unexpected Daily Respite may be utilized again.
4) Unexpected Respite Daily service is limited to 40 days per service plan year.

Respite Care may be provided in the participant's home/private place of residence, or any facility licensed by the Indiana Family and Social Services Administration Division of Family Resources, or the Indiana Department of Child Services. Approved CMHW service providers may also include:

1) DMHA-authorized CMHW Respite Care provider meeting standards and qualifications for an Individual service provider. Any CMHW-approved facility licensed by the Indiana Family and Social Services Administration or the Indiana Department of Child Services.
2) A relative related by blood, marriage, or adoption, who is not the legal guardian, does not live in the home with the Participant, approved by the Child and Family Team, and meets the standards and qualifications of an Individual CMHW service provider. DMHA will monitor any Respite Care services provided by an authorized relative to ensure the service is being provided as specified by CMHW policy which may include, but is not limited to, an unannounced visit during service provision by a CMHW service provider.

Respite Care services must be provided in the least restrictive environment available and ensure the health and welfare of the participant. A participant who needs consistent 24-hour supervision, with regular monitoring of medications or behavioral symptoms should be placed in a facility under the supervision of a psychologist, psychiatrist, physician or nurse who meets respective licensing or certification requirements of his/her

profession in the state of Indiana.

Excluding facility-based respite, while participating in this service, transportation to and from community-based activities can be requested under this 1915(i) benefit if required and based on an assessed need. Transportation services must not duplicate services offered under the state plan.

Allowed Respite Care service activities include:

1) Assistance with daily living skills
2) Assistance with accessing/transporting to/from community activities
3) Assistance with grooming and personal hygiene
4) Meal preparation, serving and cleanup
5) Administration of medications
6) Supervision
7) Recreational and leisure activities

Service exclusions include:

1) Respite Care provided by:
    a) Parents of a participant who is a minor child
    b) Any relative who is the primary caregiver of the Participant
    c) Anyone living in the Participant's residence
2) Respite services must not be provided as a substitute for regular childcare to allow the parent/caregiver to hold a job, engage in job-related or job search activities; or attend school
3) Respite care must not be provided in an Individual CMHW respite care service provider's residence unless that individual provider is a relative related by blood, marriage, or adoption, who is not the legal guardian, does not live in the home with the Participant, approved by the Child and Family Team, and meets the standards and qualifications of an Individual CMHW service provider. DMHA will monitor any Respite Care services provided by an authorized relative to ensure the service is being provided as specified by CMHW policy which may include, but is not limited to, an unannounced visit during service provision by a CMHW service provider.
4) Respite care shall not be used to provide service to the Participant while he/she is attending school.
5) All services and supports are decided upon by the Child and Family Treatment Team with required input from the participant and family. The state reviews and authorizes services prior to services being rendered by a provider. The Child and Family Treatment Team, with input from the participant and family, monitors all services and supports on a monthly basis during team meetings. The Wraparound Facilitator is responsible for oversight of this process with the Child and Family Treatment Team. Providers are also required to submit monthly summaries listing days of service. DMHA's quality team conducts periodic reviews of providers which includes comparison of service notes, monthly summaries, and claims.

Additional needs-based criteria for receiving the service, if applicable *(specify):*	
None	
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*	
☑	Categorically needy *(specify limits):*
	Respite provided at Daily Rate (routine and unexpected) 7 to 24 hours in the same day) cannot exceed 14 consecutive days.
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Accredited Agency	For facility-based Respite only: 1) Emergency shelters licensed under 465 IAC 2-10; 2) Foster Homes licensed under IC 31- 27-4 and IC 31-27-4-3only when the Licensed Child Placing Agency (LCPA) is the 1915(i) approved agency provider. DMHA will have the authority to	DMHA-approved accreditation as a mental health service provider or AAAHC, COA, URAC, CARF, ACAC, JCAHO, or NCQA Accreditation	Agency must maintain documentation that individual providing the service meets the following requirements and standards: 1) Individual is at least 21 years of age and has a high school diploma, or equivalent. 2) Individual has one (1) year of qualifying experience working with or caring for SED children/youth, as defined by DMHA. 3) Completed with qualifying results the following screens: a) Fingerprint based national and state criminal history background screen b) Local law enforcement screen c) State and local Department of Child Services abuse registry screen d) Five-panel drug screen, or Agency meets same requirements specified under the Federal Drug Free Workplace Act 41 U.S.C. 10 Section 702(a) (1) 4) Documentation of the following: a. Current Driver's License b. Proof of current vehicle registration c. Proof of motor vehicle

	request a copy of the home study that was conducted on the foster parent providing 1915(i) Respite Care services; 3) Other child caring institutions licensed under IC-31- 27-3; 4) Child Care Centers licensed under IC 12- 17.2-4; 5) Child Care Homes licensed under IC 12- 17.2-5-1; 6) School Age Child Care Project licensed under IC 12-17-12; or 7) Psychiatric Residential Treatment Facility (PRTF) licensed under 465 IAC 2-11-1 as a private secure residential facility for Medicaid certification under 405 IAC 5-20-3.1.		insurance coverage All approved providers must complete DMHA and OMPP approved training for CMHW services.

Non-Accredited Agency

	For Facility-based Respite only: 1) Emergency shelters licensed under 465 IAC 2-10; 2) Foster Homes licensed under IC 31-27-4 andIC 31-27-4-3 only when the Licensed Child Placing Agency (LCPA) is the 1915(i) approved agency provider. DMHA will have the authority to request a copy of the home study that was conducted on the foster parent providing 1915(i) Respite Care services;	None	The DMHA- authorized CMHW agency must maintain documentation that individual providing the service meets the following requirements and standards: 1) Individual is at least 21 years of age and has a high school diploma, or equivalent. 2) Individual has one (1) year of qualifying experience working with or caring for SED children/youth, as defined by DMHA. 3) Completed with qualifying results the following screens: a) Fingerprint based national and state criminal history background screen b) Local law enforcement screen c) State and local Department of Child Services abuse registry screen d) Five-panel drug screen, or Agency meets same requirements specified under the Federal Drug Free Workplace Act 41 U.S.C. 10 Section 702(a) (1) 4) Documentation of the following: a. Current Driver's License b. Proof of current vehicle registration c. Proof of motor vehicle insurance coverage All approved providers must complete DMHA and OMPP approved training for CMHW services.
	3) Other child caring institutions licensed		

	under IC-31-27-3; 4) Child Care Centers licensed under IC 12-17.2-4; 5) Child Care Homes licensed under IC 12-17.2-5-1; 6) School Age Child Care Project licensed under IC 12- 17-12; or Psychiatric Residential Treatment Facility (PRTF) licensed under 465 IAC 2-11-1 as a private secure residential facility for Medicaid certification under 405 IAC 5-20-3.1.		
Individual	None	None	The DMHA- authorized CMHW individual providing the service meets the following requirements and standards: 1) Individual is at least 21 years of age and possesses a high school diploma, or equivalent. 2) Demonstrate a minimum of one (1) year of qualifying experience, as defined by DMHA, working with or caring for youth with serious emotional disturbances (SED) 3) Individual has completed and submitted proof of the following screens: a) Fingerprint based national and state criminal history background screen

			b) Local law enforcement screen c) State and local Department of Child Services abuse registry screen d) Five-panel drug screen, or Agency meets same requirements specified under the Federal Drug Free Workplace Act 41 U.S.C. 10 Section 702(a)(1) 4) Documentation of the following: a. Current Driver's License b. Proof of current vehicle registration c. Proof of motor vehicle insurance coverage All approved providers must complete DMHA and OMPP approved training for CMHW services.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Accredited	DMHA	Verification documentation submitted to DMHA: Initially at point of DMHA authorization of the CMHW agency and at least every three years thereafter.
Non-Accredited	DMHA	Verification documentation submitted to DMHA: Initially at point of DMHA authorization of the CMHW agency and at least every two years thereafter.
Individual	DMHA	Verification documentation submitted to DMHA: Initially at point of DMHA authorization of the CMHW agency and at least every two years thereafter.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

1d. State plan HCBS.

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Training and Support for Unpaid Caregivers
Service Definition (Scope)*:*	

Training and Support for Unpaid Caregivers is a service provided to an individual who is providing unpaid support, training, companionship, or supervision for the participant. The intent of the service is to provide education and supports to the caregiver that preserve the family unit.

Training and support activities, and the providers selected for these activities, are based on the family/caregiver's unique needs and are identified in the POC. Covered activities may include, but are not limited to, the following:

1) Practical living and decision-making skills
2) Child development and parenting skills
3) Home management skills
4) Use of community resources and development of informal supports
5) Conflict resolution
6) Coping skills
7) Gaining an understanding of the Participant's mental health needs
8) Learning communication and crisis de-escalation skills geared for working with Participant's mental health and behavioral needs

Provision of service is available as:

1) An hourly service schedule for training by an approved CMHW service provider to a youth's caregivers, as documented on the participant's POC. In recognition that learning happens in real time, up to two hours per month may be provided via telephone.
2) A non-hourly service that reimburses for the costs of registration/conference training fees, books and supplies associated with the training and support needs, as documented on the participant's POC

Non-hourly Training and Support for Unpaid Caregivers may be delivered by the following types of resources:

1) Non-profit, civic, faith-based, professional, commercial, or government agency or organization
2) Community colleges, vocational schools or university
3) Lecture series, workshop, conference or seminar
4) On-line training program
5) Community Mental Health Center
6) Other qualified community service agency

While participating in this service, transportation to and from community-based activities can be requested under this 1915(i) benefit if required and based on an assessed need. Transportation services must not duplicate services offered under the state plan.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

None

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑

	Categorically needy *(specify limits):*
	Hourly service (billed in quarter-hour units) is limited to a maximum of two hours (or 8 units) per day. There is no monthly or annual limit for hourly Training and Support for Unpaid Caregivers. The maximum annual limit for non-hourly Training and Support for Unpaid Caregivers is $500. Reimbursement is not available for the costs of travel, meals, or overnight lodging.

☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Accredited Agency	None	AAAHC, COA, URAC, CARF, ACAC, JCAHO, or NCQA Accreditation	DMHA-approved accreditation as a mental health service provider or DMHA authorized Accredited agencies must receive authorization from DMHA for an individual to provide this service based on the qualifications of the individual. Agencies must maintain documentation that the individual providing the service meets the following requirements and standards: 1) Individual is at least 21 years of age and possesses a high school diploma, or equivalent. 2) Demonstrate a minimum of two (2) years of qualifying experience, as defined by DMHA, working with or caring for youth with serious emotional disturbances (SED), or certification as a Parent Support Provider 3) Individual has completed with qualifying results the following screens: a) Fingerprint based national and state criminal history background screen b) Local law enforcement screen c) State and local Department of Child Services abuse registry screen d) Five-panel drug screen, or Agency meets same requirements specified under the Federal Drug Free Workplace Act 41 U.S.C. 10 Section 702(a)(1) 4) For every thirty (30) hours of Training and Support for the

			Unpaid Caregiver services provided, the provider must obtain one (1) hour of face-to-face supervision with a DMHA authorized mental health service provider employed by or contracted with the agency that meets one (1) of the following licensure requirements: a) Licensure in psychology (HSPP) as defined in IC 25-33-1. b) Licensed marriage and family therapist (LMFT) under IC 25-23.6-8. c) Licensed clinical social worker (LCSW) under IC 25-23.6-5. d) Licensed mental health counselor (LMHC) under IC 25-23.6-8.5. e) Advanced practice nurse (APN) under IC 12-15-5-14(d) 5) Complete the DMHA required service provider training: a) CMHW services orientation b) CPR certification

Non-Accredited Agency	None	None	Agencies must maintain documentation that the individual providing the service meets the following requirements and standards: 1) Individual is at least 21 years of age and possesses a high school diploma, or equivalent. 2) Demonstrate a minimum of two (2) years of qualifying experience, as defined by DMHA, working with or caring for youth with serious emotional disturbances (SED), or certification as a Parent Support Provider. 3) Individual has completed with qualifying results the following screens: a) Fingerprint based national and state criminal history background screen b) Local law enforcement screen

			c) State and local Department of Child Services abuse registry screen d) Five-panel drug screen, or Agency meets same requirements specified under the Federal Drug Free Workplace Act 41 U.S.C. 10 Section 702(a)(1) 4) For every thirty (30) hours of Training and Support for the Unpaid Caregiver services provided, the provider must obtain one (1) hour of face-to-face supervision with a DMHA authorized mental health service provider employed by or contracted with the agency that meets one (1) of the following licensure requirements: a) Licensure in psychology (HSPP) as defined in IC 25-33-1. b) Licensed marriage and family therapist (LMFT) under IC 25-23.6-8. c) Licensed clinical social worker (LCSW) under IC 25-23.6-5. d) Licensed mental health counselor (LMHC) under IC 25-23.6-8.5. e) Advanced practice nurse (APN) under IC 12-15-5-14(d) 5) Complete the DMHA required service provider training: a) CMHW services orientation b) CPR certification

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:		
Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Accredited Agency	DMHA	Verification documentation submitted to DMHA: Initially at point of DMHA authorization of the CMHW agency and at least every three years thereafter.
Non-Accredited Agency	DMHA	Verification documentation submitted to DMHA: Initially at point of DMHA authorization of the CMHW agency and at least every two years thereafter.

		every two years thereafter.

Service Delivery Method. *(Check each that applies)*:			
☐	Participant-directed	☑	Provider managed

1e. State plan HCBS.

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Transportation
Service Definition (Scope)*:*	

Services offered to enable participants served under the benefit to gain access to Services based on an assessed need.

SERVICE STANDARDS

Transportation services must follow a written service plan addressing specific needs determined by the participant's plan of care and approved by the state.

This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them.

Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

DOCUMENTATION STANDARDS

Assessedneed in the service plan. Services outlined in the service plan. A provider or its agent shall maintain documentation that the provider meets and maintains the requirements for providing services as detailed below.

Additional needs-based criteria for receiving the service, if applicable *(specify):*
None

Services provided under Transportation service will not duplicate services provided under the Medicaid State Plan, early and Periodic Screening, Diagnostic, and Treatment (EPSDT),or any other waiver service.	
(Choose each that applies):	
☑	Categorically needy *(specify limits):*
	This service is limited to transportation to and from facility-based respite.
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certificati on *(Specify):*	Other Standard *(Specify):*

Accredited Agency	For facility-based Respite only: 1) Emergency shelters licensed under 465 IAC 2-10; 2) Licensed Child Placing Agency (LCPA). DMHA will have the authority to request a copy of the home study that was conducted on the foster parent providing 1915(i) Respite Care services; 3) Other child caring institutions licensed under IC-31- 27-3; 4) Child Care Centers licensed under IC 12- 17.2-4;	AAAHC, COA, URAC, CARF, ACAC, JCAHO, or NCQA Accreditation	DMHA authorized accredited agencies must receive authorization from DMHA for licensed facility. Individuals providing the service must be authorized by DMHA. Agencies must maintain documentation that the individual providing the service meets the following requirements and standards: 1) Individual is at least 21 years of age and possesses a high school diploma, or equivalent. 2) Individual has completed and submitted proof of the following screens: e) Finger-print based national and state criminal history background screen f) Local law enforcement screen g) State and local Department of Child Services abuse registry screen h) Five-panel drug screen, or Agency meets same requirements specified under the Federal Drug Free Workplace Act 41 U.S.C. 10 Section 702(a)(1) 3)Documentation of the following: a) Current Driver's License b) Proof of current vehicle registration c) Proof of motor vehicle insurance coverage 4) Complete the DMHA required service provider training: a) CMHW services orientation b) CPR certification

Non- Accredited Agency	For facility-based Respite only: 5) Emergency shelters licensed under 465 IAC 2-10; 6) Licensed Child Placing Agency (LCPA). DMHA will have the authority to request a copy of the home study that was conducted on the foster parent providing 1915(i) Respite Care services; 7) Other child caring institutions licensed under IC-31- 27-3; 8) Child Care Centers licensed under IC 12-17.2-4;	None	DMHA authorized non-accredited agencies must receive authorization from DMHA for licensed facility-based respite care. Individuals providing the service must be authorized by DMHA. Agencies must maintain documentation that the individual providing the service meets the following requirements and standards: 5) Individual is at least 21 years of age and possesses a high school diploma, or equivalent. 4) Individual has completed and submitted proof of the following screens: a) Finger-print based national and state criminal history background screen b) Local law enforcement screen c) State and local Department of Child Services abuse registry screen d) Five-panel drug screen, or Agency meets same requirements specified under the Federal Drug Free Workplace Act 41 U.S.C. 10 Section 702(a)(1) 5) Documentation of the following: a) Current Driver's License b) Proof of current vehicle registration c) Proof of motor vehicle insurance coverage 8) Complete the DMHA required service provider training: a) CMHW services orientation b) CPR certification

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*

DMHA	Accredited agencies must submit verification documentation to DMHA: Initially at point of DMHA authorization of the CMHW agency and at least every three years thereafter.
DMHA	Non-accredited agencies must submit verification documentation to DMHA: Initially at point of DMHA authorization of the CMHW agency and at least every two years thereafter.

Service Delivery Method. *(Check each that applies)*:			
☐	Participant-directed	☑	Provider managed

2. ☑ Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians. *(By checking this box the state assures that):* There are policies pertaining to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

When other CMHW providers are not local to the participant, or the Participant's Child and Family Team has identified that it is in the best interest of the youth, CMHW Respite Care services may be provided by any relative related by blood, marriage, or adoption who is not the legal guardian and who does not live in the home with the Participant. Respite Care providers who are relatives must meet the following criteria and standards:

1) Be approved by DMHA as an Individual CMHW Respite Care service provider
2) Be selected by the family/youth to provide the service
3) Follow and maintain the policy and procedures required for the CMHW Respite Care service

DMHA will monitor Respite Care services provided by a relative approved to provide the Respite Care service to ensure the service is being provided as specified by CMHW policy and procedure; which may include, but is not limited to, an unannounced visit in the home by a CMHW service provider during service provision.

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. Election of Participant-Direction. (S*elect one):*

☑	The state does not offer opportunity for participant-direction of State plan HCBS.
○	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. *(Specify criteria):*

2. Description of Participant-Direction. (Provide an overview of the opportunities for participant-*direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

3. Limited Implementation of Participant-Direction. (*Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

○	Participant direction is available in all geographic areas in which State plan HCBS are available.
○	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self- directed service delivery options offered by the state, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the state affected by this option)*:

4. Participant-Directed Services. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐

5. Financial Management. (*Select one)* :

○	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
○	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. ☐ **Participant–Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person- centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:

- Specifies the State plan HCBS that the individual will be responsible for directing;
- Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget;
- Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual;
- Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
- Specifies the financial management supports to be provided.

7. Voluntary and Involuntary Termination of Participant-Direction. *(Describe how the state facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

8. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can select, manage, and dismiss State plan HCBS providers). (*Select one):*

○	The state does not offer opportunity for participant-employer authority.	
○	Participants may elect participant-employer Authority *(Check each that applies):*	
	☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
	☐	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. Participant–Budget Authority (individual directs a budget that does not result in payment for medical assistance to the individual). (*Select one):*

○ The state does not offer opportunity for participants to direct a budget.
○ Participants may elect Participant–Budget Authority.
Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):*
Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.*

Quality Improvement Strategy

Quality Measures

(Describe the state's quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

1. Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and (c document choice of services and providers.

Requirement	***1a. Service plans address assessed needs of the 1915(i) participants***
Discovery	
Discovery Evidence *(Performance Measure)*	The total number and percent of service plans that identify and address the participant's assessed needs. *N=Number of service plans that identify and address the participant's assessed needs.* *D=Number of service plans submitted*
Discovery Activity *(Source of Data & sample size)*	DMHA Database 100% review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
Frequency	Continuous and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA 45 days
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***1b. Service plans are updated annually***
Discovery	
Discovery Evidence *(Performance Measure)*	Total number and percent of participants whose plans of care were reviewed and revised on or before annual review date. *N= Total number of participants whose plans were updated annually.* *D= Total number of participants due for annual POC review.*
Discovery Activity *(Source of Data & sample size)*	DMHA Database 100% review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
Frequency	Continuous and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA 45 days
Frequency *(of Analysis and Aggregation)*	Annually
Requirement	***1c. Service plans are updated/revised when warranted by changes in the participant's needs.***
Discovery	
Discovery Evidence *(Performance Measure)*	The total number and percent of service plans that were reviewed and revised when warranted by changes in the waiver participant's needs. *N=Number of participants whose plans were reviewed and revised when*

	warranted by changes in the participant's needs. *D=Number of participants enrolled*
Discovery Activity *(Source of Data & sample size)*	DMHA Database 100% review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
Frequency	Continuous and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA 45 days
Frequency *(of Analysis and Aggregation)*	Annually
Requirement	***1d. Service Plans document choice of services.***
Discovery	
Discovery Evidence *(Performance Measure)*	Total number and percent of participant records with a signed Choice of Service Statement indicating they were afforded choice of eligible services. *N=Total number of participant records with a signed Choice of Service Statement.* *D=Total number of participants.*
Discovery Activity *(Source of Data & sample size)*	DMHA Database 100%

Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
Frequency	Continuous and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA 45 days
Frequency *(of Analysis and Aggregation)*	Annually
Requirement	***1e. Service plans document choice of providers***
Discovery	
Discovery Evidence *(Performance Measure)*	Total number and percent of participant records with a signed provider pick list indicating they were afforded choice of providers. *N=Total number of participant records with a signed provider pick list.* *D=Total number of participants.*
Discovery Activity *(Source of Data & sample size)*	DMHA Database 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
Frequency	Continuous and ongoing

Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA 45 days
	Frequency *(of Analysis and Aggregation)*	Annually

2. Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all individuals for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.

Requirement		***2a. An evaluation for 1915(i) State Plan HCBS eligibility is provided to all individuals for whom there is a reasonable indication that 1915(i) services may be needed in the future.***
Discovery		
	Discovery Evidence *(Performance Measure)*	The number and percent of new enrollees who had an evaluation for CMHW eligibility prior to enrollment. *N=The number of new enrollees who had an evaluation for CMHW eligibility prior to enrollment* *D=The total number of new enrollees*
	Discovery Activity *(Source of Data & sample size)*	DMHA database 100% review
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA

Frequency	Quarterly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA 45 days
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***2b. The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately*** *as determined by the algorithms from Child and Adolescent Needs and Strengths assessment*
Discovery	
Discovery Evidence *(Performance Measure)*	The number and percent of eligibility reviews completed accurately. *N=The total number of participants' eligibility reviews completed accurately as determined by the algorithms from Child and Adolescent Needs and Strengths assessment* *D=The total number of participants' eligibility reviews.*
Discovery Activity *(Source of Data & sample size)*	DMHA Database 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
Frequency	Monthly
Remediation	

	Remediation Responsibilities *(Who corrects, analyzes, and aggregates*	DMHA 45 days

remediation activities; required timeframes for remediation)	
Frequency *(of Analysis and Aggregation)*	Annual

Requirement	***2c. The 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS***
Discovery	
Discovery Evidence *(Performance Measure)*	The number and percent of active CMHW participants whose eligibility was reviewed within 365 days of their previous eligibility review. *N=The total number of CMHW participants whose eligibility was reviewed within 365 days of their previous eligibility review* *D=The total number of CMHW participants whose eligibility was due*
Discovery Activity *(Source of Data & sample size)*	DMHA database 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
Frequency	Quarterly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA 45 days

	Frequency *(of Analysis and Aggregation)*	Annually

3. Providers meet required qualifications.

Requirement	***3a. Providers meet required qualifications (initially)***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of service providers who initially met required licensure and/or authorization standards prior to furnishing CMHW services. *N=Total number of service providers who met required licensure and/or authorization standards prior to furnishing CMHW services.* *D=Total number of newly authorized CMHW service providers initially furnishing CMHW services.*
Discovery Activity *(Source of Data & sample size)*	DMHA database 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
Frequency	Continuous and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA 45 days
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***3b. Providers meet required qualifications (ongoing)***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of reauthorized providers who met required qualifications prior to reauthorization. *N=Total number of providers reauthorized who met required qualifications prior to reauthorization.* *D=Total number of provider reauthorized.*
Discovery Activity *(Source of Data & sample size)*	DMHA database 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
Frequency	Quarterly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA 45 days
Frequency *(of Analysis and Aggregation)*	Annually

4. Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).

Requirement	***4a. Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).***
Discovery	
Discovery Evidence	Number and percent of participants whose residential setting meets the home and

	(Performance Measure)	community-based settings requirements prior to enrollment *N=Total number of participants whose residential settings met the home and community-based settings requirement prior to enrollment* *D=Total number of participants enrolled*
	Discovery Activity *(Source of Data & sample size)*	DMHA database
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA 100%
	Frequency	Continuous and ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA 90 days
	Frequency *(of Analysis and Aggregation)*	Annually
Requirement		**4b. Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).**
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of participants whose service plans indicate a setting for service delivery that meets the requirements as specified in this SPA and in accordance with 42 CRF 441.710(a)(1) and (2). *N=Total number of participants whose service plans indicate a setting for service delivery that meets the requirements as specified in this SPA and in accordance with 42 CRF 441.710(a)(1) and (2).* *D=Total number of service plans reviewed.*
	Discovery	DMHA Database

	Activity *(Source of Data & sample size)*	100% Review
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
	Frequency	Quarterly
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA 45-days
	Frequency *(of Analysis and Aggregation)*	Annually

5. The SMA retains authority and responsibility for program operations and oversight.

Requirement	**The SMA retains authority and responsibility for program operations and oversight.**
Discovery	

	Discovery Evidence *(Performance Measure)*	Number and percent of performance measure data reports from DMHA reviewed to ensure the SMA retains administrative oversight. *N=Number of data reports provided timely and in correct format.* *D=Number of data reports due.*
	Discovery Activity *(Source of Data & sample size)*	DMHA Administrative Authority Quality Management Report 100% review
	Monitoring	OMPP

	Responsibilities *(Agency or entity that conducts discovery activities)*	
	Frequency	Quarterly
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	OMPP
	Frequency *(of Analysis and Aggregation)*	Quarterly

6. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.

Requirement		**6a. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.**
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of claims paid during the review period according to the published service rate. *N=Number of claims paid during the review period according to the published service rate.* *D=Number of claims submitted during the review period.*
	Discovery Activity *(Source of Data & sample size)*	Medicaid Management Information System (MMIS) claims data reports 100% review
	Monitoring Responsibilities *(Agency or entity that*	OMPP & Medicaid fiscal contractor

conducts discovery activities)	
Frequency	Monthly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	OMPP & DMHA 45 days
Frequency *(of Analysis and Aggregation)*	Monthly
Requirement	**6b. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of claims paid during the review period for participants enrolled in the *CMHW services* on the date that the service was delivered. *N=Number of claims paid during the review period for participants enrolled in the CMHW services on the date that the service was delivered.* *D=Number of claims submitted during the review period.*
Discovery Activity *(Source of Data & sample size)*	OMPP & Medicaid Management Information System (MMIS) claims data reports 100% review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Medicaid fiscal contractor
Frequency	Monthly
Remediation	

Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	OMPP & DMHA 45 days
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement 6c:**The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.**

Discovery

Discovery Evidence *(Performance Measure)*	Number and percent of claims paid during the review period for services that are specified in the participant's approved service plan. *N=Number of claims paid during the review period due to services having been identified on the approved service plan.* *D=Number of claims submitted during the review period.*
Discovery Activity *(Source of Data & sample size)*	Medicaid Management Information System (MMIS) claims data reports 100% review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	OMPP & Medicaid
Frequency	Monthly

Remediation

Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation*	OMPP & DMHA 45 days

required timeframes for remediation)	
Frequency *(of Analysis and Aggregation)*	Monthly

7. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.

(Table repeats for each measure for each requirement and lettered sub-requirement above.)

Requirement	***7a. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***
Discovery	
Discovery Evidence *(Performance Measure)*	The Number and percent of incidents reported within required timeframe by type of incident. *N= Total number of incidents reported within required timeframes according to policy.* *D=Total number of incidents reported*
Discovery Activity *(Source of Data & sample size)*	DMHA database 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
Frequency	Continuous and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities;*	DMHA 45 days

	timeframes for remediation)	
	Frequency *(of Analysis and Aggregation)*	Annually

Requirement		***7b. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***
Discovery		
	Discovery Evidence *(Performance Measure)*	Total number and percent of reports of abuse, neglect, exploitation and unexplained death incidents that were referred to appropriate investigative entities for follow up (e.g. law enforcement, child protective services, etc.). *N=Total number of reports of abuse, neglect, exploitation and unexplained death incidents that were referred to appropriate investigative entities for follow up (e.g. law enforcement, child protective services, etc.).* *D=Total number of reports of abuse, neglect, exploitation and unexplained death incidents submitted.*
	Discovery Activity *(Source of Data & sample size)*	DMHA database 100%
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
	Frequency	Continuous and ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA 45 days

	Frequency *(of Analysis and Aggregation)*	Annually

Requirement		***7c. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***
Discovery		
	Discovery Evidence *(Performance Measure)*	The number and percent of reported incidents of abuse, neglect, and/or exploitation where appropriate follow-up (e.g. safety plans, corrective action plans, provider sanctions, etc.) was completed. *N=Total number of reported incidents of abuse, neglect, and/or exploitation individually remediated (e.g. safety plan, corrective action plan, provider sanction, etc.)* *D=Total number of reported incidents of abuse, neglect, and/or exploitation*
	Discovery Activity *(Source of Data & sample size)*	DMHA database 100%
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
	Frequency	Continuous and ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA 45-days
	Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***7d. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***
Discovery	
Discovery Evidence *(Performance Measure)*	The number and percent of complaints involving abuse, neglect, and/or exploitation that were individually remediated. *N= Total number of complaints involving abuse, neglect, and/or exploitation that were individually remediated.* *D= Total number of complaints involving abuse, neglect, and/or exploitation.*
Discovery Activity *(Source of Data & sample size)*	Spreadsheet maintained on DMHA private, secure SharePoint Site 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
Frequency	Continuous and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA 45-days
Frequency *(of Analysis and Aggregation)*	Annually

System Improvement

(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. Methods for Analyzing Data and Prioritizing Need for System Improvement

DMHA will collect and track complaints related to implementation, providers and services offered through the 1915(i). Complaints could be received from consumers, family members, concerned citizens, providers or advocates. Complaints will be categorized as individual issue or system challenge/barrier.

2. Roles and Responsibilities

DMHA and OMPP meet monthly to discuss and evaluate the need for new system changes, as well as the effectiveness of pervious system changes. Additional changes will be made as necessary, including changes in provider training, bulletins, policy changes, and refinements.

3. Frequency

Monthly, Quarterly, and Annually

4. Method for Evaluating Effectiveness of System Changes

DMHA and OMPP meet quarterly to review performance measure data. For performance measure that are trending near or below 86% OMPP and DMHA discuss and plan quality improvement strategies (QIS). After the QIS has been implemented, OMPP and DMHA review performance measure data quarterly to ensure data is trending toward desired outcomes. If data is still not trending in the way anticipated, OMPP and DMHA will reconvene to revise QIS until success is achieved.

1915(i) State plan Home and Community-Based Services

Administration and Operation

The state implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit *for elderly and disabled individuals as set forth below.*

1. Services. *(Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):*

Adult Mental Health Habilitation (AMHH)
Adult Day Services
Home and Community Based (HCB) Habilitation and Support – Individual Setting
HCB Habilitation and Support – Family/Couple with the Recipient Present (Individual Setting)
HCB Habilitation and Support – Family/Couple without the Recipient Present (Individual Setting)
HCB Habilitation and Support – Group Setting
HCB Habilitation and Support – Family/Couple with Recipient Present (Group Setting)
HCB Habilitation and Support – Family/Couple without Recipient Present (Group Setting)
Respite Care
Therapy and Behavioral Support Services – Individual Setting
Therapy and Behavioral Support Services – Family/Couple with Recipient Present (Individual Setting)
Therapy and Behavioral Support Services – Family/Couple without Recipient Present (Individual Setting)
Therapy and Behavioral Support Services – Group Setting
Therapy and Behavioral Support Services – Family/Couple with Recipient Present (Group Setting)
Therapy and Behavioral Support Services – Family/Couple without Recipient Present (Group Setting)
Addiction Counseling – Individual Setting
Addiction Counseling – Family/Couple with Recipient Present (Individual Setting)
Addiction Counseling – Family/Couple without Recipient Present (Individual Setting)
Addiction Counseling – Group Setting
Addiction Counseling – Family/Couple with Recipient Present (Group Setting)
Addiction Counseling – Family/Couple without Recipient Present (Group Setting)
Supported Community Engagement Services
Care Coordination
Medication Training and Support – Individual Setting
Medication Training and Support – Family/Couple with Recipient Present (Individual Setting)
Medication Training and Support – Family/Couple without Recipient Present (Individual Setting)
Medication Training and Support – Group Setting
Medication Training and Support – Family/Couple with Recipient Present (Group Setting)

Medication Training and Support – Family/Couple without Recipient Present (Group Setting)

2. Concurrent Operation with Other Programs. (*Indicate whether this benefit will operate concurrently with another Medicaid authority)*:

***Select one*:**

○	**Not applicable**
☒	**Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act.** The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. *Specify:*
(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);
(b) the geographic areas served by these plans;
(c) the specific 1915(i) State plan HCBS furnished by these plans;
(d) how payments are made to the health plans; and
(e) whether the 1915(a) contract has been submitted or previously approved.

☒ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

The updated 1915(b)(4) application was submitted December 30, 2019.

Specify the §1915(b) authorities under which this program operates (*check each that applies*):

☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
☐	§1915(b)(2) (central broker)	☒	§1915(b)(4) (selective contracting/limit number of providers)

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1115 of the Act.** *Specify the program*:

3. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit.
(Select one):

☑	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:		
	○	The Medical Assistance Unit *(name of unit)*:	
	☑	Another division/unit within the SMA that is separate from the Medical Assistance Unit	
		(name of division/unit) This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.	The Division of Mental Health & Addiction (DMHA) is the operating agency under the umbrella of Indiana's SMA. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.
☐	The State plan HCBS benefit is operated by *(name of agency)*		

4. Distribution of State plan HCBS Operational and Administrative Functions.

☑ *(By checking this box the state assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	☑	☑	☐	☐
2 Eligibility evaluation	☑	☑	☐	☐
3 Review of participant service plans	☑	☑	☐	☐
4 Prior authorization of State plan HCBS	☑	☑	☐	☐
5 Utilization management	☑	☑	☑	☐
6 Qualified provider enrollment	☑	☑	☑	☐
7 Execution of Medicaid provider agreement	☑	☑	☑	☐
8 Establishment of a consistent rate methodology for each State plan HCBS	☑	☑	☑	☐
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☑	☐	☐
10 Quality assurance and quality improvement activities	☑	☑	☐	☑

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

Functions 1-10 are performed/administered by the Division of Mental Health and Addiction (DMHA) or a State contracted entity. The Office of Medicaid Policy and Planning (OMPP) is responsible for quality and program oversight for Functions 1-10. OMPP meets quarterly for trending and analysis of performance measure data for all functions. OMPP works with DMHA and/or contracted entities to develop and evaluate quality improvement strategies.

Function #4 – Prior Authorization

On behalf of the Family and Social Services Administration (FSSA), the State Evaluation Team (SET) reviews all Adult Mental Health Habilitation Prior Authorization requests for Indiana Health Coverage Programs (IHCP) members on a case-by- case basis through the Data Assessment Registry Mental Health and Addiction (DARMHA) system.

Function #5 – Utilization Management

The contracted entity is the Medicaid Surveillance Utilization Review Contractors. ,

The benefit auditing function is incorporated into the Surveillance Utilization Review (SUR) functions of the contract between the OMPP and SUR Contractor. OMPP has expanded its program integrity activities by using a multi-pronged approach to SUR activity that includes provider self-audit, contractor desk audit and full on-site audit functions. The SUR Contractor sifts and analyzes claims data and identifies providers/claims that indicate aberrant billing patterns and/or other risk factors.

The audit process utilizes data mining, research, identification of outliers, problematic billing patterns, aberrant providers and issues that are referred by DMHA and OMPP. The SUR Unit meets with DMHA and OMPP at least quarterly to discuss audits and outstanding issues. The SUR Contractor is a Subject Matter Expert (SME) responsible for directly coordinating with the DMHA and OMPP. This individual also analyzes data to identify potential areas of program risk and identify providers that appear to be outliers warranting review. The contractor may also perform desk or on-site audits and be directly involved in review of the benefit program and providers. Throughout the entire SUR process, oversight is maintained by OMPP. The SUR Unit offers education regarding key program initiatives and audit issues at provider meetings to promote ongoing compliance with Federal and State guidelines, including all Indiana Health Coverage Programs (IHCP) and benefit requirements.

Function #6 – Qualified Provider Enrollment

The contracted entity is DMHA and Medicaid Fiscal Agent

Providers interested in providing AMHH services must first apply for certification through DMHA. Next, the provider must enroll as a Medicaid provider with Indiana Health Coverage Programs (IHCP). OMPP contracts with a fiscal agent to process IHCP provider enrollments. The fiscal agent processes the applications, verifies licensure and certification requirements are met, maintains the provider master file, assigns provider ID numbers, and stores National Provider Identifier and taxonomy information. Upon successful completion of the provider enrollment process an enrollment confirmation letter is mailed to the new provider.

Function #7 – Execution of Medicaid Provider Agreement (Medicaid Fiscal Agent):

The contracted entity is the Medicaid Fiscal Agent

OMPP has a fiscal agent under contract which is obligated to assist OMPP in processing approved

Medicaid Provider Agreements to enroll approved eligible providers in the Medicaid MMIS for claims processing. This includes the enrollment of DMHA approved 1915(i) providers. The fiscal agent also conducts provider training and provides technical assistance concerning claims processing. The Medicaid Fiscal Agent contract defines the roles and responsibilities of the Medicaid fiscal contractor. DMHA tracks all provider enrollment requests and receives information directly from the MMIS Fiscal

Agent contractor regarding provider enrollment activities as they occur for monitoring of completion, timeliness, accuracy, and to identify issues. Issues are shared with OMPP.

DMHA and/or OMPP attend the MMIS Fiscal Agent's scheduled provider training sessions required in OMPP's contract with the fiscal agent. DMHA may also participate in the fiscal agent's individualized provider training for providers having problems.

Function #8 – Establishment of a consistent rate methodology for each State Plan HCBS (Medicaid Actuarial Contractor):

The contracted entity is an actuarial service.

OMPP has an actuarial service under contract to develop and assess rate methodology for HCBS. Rate methodology for AMHH services is assessed and reviewed at least every five years. The actuarial contractor completes the cost surveys and calculates rate adjustments. OMPP reviews and approves the fee schedule to ensure consistency, efficiency, economy, quality of care, and sufficient access to providers for AMHH services.

(By checking the following boxes the State assures that):

5. ☑ **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual, or any paid caregiver of the individual
- financially responsible for the individual
- empowered to make financial or health-related decisions on behalf of the individual
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*

The Independent State Evaluation Team (SET) is responsible for determining the 1915(i) eligibility and approving the individualized services requested in the proposed care plan. The members of the SET are prohibited from having any financial relationships with the applicant/recipient requesting services, their families, or the entity selected to provide services. Assessments are completed and proposed plans of care (Individualized Integrated Care Plan – IICP) are submitted by a qualified provider entity to the SET for final eligibility determination and care plan approval.

Responsibility for 1915(i) program eligibility determination and approval of the IICP proposed services in all cases is retained by the SET in order to ensure no conflict of interest in the final determinations. The DMHA approved AMHH provider agency submits the results from the face-to-face or telehealth according to Indiana Administrative Code assessment, required supporting documentation, and a proposed care plan to SET for independent review. The SET determines eligibility for 1915(i) services based upon their review of the clinical documentation of applicant's identified needs and alignment of needs, goals, and recommended services.

The State also requires documentation, signed by the applicant/recipient that attests to the following:

1) The recipient and/or legal guardian is an active participant in the planning and development of the 1915(i) IICP.
2) The recipient is the person requesting 1915(i) services on the IICP.
3) The recipient received a randomized list of eligible 1915(i) service provider agencies in his/her community; and has selected the provider(s) of his or her choice to deliver the 1915(i) service on the IICP.
4) The recipient and/or legal guardian was offered a copy of the completed IICP

In addition, AMHH provider agencies are required to have written policies and procedures available for review by the State which clearly define and describe how conflict of interest requirements are implemented and monitored. The State ensures compliance through policies designed to be consistent with CMS conflict of interest assurances and through quality assurance activities.

6. ☑**Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. ☑**No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. ☑**Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time

as another service that is the same in nature and scope regardless of source, including Federal, state, local,

and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. **Projected Number of Unduplicated Individuals To Be Served Annually.**
(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	10/1/2023	9/30/2024	25
Year 2			
Year 3			
Year 4			
Year 5			

2. ☑**Annual Reporting.** *(By checking this box the state agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

Financial Eligibility

1. ☑ **Medicaid Eligible.** *(By checking this box the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

2. **Medically Needy** (*Select one*):

☑ The State does not provide State plan HCBS to the medically needy.

☐ The State provides State plan HCBS to the medically needy. (*Select one*):

☐ The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services.

☐ The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

Evaluation/Reevaluation of Eligibility

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual. Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are

performed (*Select one*):

☒	Directly by the Medicaid agency
○	By Other (*specify State agency or entity under contract with the State Medicaid agency*):

2. **Qualifications of Individuals Performing Evaluation/Reevaluation**. The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

Individuals conducting the State evaluation for eligibility determination and approval of plans of care hold at least a bachelor's degree in social work, counseling, psychology, or similar field.

3. **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

Information about 1915(i) services is posted on the DMHA and OMPP public websites. These websites summarize the eligibility criteria and note all available series, service provider agencies, locations where potential enrollees may go to apply, and how to access assessments and services. Any provider may identify potential enrollees who met the 1915(i) eligibility criteria or individuals may notify their provider of an interest in the home and community-based services. Any individual may contact the state for information about AMHH eligibility and the process to apply. The individual is given a list of AMHH eligible provider agencies that may be chosen to assist in the application process. After agency staff reviews the program information with the applicant, the two individuals discuss the options under this program, and together determine whether to complete an application for the 1915(i) services. In deciding whether or not a referral of 1915(i) services is appropriate, the agency staff and applicant review the target group criteria and discuss whether a referral is merited.

Each person referred for 1915(i) services must receive a bio-psychosocial needs assessment by the referring provider projection including, but not limited to, the Adult Needs and Strengths Assessment (ANSA) tool. All assessments must be conducted face to face or via telehealth in accordance with Indiana Administrative Code and Federal 1915(i) regulations.

The ANSA tool consists of items that are rated as:
'0' no evidence or no need for action
'1' need for watchful waiting to see whether action is needed
'2' need for action
'3' need for either immediate or intensive action due to a serious disability need.

The items are grouped into categories or domains. Once the assessment has been completed, the agency staff receives a level of care decision to support the recommendation based on the individual item ratings. The level of care recommendation from the ANSA is not intended to be a mandate for the level of services that an individual receives. There are many factors, including individual preferences and choice, which may influence the actual intensity of treatment services.

The user's manual for the ANSA is found on-line at:

Https://dmha.fssa.in.gov/DARMHA/Documents/ANSAManual_712011.pdf

TheANSA and supporting documentation provide specific information about the person's health status, current living situation, family functioning, vocation/employment status, social functioning, living skills, self-care skills, capacity for decision making, living situation, potential for self-injury or harm to others, substance use/abuse, and medication adherence.

The agency staff and the applicant jointly develop a proposed plan of care (Individualized Integrated Care Plan (IICP) that includes desired goals. Upon completion of the IICP, the agency staff submit the plan to DMHA through a secure electronic file transfer process. The application packet in full includes, the ANSA, and proposed plan of care.

Upon receipt of the referral packet, the state evaluation team reviews all submitted documentation and determines whether the applicant is eligible for 1915(i) AMHH program and services.

Time spent for the initial evaluation, IICP development cannot be billed or reimbursed for the 1915(i) benefit before eligibility for this benefit has been determined. The eligibility determination process completed by the (SET) is billed as administrative activities.

If determined eligible for 1915(i) services, an eligibility determination and care plan service approval letter is sent and includes an end date for Medicaid Rehabilitation Option (MRO) eligibility and a start date for 1915(i) eligibility (consecutive dates so there is no lapse in service). Once eligible, services may begin immediately.

If determined ineligible for 1915(i) services, a denial letter is sent to the applicant and the agency staff member informing them that their application for services has been denied. The denial letter is generated by DMHA. The denial letter includes the reason for denial, appeal rights, and process.

Annual re-evaluations for continued 1915(i) services follow this same process.

4. ☑ **Reevaluation Schedule.** *(By checking this box the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

5. ☑ **Needs-based HCBS Eligibility Criteria.** *(By checking this box the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

In the context of needs base criteria, "significant" is operationally defined in the algorithm for the 1915(i) as an assessed "need for immediate or intensive action due to a serious or disabling need."

All of the following needs-based criteria must be met for 1915(i) eligibility:

1. Without ongoing habilitation services as demonstrated by written attestation by a psychiatrist, Health Services Provider in Psychology (HSPP), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Mental Health Counselor (LMHC), or Licensed Clinical Addiction Counselor (LCAC), the person is likely to deteriorate and be at risk of institutionalization (e.g., acute hospitalization, State hospital, nursing home, jail).
2. The recipient must demonstrate the need for significant assistance** in major life domains related to their mental illness (e.g., physical problems, social functioning, basic living skills, self-care, potential for harm to self or others).
3. The recipient must demonstrate significant needs related to his/her behavioral health.
4. The recipient must demonstrate significant impairment in self-management of his/her mental illness or demonstrate significant needs for assistance with mental illness management.
5. The recipient must demonstrate a lack of sufficient natural supports to assist with mental illness management.
6. The recipient is not a danger to self or others at the time of application for AMHH services program eligibility is submitted for State review and determination.

**Assistance includes any support from another person (mentoring, supervision, reminders)

6. ☑ **Needs-based Institutional and Waiver Criteria.** *(By checking this box the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)

Needs based eligibility criteria are specified in Item five above.	Indiana law allows reimbursement to NFs for eligible persons who require skilled or intermediate nursing care as defined in 405 Indiana Administrative Code 1-3-1 and 1-3-2. 405 IAC 1-3-1(a) Skilled nursing services, as ordered by a physician, must be required and provided on a daily basis,	Indiana Law allows reimbursement to ICF/MRs for eligible persons as defined in 405 IAC 1-1-11. A person may be functionally eligible for an ICF/MR LOC waiver when documentation shows the individual meets the following conditions:	Dangerous to self or others or gravely disabled. (IC-12-26-1)

	essentially seven days a week. 405 IAC 1-3-2 (a) Intermediate nursing level of care includes care for patients with long term illnesses or disabilities which are relatively stable, or care for patients nearing recovery and discharge who continue to require some professional medical or nursing supervision and attention. A person is functionally eligible for either NF or an NF level of care waiver if the need for medical or nursing supervision and attention is determined by any of the following findings from the functional screening: 1. Need for direct assistance at least 5 days per week due to unstable, complex medical conditions. 2. Need for direct assistance for 3 or more substantial medical conditions including activities of daily living	1. Has a diagnosis of intellectual disability (mental retardation), cerebral palsy, epilepsy, autism, or condition similar to intellectual disability (mental retardation). 2. Condition identified in #1 is expected to continue. 3. Condition identified in #1 had an age of onset prior to age 22. 4. Individual needs a combination or sequence of services. 5. Has 3 of 6 substantial functional limitations as defined in 42 CFR 435.1010 in areas of (1) self-care, (2) learning, (3) self-direction, (4) capacity for independent living, (5) language, and (6) mobility.	

*Long Term Care/Chronic Care Hospital

**LOC= level of care

7. ☑ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5-year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

The AMHH Program Eligibility, 405 IAC 5-21.6-4:

- Age 19 or over
- Medicaid enrolled
- ANSA Level of Need 3 or higher
- Approved AMHH eligible primary diagnosis
  (not a complete list, see http://provider.indianamedicaid.com/ihcp/Publications/providerCodes/Adult_Mental_Health_Habilitation_Codes.pdf)

  Code ICD-10 Description
  - F20.0 Paranoid schizophrenia
  - F20.1 Disorganized schizophrenia
  - F20.2 Catatonic schizophrenia
  - F20.3 Undifferentiated schizophrenia
  - F20.5 Residual schizophrenia
  - F20.81 Schizophreniform disorder
  - F20.89 Other schizophrenia
  - F20.9 Schizophrenia
  - F22 Delusional Disorder
  - F25.0 Schizoaffective disorder, bipolar type
  - F25.1 Schizoaffective disorder, depressive type
  - F25.8 Other schizoaffective disorders
  - F25.9 Schizoaffective disorder, unspecified
  - F29 Unspecified schizophrenia spectrum and other psychotic disorder
  - F30.10 Manic episode without psychotic symptoms, unspecified
  - F30.12 Manic episode without psychotic symptoms, moderate
  - F30.13 Manic episode, severe, without psychotic symptoms
  - F30.2 Manic episode, severe with psychotic symptoms
  - F30.3 Manic episode in partial remission
  - F30.9 Manic episode, unspecified
  - F31.0 Bipolar I disorder, current or most recent episode hypomanic
  - F31.10 Bipolar disorder, current episode manic without psychotic features, unspecified
  - F31.12 Bipolar I disorder, current or most recent episode manic, moderate
  - F31.13 Bipolar I disorder, current or most recent episode manic, severe
  - F31.2 Bipolar I disorder, current or most recent episode manic, with psychotic features
  - F31.30 Bipolar disorder, current episode depressed, mild or moderate severity, unspecified
  - F31.32 Bipolar I disorder, current or most recent episode depressed, moderate
  - F31.4 Bipolar I disorder, current or most recent episode depressed, severe
  - F31.5 Bipolar I disorder, current or most recent episode depressed, with psychotic features
  - F31.60 Bipolar disorder, current episode mixed, unspecified
  - F31.62 Bipolar disorder, Current episode mixed, moderate
  - F31.63 Bipolar disorder, current episode mixed, severe, without psychotic features
  - F31.64 Bipolar disorder, current episode mixed, severe, with psychotic features
  - F31.71 Bipolar disorder, in partial remission, most recent episode hypomanic

- F31.73 Bipolar I disorder, current or most recent episode hypomanic, in partial remission

- F31.75 Bipolar I disorder, Current or most recent episode depressed, in partial remission
- F31.77 Bipolar disorder, in partial remission, most recent episode mixedF31.81 Bipolar II disorder
- F31.89 Other specified bipolar and related disorder
- F31.9 Bipolar I disorder, current or most recent episode depressed, hypomanic or manic, unspecified or Unspecified bipolar and related disorder
- F33.1 Major depressive disorder, recurrent episode, moderate
- F33.2 Major depressive disorder, recurrent episode, severe
- F33.3 Major depressive disorder, recurrent episode, with psychotic features
- F33.41 Major depressive disorder, recurrent episode, in partial remission
- F33.9 Major depressive disorder, recurrent episode, unspecified
- F42.3 Hoarding disorder
-

☐ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. (Specify the phase-in plan):

(By checking the following box the State assures that):

8. ☑**Adjustment Authority**. The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

9. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	**Minimum number of services**. The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is*:* 1
ii.	**Frequency of services**. The state requires (select one):

○	**The provision of 1915(i) services at least monthly**
☑	**Monthly monitoring of the individual when services are furnished on a less than monthly basis** If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency: *Every 90 days/Quarterly by the Community Mental Health Center. Monitoring can be face to face or telehealth, in accordance with Indiana Administrative Code. Face to face or telehealth should be based on what is clinically appropriate and the preferences of the individual receiving care. There must be at least one monitoring service that is conducted face to face during the 360 day package period, however other monitoring services should also be based on what is clinically appropriate and the preferences of the individual receiving care.*

Home and Community-Based Settings

(By checking the following box the State assures that):

1. ☑**Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (*Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):*

   (Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)

Applicants that are interested in applying for Adult Mental Health Habilitation (AMHH) must receive their mental health services from one of the DMHA-approved CMHCs. HCBS requires the applicant reside in an HCBS compliant setting in order to receive HCBS services.

The majority of individuals receiving HCBS services reside in their own private/independent home while receiving mental health services. At this time, CMS has made the assumption that private/independent homes are compliant with the HCBS Final Settings Rule. In regard to residential and non-residential settings, DMHA Adult 1915(i) requires CMHC's to identify and notify DMHA of settings that an HCBS provider owns, controls and/or operates (POCO). The following are types of residential settings where an HCBS member can reside while receiving services through their CMHC:

1. Alternative family homes for adults- AFA
2. Supervised group living- SGL
3. Semi-independent living facility- SILP
4. Transitional residential living facility- TRS

When a provider notifies the DMHA State Evaluation Team (SET) of a new or previously unidentified CMHC POCO residential and non-residential setting, a provider self-assessment and, if required, a member survey is completed and return to the DMHA SET for review. Both the provider self-assessment and the member surveys were developed from the exploratory questions provided by Centers for Medicaid and Medicare Services (CMS). For CMHC POCO settings, the DMHA SET will review the provider and member survey responses to assess compliance with the HCBS Final Settings Rule. When there are non-compliant findings, the provider is required to complete a Setting Action Plan (SAP) which describes their plan to address the non-compliant findings in order to bring the setting into full compliance with the HCBS Final Settings Rule. For non-CMHC POCO settings that are under the authority of Division of Aging (DA) and/or Division of Disability and Rehabilitative Services (DDRS), assessment and compliance determinations are made by DA and/or DDRS. For settings that are neither a CMHC POCO nor a non-CMHC POCO, these settings are defined as non-POCO settings. The local CMHC works with the Setting Operating Authority (SOA) to assess the setting for HCBS compliance and address any non-compliant findings in order for the setting to come into compliance with the HCBS Settings Final Rule.

Person-Centered Planning & Service Delivery

(By checking the following boxes the state assures that):

1. ☑There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

2. ☑Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

3. ☑ The person-centered service plan is reviewed and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

4. Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities. There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):*

The agency staff member conducting the face-to-face assessment must be a certified user of the State required standardized assessment tool, with supervision by a certified Super User of the tool. Minimum qualification for the person conducting the independent evaluation (1): Bachelor's in social sciences or related field with two or more years of clinical experience; (2) Have completed DMHA and OMPP approved training and orientation for 1915(i) eligibility and determination; (3) Have agency staff that have completed assessment tool Certification training. Assessments must be conducted face to face or via telehealth in accordance with Indiana Administrative Code.

5. Responsibility for Development of Person-Centered Service Plan. There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*

Licensed professional means any of the following persons:

- a licensed psychiatrist;
- a licensed physician;
- a licensed psychologist or a psychologist endorsed as a health service provider in psychology (HSPP);
- a licensed clinical social worker (LCSW);
- a licensed mental health counselor (LMHC);
- a licensed marriage and family therapist (LMFT); or
- a licensed clinical addiction counselor (LCAC), as defined under IC 25-23.6-10.5.

Qualified behavioral health professional (QBHP) means any of the following persons:

- an individual who has had at least two (2) years of clinical experience treating persons with mental illness under the supervision of a licensed professional, as defined above, such experience occurring after the completion of a master's degree or doctoral degree, or both, in any of the following disciplines:
  - in psychiatric or mental health nursing from an accredited university, plus a license as a registered nurse in Indiana;
  - in pastoral counseling from an accredited university; or
  - in rehabilitation counseling from an accredited university.
- an individual who is under the supervision of a licensed professional, as defined above, is eligible for and working toward licensure, and has completed a master's or doctoral degree, or both, in any of the following disciplines:
  - in social work from a university accredited by the Council on Social Work Education;
  - in psychology from an accredited university;
  - in mental health counseling from an accredited university; or
  - in marital and family therapy from an accredited university.
- a licensed independent practice school psychologist under the supervision of a licensed professional, as defined above.
- an authorized health care professional (AHCP), defined as follows:
  - a physician assistant with the authority to prescribe, dispense and administer drugs and medical devices or services under an agreement with a supervising physician and subject to the requirements of IC 25-27.5-5.
  - a nurse practitioner or a clinical nurse specialist, with prescriptive authority and performing duties within the scope of that person's license and under the supervision of, or under a supervisory agreement with, a licensed physician pursuant to IC 25-23-1.

Other behavioral health professional (OBHP) means any of the following persons:

- an individual with an associate or bachelor's degree, and/or equivalent behavioral health experience, meeting minimum competency standards set forth by the behavioral health service provider and supervised by a licensed professional, as defined above, or QBHP, as defined above; or
- a licensed addiction counselor, as defined under IC 25-23.6-10.5 supervised by a licensed professional, as defined above, or QBHP, as defined under above.

6. **Supporting the Participant in Development of Person-Centered Service Plan**. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

Person centered planning is an existing requirement for DMHA approved provider agencies in Indiana. This requirement is covered via certification rules, requirement for national accreditation, and contracts connected to DMHA funding. All IICPs are to be developed with the recipient driving the care. The recipient has authority to determine who is included in the process. IICPs require staff and recipient signatures as well as clinical documentation of recipient participation.

The Independent State Evaluation Team (SET) reviews and approves or denies all proposed AMHH services submitted for consideration to ensure the applicant/recipient participated in the IICP development and to prevent a conflict of interest. The following process and expectations are adhered to by provider agencies assisting recipients in developing the IICP:

The IICP is developed through a collaboration process that includes the applicant/recipient, identified community supports (family/nonprofessional caregivers), and all individuals/agency staff involved in assessing and/or providing care for the applicant/recipient. The IICP is a treatment plan that integrates all components and aspects of care that are deemed medically necessary, needs based, are clinically indicated, and are provided in the most appropriate setting to achieve the recipient's goals. An IICP must be developed with each applicant/recipient (405 IAC 5-21.5-16). The IICP must include all indicated medical and support services needed by the applicant/recipient in order to reside in the community, to function at the highest level of independence possible, and to achieve his/her goals.

The IICP is developed after completing a holistic clinical and bio-psychosocial assessment. The holistic assessment includes documentation in the applicant/recipient's medical record of the following:

- Review, discussion, and documentation of the applicant/recipient's desires, needs, and goals. Goals are recovery/habilitative in nature with outcomes specific to the habilitative needs identified by the applicant/recipient.
- Review of psychiatric symptoms and how they affect the applicant/recipient's functioning, and ability to attain desires, needs and goals.
- Review of the applicant/recipient's skills and the support needed for the applicant/recipient to participate in a long-term recovery process, including stabilization in the community and ability to function in the least restrictive living, working, and learning environments.
- Review of the applicant/recipient's strengths and needs, including medical, behavioral, social, housing, and employment.

A member of the treatment team involved in assessing the applicant/recipient's needs and desires fulfills the role of care coordinator and is responsible for documenting the IICP with the applicant/recipient's participation. In addition to driving the IICP development, the applicant/recipient is given a list of eligible provider agencies and services offered in their geographic area. The applicant/recipient is asked to select the provider agency of choice. The referring provider agency is responsible for linking the recipient to their selected provider. The provider agencies are required have mechanisms in place to support the applicant/recipient's choice of care coordinator.

The IICP must reflect the applicant/recipient's desires and choices. The applicant/recipient's signature demonstrating their participation in the development of an ongoing IICP reviews is required to be submitted to the SET. Infrequently, an applicant/recipient may request services but refuse to sign the IICP for various reasons (i.e. thought disorder, paranoia, etc.). If a recipient refuses to sign the IICP, the agency staff member is required to document on the plan of care that

the recipient agreed to the plan but refused to sign the plan. The agency staff member must also document in the clinical record progress notes that a planning meeting with the recipient did occur and that the IICP reflects the recipient's choice of services and agreement to participate in the services identified in the IICP. The progress note must further explain any known reasons why the recipient refused to sign the plan and how those will be addressed in the future.

Each eligible AMHH provider agency is required to ensure a written statement of rights is provided to each recipient. The statement shall include:
(1) The toll-free consumer service line number and the telephone number for Indiana Disability Rights.
(2) Document that agency staff provides both a written and an oral explanation of these rights to each applicant/recipient.

In addition, all approval/denial notification letters include an explanation of the action to be taken and the appeal rights. Applicants/recipients/authorized representatives may file a complaint or grievance with the State. All complaints/grievances regarding AMHH provider agencies are accepted by the following means:

(1) The "Indiana Disability Rights Line" (800-622-4845);
(2) The "Consumer Service Line" (800-901-1133)
(3) In-person to a DMHA staff member; or
(4) Via written complaint or email that is submitted to DMHA.

The IICP must also include the following documentation:

- Outline of goals that promote stability and potential movement toward independence and integration into the community, treatment of mental illness symptoms, and habilitating areas of functional deficits related to the mental illness.
- Individuals or teams responsible for treatment, coordination of care, linkage, and referrals to internal or external resources and care providers to meet identified needs.

7. Informed Choice of Providers. *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

The State maintains a network of Community Mental Health Centers (CMHCs). As a DMHA-approved AMHH provider agency, each CMHC is an enrolled Medicaid provider that offers a full continuum of behavioral health care services, as is mandated by DMHA for all CMHCs, in addition to providing AMHH services as documented in the Indiana benefit and this waiver. The care coordinator explains the process for making an informed choice of provider(s) and answers questions. The applicant/recipient is also advised that choice of providers and provider agencies is ongoing for the duration of the program. Therefore, providers within an agency and provider agencies themselves can be changed as necessary. As a service is identified, a list is generated in randomized sequence of qualified agency providers of the 1915(i) and is presented to the applicant/recipient by the care coordinator. A listing of approved/enrolled 1915(i) provider agencies is also posted on the Indiana Medicaid website at www.indianamedicaid.com. Applicants/recipients and family members may interview potential service providers and make their own choice.

This 1915(i) State Plan benefit is to run concurrently with the 1915(b)(4) Fee-For-Service Selective Contracting waiver (IN-02).

When accessing indianamedicaid.com website, the individual has a choice of a "Member" tab and "Provider" tab. The Member tab notes: *If you are an Indiana Medicaid Member or are interested in applying to becoming a Member, please click the "Member" tab.*

Selection of the Member tab provides an array of information to individuals applying for or eligible for Medicaid services, including a "Find a Provider" link. This link allows the individual to target their search by selecting types of providers by city, county, or state. The resulting lists include the provider's name, address, telephone number and a link to the map for each provider location.

8. **Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency**. *(Describe the process by which the person-centered service plan is made subject to the approval of the Medicaid agency):*

The Indiana Office of Medicaid Policy and Planning (OMPP) retains responsibility for service plan approvals made by the Division of Mental Health and Addiction (DMHA). As part of its routine operations, DMHA reviews each service plan submitted to OMPP to ensure that the plan addresses all pertinent issues identified through the assessment, including physical health issues.

OMPP reviews and approves the policies, processes, and standards for developing and approving 1915(i) plans of care. In the instance of a complaint from a 1915(i) provider or applicant/recipient, the IICP submitted to DMHA may be reviewed by OMPP. Based on the terms and conditions of the 1915(i), the Medicaid agency may overrule the approval or disapproval of any specific IICP acted upon by the DMHA serving in its capacity as the administrating agency for the 1915(i).

9. **Maintenance of Person-Centered Service Plan Forms**. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

☐	Medicaid agency	☑	Operating agency	☐	Case manager
☐	Other (*specify):*				

Services

1. **State plan HCBS.** *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Adult Day Services

Service Definition (Scope)*:*

Community-based group programs designed to meet the needs of adults with significant behavioral health impairments as identified in the IICPs. These comprehensive, non-residential programs provide health, wellness, social, and therapeutic activities. These services are provided in a structured, supportive environment. The services provide supervision, support services, and personal care as required by the IICP.

Service Requirements include:

- Direct service providers must be supervised by a licensed professional;
- Clinical oversight must be provided by a licensed physician, who is on-site at least once a week and available to program staff when not physically present;
- Each date of service must be appropriately documented.
- At minimum a weekly review and update of progress toward habilitative goals occurs and is documented in the recipient's clinical record;

- Adult Day Services that are included are:
  - care planning,
  - treatment,
  - monitoring of weight, blood glucose level, and blood pressure,
  - medication administration,
  - nutritional assessment and planning,
  - individual or group exercise training,
  - training in activities of daily living,
  - skill reinforcement on established skills, and
  - other social activities.

Additional needs-based criteria for receiving the service, if applicable *(specify): N/A*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑	Categorically needy *(specify limits):*

	The service is offered in half day units, A single half-day (1/2 day) day unit is defined as one unit of a minimum of three (3) hours to a maximum of five (5) hours/day. Two units are defined as more than five (5) hours to a maximum of 8 hours/day. A maximum of two half-day (1/2 day) units/day is allowed up to 5 days per week. Exclusions: • Recipient receiving MRO services • Recipient receiving inpatient or partial hospitalization through the Clinic Option on the same day Services shall not be reimbursed when provided in a residential setting as defined by DMHA.
☐	Medically needy *(specify limits): N/A*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full-continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that individual agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional; (B) QBHP; or (C) OBHP. Medication administration provided within Adult Day Services must be provided within the scope of practice as defined by federal and State law. Providers must meet the following qualifications: (A) physician;

			(B) authorized health care professional (AHCP); (C) registered nurse (RN); (D) licensed practical nurse (LPN) or (E) a medical assistant who has graduated from a two year clinical program Nutritional assessment and planning services must be provided by a certified dietician as defined in IC 25-14.5-1-4 and within the scope of practice as defined in state and federal law.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Home and Community Based Habilitation and Support – Individual Setting

Service Definition (Scope)*:*

Individualized face-to-face services directed at the health, safety and welfare of the recipient and assisting in the management, adaptation and/or retention of skills necessary to support recipients to live successfully in the most integrated setting appropriate to the recipient's needs. Assist recipient to gain an understanding of/and self-management of behavioral and medical health conditions. Services are provided in the recipient's home (living environment) or other community-based settings outside of a clinic/office environment. Skills training as used in this service description means: Assisting in the reinforcement, management, adaptation and/ or retention of skills necessary to live successfully in the community.

- Service requires face-to-face contact in an individual setting.
- Recipients are expected to benefit from services.
- Services must be goal-oriented and related to the IICP.
- Activities include implementation of the individualized support plan, assistance with personal care, coordination and facilitation of medical and non-medical services to meet healthcare needs.
- Services that are included:
  - Skills training in food planning and preparation, money management, maintenance of living environment.
  - Training in appropriate use of community services.

	○ Training in skills needed to locate and maintain a home, renter skills training including landlord/tenant negotiations, budgeting to meet housing and housing-related expenses, how to locate and interview prospective roommates, and renter's rights and responsibilities training.
Additional needs-based criteria for receiving the service, if applicable *(specify):N/A*	
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*	
☑	Categorically needy *(specify limits):*
	Home and Community Based Habilitation and Support, including all subtypes (individual, group, family/couple, with and without recipient present) may be provided for up to a total of six (6) hours per day (twenty-four 15-minute units per day). Exclusions: • Recipient receiving MRO services • Recipients in partial hospitalization or inpatient hospitalization on the same day
☐	Medically needy *(specify limits): N/A*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify

			that agency staff providing an AMHH

			service must meet the following standards for this service, as follows: (A) Licensed professional; (B) QBHP; or (C) OBHP.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	DMHA	Initially and at time of DMHA certification renewal

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Service Title:	Home and Community Based Habilitation and Support – Family/Couple with the Recipient Present – Individual Setting

Service Definition (Scope)*: Definition*

Individualized face-to-face services directed at the health, safety and welfare of the recipient and assisting in the acquisition, improvement, and retention of skills necessary to support recipients to live successfully in the community. Training and education to instruct a parent, or other family member, or primary caregiver about the treatment regimens appropriate to the recipient; and to improve the ability of the parent, family member or primary caregiver to provide the care to or for the recipient. Skills training as used in this service description means: Assisting in the reinforcement, management, adaptation and/ or retention of skills necessary to live successfully in the community.

Service Requirements include:

- Service requires face-to-face contact in an individual setting.
- Recipients are expected to show benefit from services.
- Services must be goal-oriented and related to the IICP.
- Activities include implementation of the individualized support plan, assistance with personal care, coordination, and facilitation of medical and non-medical services to meet healthcare needs.

- Services that are included:
-
    - Skills training in food planning and preparation, money management, maintenance of living environment.
    - Training in appropriate use of the community services
    - Medication-related education and training by non-medical staff.
    - Training in skills needed to locate and maintain a home, renter skills training including landlord/tenant negotiations, budgeting to meet housing and housing-related expenses, how to locate and interview prospective roommates, and renter's rights and responsibilities training.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*	
☑	Categorically needy *(specify limits): Insert Program Standards*
	Home and Community Based Habilitation and Support, including all subtypes (individual, group, family/couple, with and without recipient present) may be provided for up to a total of six (6) hours per day (twenty-four 15-minute units per day). Exclusions: •Recipients receiving MRO services •Recipients in partial hospitalization or inpatient hospitalization on the same day
☐	Medically needy *(specify limits): N/A*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA - certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional; (B) QBHP; or (C) OBHP.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*

Agency	DMHA	Initially, and at the time of DMHA certification renewal.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Home and Community Based Habilitation and Support – Family/Couple without the Recipient Present – Individual Setting

Service Definition (Scope)*:*

Skills training and education instructs a parent, or other family member, or primary caregiver about the treatment regimens appropriate to the recipient; and how to improve the ability of the parent, family member or primary caregiver to assist the beneficiary more effectively in learning/implementing skills for activities of daily living. This service includes individualized face-to-face services directed at the health, safety and welfare of the recipient and assisting in the acquisition, improvement, and retention of skills necessary to support recipients to live successfully in the community. Skills training as used in this service description means: Assisting in the reinforcement, management, adaptation and/ or retention of skills necessary to live successfully in the community.

Service Requirements include:

- Service requires face-to-face contact with family members or non-professional caregivers in an individual setting.
- Recipients are expected to show benefit from services.
- Services must be goal-oriented and related to the IICP.
- Activities include implementation of the individualized support plan, assistance with personal care, coordination and facilitation of medical and non-medical services to meet healthcare needs.

Services that are included:

- Skills training in food planning and preparation, money management, maintenance of living environment.
- Training in appropriate use of community services
- Medication-related education and training by non-medical staff.
- Training in skills needed to locate and maintain a home, renter skills training including landlord/tenant negotiations, budgeting to meet housing and housing-related expenses, how to locate and interview prospective roommates, and renter's rights and responsibilities training.

Additional needs-based criteria for receiving the service, if applicable *(specify): N/A*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):	
☑	Categorically needy *(specify limits):*
	Home and Community Based Habilitation and Support, including all subtypes (individual, group, family/couple, with and without recipient present) may be provided for up to a total of six (6) hours per day (twenty-four 15-minute units per day). Exclusions: • Recipients receiving MRO services • Recipients in partial hospitalization or inpatient hospitalization on the same day
☐	Medically needy *(specify limits): N/A*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional; (B) QBHP; or (C) OBHP.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*

Agency	DMHA	Initially, and at the time of DMHA certification renewal.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Home and Community Based Habilitation and Support – Group Setting

Service Definition (Scope)*:*

Face-to-face services provided in a group setting directed at the health, safety and welfare of the recipient and assisting in the management, adaptation and/or retention of skills necessary to support recipients to live successfully in the most integrated setting appropriate to the recipient's needs. Assisting recipients to gain an understanding of/and self-management of behavioral and medical health conditions. Services are provided in the recipient's home (living environment) or other community based settings outside of a clinic/office environment. Skills training as used in this service description means: Assisting in the reinforcement, management, adaptation and/ or retention of skills necessary to live successfully in the community.

Service Requirements include:

- Recipients are expected to show benefit from services.
- Services must be goal-oriented and related to the IICP.
- Activities include implementation of the individualized support plan, assistance with personal care, coordination and facilitation of medical and non-medical services to meet healthcare needs.

Services that are included:

- Skills training in food planning and preparation, money management, maintenance of living environment.
- Training in appropriate use of community services.
- Medication-related education and training by non-medical staff.
- Training in skills needed to locate and maintain a home, renter skills training include landlord/tenant negotiations, budgeting to meet housing and housing-related expenses, how to locate and interview prospective roommates, and renter's rights and responsibilities training.

Additional needs-based criteria for receiving the service, if applicable *(specify): N/A*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration, and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑	Categorically needy *(specify limits):*

	Home and Community Based Habilitation and Support, including all subtypes (individual, group, family/couple, with and without consumer present) may be provided for up to a total of six (6) hours per day (twenty-four 15- minute units per day). Exclusions: • Recipients receiving MRO services • Recipients in partial hospitalization or inpatient hospitalization on the same day
☐	Medically needy *(specify limits): N/A*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional; (B) QBHP; or (C) OBHP.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*

Agency	DMHA	Initially, and at the time of DMHA certification renewal.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Title:	Home and Community Based Habilitation and Support – Family/Couple with Recipient Present (Group Setting)

Service Definition (Scope)*: Definition*

Face-to-face services provided in a group setting directed at the health, safety and welfare of the recipient and assist in the management, adaptation and/or retention of skills necessary to support recipients to live successfully in the most integrated setting appropriate to the recipient's needs. Training and education to instruct a parent, or other family member, or primary caregiver about the treatment regimens appropriate to the recipient; and to improve the ability of the parent, family member or primary caregiver to provide the care to or for the recipient. Skills training as used in this service description means: Assisting in the reinforcement, management, adaptation and/ or retention of skills necessary to live successfully in the community.

Service Requirements include:

- Service requires face-to-face contact in a group setting.
- Recipients are expected to show benefit from services.
- Services must be goal-oriented and related to the IICP.
- Activities include implementation of the individualized support plan, assistance with personal care, coordination, and facilitation of medical and non-medical services to meet healthcare needs.

- Services that are included:
  - Skills training in food planning and preparation, money management, maintenance of living environment.
  - Training in appropriate use of community services.
  - Medication-related education and training by non-medical staff.
  - Training in skills needed to locate and maintain a home, renter skills training including landlord/tenant negotiations, budgeting to meet housing and housing-related expenses, how to locate and interview prospective roommates, and renter's rights and responsibilities training.

Additional needs-based criteria for receiving the service, if applicable *(specify): N/A*

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

☑	Categorically needy *(specify limits):*
	Home and Community Based Habilitation and Support, including all subtypes (individual, group, family/couple, with and without recipient present) may be provided for up to a total of six (6) hours per day (twenty-four 15-minute units per day). Exclusions: • Recipients receiving MRO services • Recipients in partial hospitalization or inpatient hospitalization on the same day

☐	Medically needy *(specify limits):N/A*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional; (B) QBHP; or (C) OBHP.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Service Title:	Home and Community Based Habilitation and Support – Family/Couple without Recipient Present (Group Setting)

Service Definition (Scope)*: Definition*

Skills training and education in a group setting instructs a parent, or other family member, or primary caregiver about the treatment regimens appropriate to the recipient; and to improve the ability of the parent, family member or primary caregiver to effectively assist the beneficiary in learning/implementing skills for activities of daily living. This service includes individualized face-to-face services with the family or nonprofessional caregivers directed at the health, safety and welfare of the recipient and assisting in the acquisition, improvement, and retention of skills necessary to support recipients to live successfully in the community.

Home and Community Based Habilitation and Support – Family/Couple without the recipient present (group setting) involves face-to-face contact with the family or nonprofessional caregivers that result in the recipient's development and/or retention of skills (for example, self-care, daily life management, or problem-solving skills), in a group setting. The service is focused on the health, safety and welfare of the recipient and assisting in the acquisition, improvement, and retention of skills necessary to support recipients to live successfully in the community. This service is provided through structured interventions for attaining goals identified in the IICP and the monitoring of the recipient's progress in achieving those skills.

Skills training as used in this service description means: Assisting in the reinforcement, management, adaptation and/ or retention of skills necessary to live successfully in the community.

Service Requirements include:

- Service requires face-to-face contact in a group setting.
- Recipients are expected to show benefit from services.
- Services must be goal-oriented and related to the IICP.
- Activities include implementation of the individualized support plan, assistance with personal care, coordination and facilitation of medical and non-medical services to meet healthcare needs.
- Services that are included:
  - Skills training in food planning and preparation, money management, maintenance of living environment.
  - Training in appropriate use of community services
  - Medication-related education and training by non-medical staff.
  - Training in skills needed to locate and maintain a home, renter skills training including landlord/tenant negotiations, budgeting to meet housing and housing-related expenses, how to locate and interview prospective roommates, and renter's rights and responsibilities training.

Additional needs-based criteria for receiving the service, if applicable *(specify): N/A*

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

☑ Categorically needy *(specify limits): Insert Program Standards*

Home and Community Based Habilitation and Support, including all subtypes (individual, group, family/couple, with and without recipient present) may be provided for up to a total of six (6) hours per day (twenty-four 15-minute units per day).

Exclusions:

- Recipients receiving MRO services
- Recipients in partial hospitalization or inpatient hospitalization on the same day

☐	Medically needy *(specify limits): N/A*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional; (B) QBHP; or (C) OBHP.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Respite Care

Service Definition (Scope)*:*

Services provided to recipients who are unable to care for themselves and are living with a non-professional (unpaid) caregiver. These services are furnished on a short-term basis because of the non-professional caregiver's absence or need for relief. These services can be provided in the recipient's home or place of residence, in the caregiver's home, or in a non-private residential setting (such as a group home or adult foster care).

Service Requirements include:

- Recipient must be living with a non-professional (unpaid) caregiver.
- Location of service and level of professional care is based on the needs of the recipient receiving the service including regular monitoring of medications or behavioral symptoms as identified in the IICP.
- Service must be provided in the least restrictive environment available and ensure the health and welfare of the recipient.

Additional needs-based criteria for receiving the service, if applicable *(specify): N/A*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑ Categorically needy *(specify limits):*

This service is offered at a 15-minute unit rate for up to seven (7) hours (28 15-minute units) per day and a maximum of 75 hours per year (300 15-minute units). Eight (8) hours to 24 hours of Respite Care a day is offered at the daily rate. Respite care may be provided for up to 14 consecutive days for a maximum of 28 days during any year.

Exclusions:

- Shall not be used as care to allow the persons normally providing care to go to work or attend school.
- Services provided to a recipient living in a DMHA licensed residential facility.
- Services provided to a recipient living in supportive housing.
- Respite care must not duplicate any other service being provided under the recipient's IICP.

☐ Medically needy *(specify limits): N/A*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled

			Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional; (B) QBHP; or (C) OBHP. Medication administration and medical support services provided within Respite Care must be provided within the scope of practice as defined by federal and state law. Providers must meet the following qualifications: (A) Physician; (B) Advanced Practice Nurse (APN); (C) Physician Assistant (PA); (D) Registered Nurse (RN); or (E) Licensed Practical Nurse (LPN).

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Therapy and Behavioral Support Services – Individual Setting
Service Definition (Scope)*:*	

Therapy and behavioral support services is a series of time-limited, structured, face-to-face or telehealth according to Indiana Administrative Code. Sessions that work toward the goals identified in the individualized integrated care plan. Therapy and behavioral support services must be provided at the recipient's home (living environment) or at other locations outside the clinic setting.

Service Requirements include:

- The Medicaid identified recipient is the focus of the treatment.
- Documentation must support how the service specifically benefits the identified recipient.
- Therapy / behavioral support services must demonstrate progress toward and/or achievement of individual treatment goals.
- Therapy / behavioral support services goals must be habilitative in nature.
- Observation of the recipient in personal environment for purpose of care plan development.
- Development of a person-centered behavioral support plan and subsequent revisions which may be a part of the individualized integrated care plan.
- Implementation of the behavior support plan for staff, family members, roommates, and other appropriate individuals.
- Allowable training activities include:
  - assertiveness
  - stress reduction techniques
  - acquisition of socially accepted behaviors
- The number of in-person visits and the percentage of time telehealth will be the delivery method of service will be based on what is clinically appropriate and in agreement with the consumer and/or legal guardian.
- The use of telehealth should protect against isolating participants by offering services which are in-person and shall be invoked to prioritize and facilitate community integration.
- As required by 45 CFR § 164.308 (a)(1)(ii), an accurate and thorough risk analysis shall be conducted for any functions utilizing telehealth services to assess the potential risks and vulnerabilities to the confidentiality, integrity, and availability of patient data.
- All telehealth services will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc. Video cameras/monitors are not permitted in bedrooms and bathrooms. Participants are able to turn all telehealth-related devices on/off at their discretion in order to ensure privacy. The provider who is responsible for the treatment of the individual is responsible for training participants on the use of any telehealth-related devices both initially and on-going.
- Telehealth services shall consider and respond to all accessibility needs, including whether hands-on or physical assistance is needed to render the service.
- Telehealth services must ensure the health and safety of the individual receiving services by adhering to all abuse, neglect, and exploitation prevention practices that apply to in-person treatment, as well as by providing participants with resources on how to report incidences of abuse, neglect, and exploitation.

Additional needs-based criteria for receiving the service, if applicable *(specify): N/A*
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*

☑ Categorically needy *(specify limits):*

Individual setting Therapy and Behavioral Support service, including all three (3) subtypes (individual, family/couple, with and without recipient present) may be provided for a maximum of 75 hours (300 15-minute units) per year.

Exclusions:

- Recipients receiving MRO services.
- Recipients in partial hospitalization or inpatient hospitalization on the same day.
- Therapy services provided in a clinic setting are not billable under the 1915(i) but may qualify for reimbursement under the clinic option.

☐ Medically needy *(specify limits): N/A*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*

Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional, except for a licensed clinical addiction counselor, as defined under IC 25-23.6-10.5; or (B) QBHP.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Therapy and Behavioral Support Services – Family/Couple with the Recipient Present (Individual Setting)
Service Definition (Scope)*:*	

Family/Couple Counseling and Therapy with the recipient present is a series of time-limited, structured, face-to-face or telehealth according to Indiana Administrative Code. Sessions that work toward the goals identified in the individualized integrated care plan. The face-to-face or telehealth according to Indiana Administrative Code. Interaction may be with the recipient and family members or non- professional caregivers in an individual setting. Family/Couple Counseling and Therapy must be provided at home (living environment) or other locations outside the clinic setting.

Service Requirements include:

- The Medicaid identified recipient is the focus of the treatment.
- Documentation must support how the service specifically benefits the identified recipient.
- Therapy/behavioral support services must demonstrate progress toward and/or achievement of individual treatment goals.
- Therapy/behavioral support services goals must be habilitative in nature.
- Observation of the recipient in their environment for purpose of care plan development.
- Development of a person-centered behavioral support plan and subsequent revisions which may be a part of the individualized integrated care plan
- Implementation of the behavior support plan for staff, family members, roommates, and other appropriate individuals
- Allowable training activities include:
    - assertiveness
    - stress reduction techniques
    - acquisition of socially accepted behaviors
- The number of in-person visits and the percentage of time telehealth will be the delivery method of service will be based on what is clinically appropriate and in agreement with the consumer and/or legal guardian.
- The use of telehealth should protect against isolating participants by offering services which are in-person and shall be invoked to prioritize and facilitate community integration.
- As required by 45 CFR § 164.308 (a)(1)(ii), an accurate and thorough risk analysis shall be conducted for any functions utilizing telehealth services to assess the potential risks and vulnerabilities to the confidentiality, integrity, and availability of patient data.
- All telehealth services will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc. Video cameras/monitors are not permitted in bedrooms and bathrooms. Participants are able to turn all telehealth-related devices on/off at their discretion in order to ensure privacy. The provider who is responsible for the treatment of the individual is responsible for training participants on the use of any telehealth-related devices both initially and on-going.
- Telehealth services shall consider and respond to all accessibility needs, including whether hands-on or physical assistance is needed to render the service.
- Telehealth services must ensure the health and safety of the individual receiving services by adhering to all abuse, neglect, and exploitation prevention practices that apply to in-person treatment, as well as by providing participants with resources on how to report incidences of abuse, neglect, and exploitation.

Additional needs-based criteria for receiving the service, if applicable *(specify): N/A*
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*

☑	Categorically needy *(specify limits):*
	Individual setting, Therapy and Behavioral Support service, including all three (3) subtypes (individual, family/couple, with and without recipient present) may be provided for a maximum of 75 hours (300 15-minute units) per year. Exclusions: • Recipients receiving MRO services • Recipients in partial hospitalization or inpatient hospitalization on the same day • Therapy services provided in a clinic setting are not billable under the 1915(i) but may qualify for reimbursement under the clinic option
☐	Medically needy *(specify limits): N/A*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*

Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional, except for a licensed clinical addiction counselor, as defined under IC 25-23.6-10.5; or (B) QBHP.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Therapy and Behavioral Support Services – Family/Couple without the Recipient Present (Individual Setting)
Service Definition (Scope)*:*	

Family/Couple Counseling and Therapy without the recipient present is a series of time-limited, structured, face-to-face or telehealth according to Indiana Administrative Code.Sessions that work toward the goals identified in the individualized integrated care plan. Skills training and education is for the family/couple to assist the beneficiary more effectively in learning/implementing these skills. The face-to-face or telehealth according to Indiana Administrative Code. Interaction may be with family members or non-professional caregivers in an individual setting. Family/Couple Counseling and Therapy must be provided at home (living environment) or other locations outside the clinic setting.

Service Requirements include:

- The Medicaid identified recipient is the focus of the treatment.
- Documentation must support how the service specifically benefits the identified recipient.
- Therapy/behavioral support services must demonstrate progress toward and/or achievement of individual treatment goals.
- Therapy/behavioral support services goals must be habilitative in nature.
- Observation of the recipient in their environment for purpose of care plan development.
- Development of a person-centered behavioral support plan and subsequent revisions which may be a part of the individualized integrated care plan.
- Implementation of the behavior support plan for staff, family members, roommates, and other appropriate individuals.
- Allowable training activities include:
    - assertiveness
    - stress reduction techniques
    - acquisition of socially accepted behaviors.
- The number of in-person visits and the percentage of time telehealth will be the delivery method of service will be based on what is clinically appropriate and in agreement with the consumer and/or legal guardian.
- The use of telehealth should protect against isolating participants by offering services which are in-person and shall be invoked to prioritize and facilitate community integration.
- As required by 45 CFR § 164.308 (a)(1)(ii), an accurate and thorough risk analysis shall be conducted for any functions utilizing telehealth services to assess the potential risks and vulnerabilities to the confidentiality, integrity, and availability of patient data.
- All telehealth services will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc. Video cameras/monitors are not permitted in bedrooms and bathrooms. Participants are able to turn all telehealth-related devices on/off at their discretion in order to ensure privacy. The provider who is responsible for the treatment of the individual is responsible for training participants on the use of any telehealth-related devices both initially and on-going.
- Telehealth services shall consider and respond to all accessibility needs, including whether hands-on or physical assistance is needed to render the service.

Telehealth services must ensure the health and safety of the individual receiving services by adhering to all abuse, neglect, and exploitation prevention practices that apply to in-person treatment, as well as by providing participants with resources on how to report incidences of abuse, neglect, and exploitation.

Additional needs-based criteria for receiving the service, if applicable *(specify): N/A*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*	
☑	Categorically needy *(specify limits):*
	Individual setting, Therapy and Behavioral Support service, including all three (3) subtypes (individual, family/couple, with and without recipient present) may be provided for a maximum of 75 hours (300 15-minute units) per year. Exclusions: • Recipients receiving MRO services. • Recipients in partial hospitalization or inpatient hospitalization on the same day. • Therapy services provided in a clinic setting are not billable under the 1915(i) but may qualify for reimbursement under the clinic option.
☐	Medically needy *(specify limits): N/A*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*

Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional, except for a licensed clinical addiction counselor, as defined under IC 25-23.6-10.5; or (B) QBHP.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*	
Service Title:	Therapy and Behavioral Support Services – Group Setting
Service Definition (Scope)*:*	

Group Counseling and Therapy is a series of time-limited, structured, face-to-face or telehealth according to Indiana Administrative Code.Sessions that work
toward the goals identified in the individualized integrated care plan. Group Counseling and Therapy

must be provided at the recipient's home (living environment) or at other locations outside the clinic setting.

Service Requirements include:

- The Medicaid identified recipient is the focus of the treatment.
- Documentation must support how the service specifically benefits the identified recipient.
- Therapy/behavioral support services must demonstrate progress toward and/or achievement of individual treatment goals.
- Therapy/behavioral support services goals must be habilitative in nature.
- Observation of the recipient in their environment for purpose of care plan development.
- Development of a person-centered behavioral support plan and subsequent revisions which may be a part of the individualized integrated care plan.
- Implementation of the behavior support plan for staff, family members, roommates, and other appropriate individuals.
- Allowable training activities include:
    - assertiveness,
    - stress reduction techniques
    - acquisition of socially accepted behaviors.
- The number of in-person visits and the percentage of time telehealth will be the delivery method of service will be based on what is clinically appropriate and in agreement with the consumer and/or legal guardian.
- The use of telehealth should protect against isolating participants by offering services which are in-person and shall be invoked to prioritize and facilitate community integration.
- As required by 45 CFR § 164.308 (a)(1)(ii), an accurate and thorough risk analysis shall be conducted for any functions utilizing telehealth services to assess the potential risks and vulnerabilities to the confidentiality, integrity, and availability of patient data.
- All telehealth services will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc. Video cameras/monitors are not permitted in bedrooms and bathrooms. Participants are able to turn all telehealth-related devices on/off at their discretion in order to ensure privacy. The provider who is responsible for the treatment of the individual is responsible for training participants on the use of any telehealth-related devices both initially and on-going.
- Telehealth services shall consider and respond to all accessibility needs, including whether hands-on or physical assistance is needed to render the service.

Telehealth services must ensure the health and safety of the individual receiving services by adhering to all abuse, neglect, and exploitation prevention practices that apply to in-person treatment, as well as by providing participants with resources on how to report incidences of abuse, neglect, and exploitation.

Additional needs-based criteria for receiving the service, if applicable *(specify): N/A*

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

☑	Categorically needy *(specify limits):*
	Group setting, Therapy and Behavioral Support service, including all three (3) subtypes (group with recipient, and group with family/couple, with and without recipient present) may be provided for a maximum of 75 hours (300 15-minute units) per year. Exclusions: • Recipients receiving MRO services. • Recipients in partial hospitalization or inpatient hospitalization on the same day. • Therapy services provided in a clinic setting are not billable under the 1915(i) but may qualify for reimbursement under the clinic option.
☐	Medically needy *(specify limits): N/A*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance

			with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional, except for a licensed clinical addiction counselor, as defined under IC 25-23.6-10.5; or (B) QBHP.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*	
Service Title:	Therapy and Behavioral Support Services – Family/Couple with Recipient Present (Group Setting)
Service Definition (Scope)*:*	

Family/Couple Counseling and Therapy with the recipient present is a series of time-limited, structured, face-to-face or telehealth according to Indiana Administrative Code.Sessions that work toward the goals identified in the individualized integrated care plan. The face-to-face or telehealth according to Indiana Administrative Code. Interaction may be with the recipient and family members or non- professional caregivers in a group setting. Family/Couple Counseling and Therapy must be provided at home (living environment) or other locations outside the clinic setting.

Service Requirements include:

- The Medicaid identified recipient is the focus of the treatment.
- Documentation must support how the service specifically benefits the identified recipient.
- Therapy / behavioral support services must demonstrate progress toward and/or achievement of individual treatment goals.
- Therapy / behavioral support services goals must be habilitative in nature.
- Observation of the recipient in their environment for purpose of care plan development.

- Development of a person-centered behavioral support plan and subsequent revisions which may be a part of the individualized integrated care plan.
- Implementation of the behavior support plan for staff, family members, roommates, and other appropriate individuals
- Allowable training activities include:
  - assertiveness
  - stress reduction techniques
  - acquisition of socially accepted behaviors.
- The number of in-person visits and the percentage of time telehealth will be the delivery method of service will be based on what is clinically appropriate and in agreement with the consumer and/or legal guardian.
- The use of telehealth should protect against isolating participants by offering services which are in-person and shall be invoked to prioritize and facilitate community integration.
- As required by 45 CFR § 164.308 (a)(1)(ii), an accurate and thorough risk analysis shall be conducted for any functions utilizing telehealth services to assess the potential risks and vulnerabilities to the confidentiality, integrity, and availability of patient data.
- All telehealth services will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc. Video cameras/monitors are not permitted in bedrooms and bathrooms. Participants are able to turn all telehealth-related devices on/off at their discretion in order to ensure privacy. The provider who is responsible for the treatment of the individual is responsible for training participants on the use of any telehealth-related devices both initially and on-going.
- Telehealth services shall consider and respond to all accessibility needs, including whether hands-on or physical assistance is needed to render the service.

Telehealth services must ensure the health and safety of the individual receiving services by adhering to all abuse, neglect, and exploitation prevention practices that apply to in-person treatment, as well as by providing participants with resources on how to report incidences of abuse, neglect, and exploitation.

Additional needs-based criteria for receiving the service, if applicable *(specify): N/A*

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

☑ Categorically needy *(specify limits):*

Group setting Therapy and Behavioral Support service, including all three (3) subtypes (group with recipient, and group with family/couple, with and without recipient present) may be provided for a maximum of 75 hours (300 15-minute units) per year.

Exclusions:

- Recipients receiving MRO services.
- Recipients in partial hospitalization or inpatient hospitalization on the same day.
- Therapy services provided in a clinic setting are not billable under the 1915(i) but may qualify for reimbursement under the clinic option.

☐ Medically needy *(specify limits): N/A*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a
			provider agency, the agency must certify

			that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional, except for a licensed clinical addiction counselor, as defined under IC 25-23.6-10.5; or (B) QBHP.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Service Title:	Therapy and Behavioral Support Services – Family/Couple without Recipient Present (Group Setting)

Service Definition (Scope)*:*

Family/Couple Counseling and Therapy without the recipient present is a series of time-limited, structured, face-to-face or telehealth according to Indiana Administrative Code.Sessions that work toward the goals of the recipient identified in the individualized integrated care plan. Skills training and education is for the family/couple to assist the beneficiary more effectively in learning/implementing these skills. The face-to-face or telehealth according to Indiana Administrative Code. Interaction may be with family members or non-professional caregivers in a group setting.
Family/Couple Counseling and Therapy must be provided at home (living environment) or other locations outside the clinic setting.

Service Requirements include:

- The Medicaid identified recipient is the focus of the treatment.
- Documentation must support how the service specifically benefits the identified recipient.
- Therapy / behavioral support services must demonstrate progress toward and/or achievement of individual treatment goals.
- Therapy / behavioral support services goals must be habilitative in nature.
- Observation of the recipient in their environment for purpose of care plan development.
- Development of a person-centered behavioral support plan and subsequent revisions which may be a part of the individualized integrated care plan.
- Implementation of the behavior support plan for staff, family members, roommates, and other appropriate individuals.
- Allowable training activities include:
    - o assertiveness
    - o stress reduction techniques

	o acquisition of socially accepted behaviors • The number of in-person visits and the percentage of time telehealth will be the delivery method of service will be based on what is clinically appropriate and in agreement with the consumer and/or legal guardian. • The use of telehealth should protect against isolating participants by offering services which are in-person and shall be invoked to prioritize and facilitate community integration. • As required by 45 CFR § 164.308 (a)(1)(ii), an accurate and thorough risk analysis shall be conducted for any functions utilizing telehealth services to assess the potential risks and vulnerabilities to the confidentiality, integrity, and availability of patient data. • All telehealth services will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc. Video cameras/monitors are not permitted in bedrooms and bathrooms. Participants are able to turn all telehealth-related devices on/off at their discretion in order to ensure privacy. The provider who is responsible for the treatment of the individual is responsible for training participants on the use of any telehealth-related devices both initially and on-going. • Telehealth services shall consider and respond to all accessibility needs, including whether hands-on or physical assistance is needed to render the service. • Telehealth services must ensure the health and safety of the individual receiving services by adhering to all abuse, neglect, and exploitation prevention practices that apply to in-person treatment, as well as by providing participants with resources on how to report incidences of abuse, neglect, and exploitation.
Additional needs-based criteria for receiving the service, if applicable *(specify): N/A*	
Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*	
☑	Categorically needy *(specify limits):*
	Group setting Therapy and Behavioral Support service, including all three (3) subtypes (group with recipient, and group with family/couple, with and without recipient present) may be provided for a maximum of 75 hours (300 15-minute units) per year. Exclusions: • Recipients receiving MRO services. • Recipient in partial hospitalization or inpatient hospitalization on the same day. • Therapy services provided in a clinic setting are not billable under the 1915(i) but may qualify for reimbursement under the clinic option.
☐	Medically needy *(specify limits): N/A*
Provider Qualifications *(For each type of provider. Copy rows as needed)*:	

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional, except for a licensed clinical addiction counselor, as defined under IC 25-23.6-10.5; or

			(B) QBHP.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*	
Service Title:	Addiction Counseling – Individual Setting
Service Definition (Scope)*:*	

Individual Addiction Counseling is a planned and organized face-to-face or telehealth according to Indiana Administrative Code.Service with the recipient where addiction professionals and other clinicians provide counseling intervention that works toward the recipient's recovery goals identified in the IICP.

Service Requirements include:

- The recipient is the focus of Addiction Counseling.
- Documentation must support how Addiction Counseling benefits the recipient.
- Addiction Counseling requires face-to-face or telehealth according to Indiana Administrative Code, contact with the recipient.
- Addiction Counseling consists of regularly scheduled sessions.
- Counseling must demonstrate progress towards and/or achievement of goals identified in the IICP.
- Referral to available community recovery support programs is available.
- Addiction Counseling includes the following:
  - Education on addiction disorders
  - Skills training in communication, anger management, stress management, relapse prevention
- The number of in-person visits and the percentage of time telehealth will be the delivery method of service will be based on what is clinically appropriate and in agreement with the consumer and/or legal guardian.
- The use of telehealth should protect against isolating participants by offering services which are in-person and shall be invoked to prioritize and facilitate community integration.
- As required by 45 CFR § 164.308 (a)(1)(ii), an accurate and thorough risk analysis shall be conducted for any functions utilizing telehealth services to assess the potential risks and vulnerabilities to the confidentiality, integrity, and availability of patient data.
- All telehealth services will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc. Video cameras/monitors are not permitted in bedrooms and bathrooms. Participants are able to turn all telehealth-related devices on/off at their discretion in order to ensure privacy. The provider who is responsible for the treatment of the individual is responsible for training participants on the use of any telehealth-related devices both initially and on-going.
- Telehealth services shall consider and respond to all accessibility needs, including whether hands-on or physical assistance is needed to render the service.

Telehealth services must ensure the health and safety of the individual receiving services by adhering to all abuse, neglect, and exploitation prevention practices that apply to in-person treatment, as well as by providing participants with resources on how to report incidences of abuse, neglect, and exploitation.

Additional needs-based criteria for receiving the service, if applicable *(specify): N/A*

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

☑	Categorically needy *(specify limits):*
	The combined total of individual and group Addiction Counseling service may be provided for a maximum of 75 hours (1 hour = 1 unit) per year. Exclusions: • Recipients with withdrawal risk/symptoms whose needs cannot be managed at this level of care or who need detoxification services • Recipients at risk of harm to self or others • Addiction counseling sessions that consist of only education services are not reimbursed

☐	Medically needy *(specify limits): N/A*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional; (B) QBHP.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Service Title:	Addiction Counseling – Family/Couple with Recipient Present (Individual Setting)

Service Definition (Scope):

Family/Couple Addiction Counseling is a planned and organized face-to-face or telehealth according to Indiana Administrative Code. Service with the recipient, where addiction professionals and other clinicians provide counseling intervention with family and/or significant others that work toward the recipient's recovery goals identified in the IICP.

Service Requirements include:

- The Medicaid identified recipient is the focus of the treatment.
- Documentation must support how the service specifically benefits the identified recipient.
- Counseling must demonstrate progress towards and/or achievement of individual treatment goals.
- Referral to available community recovery support programs is available.
- The number of in-person visits and the percentage of time telehealth will be the delivery method of service will be based on what is clinically appropriate and in agreement with the consumer and/or legal guardian.
- The use of telehealth should protect against isolating participants by offering services which are in-person and shall be invoked to prioritize and facilitate community integration.
- As required by 45 CFR § 164.308 (a)(1)(ii), an accurate and thorough risk analysis shall be conducted for any functions utilizing telehealth services to assess the potential risks and vulnerabilities to the confidentiality, integrity, and availability of patient data.
- All telehealth services will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc. Video cameras/monitors are not permitted in bedrooms and bathrooms. Participants are able to turn all telehealth-related devices on/off at their discretion in order to ensure privacy. The provider who is responsible for the treatment of the individual is responsible for training participants on the use of any telehealth-related devices both initially and on-going.
- Telehealth services shall consider and respond to all accessibility needs, including whether hands-on or physical assistance is needed to render the service.

Telehealth services must ensure the health and safety of the individual receiving services by adhering to all abuse, neglect, and exploitation prevention practices that apply to in-person treatment, as well as by providing participants with resources on how to report incidences of abuse, neglect, and exploitation.

Additional needs-based criteria for receiving the service, if applicable *(specify): N/A*

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

☑ Categorically needy *(specify limits):*

The combined total of individual and group Addiction Counseling service may be provided for a maximum of 32 hours (128 15-minute units) per year.

Exclusions:

- Recipients with withdrawal risk/symptoms whose needs cannot be managed at this level of care or who need detoxification services.
- Recipients at risk of harm to self or others.
- Addiction counseling sessions that consist of only education services are not reimbursed.
- Addiction Counseling may not be provided for professional caregivers.

☐ Medically needy *(specify limits): N/A*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify

			that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional; (B) QBHP.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Service Title:	Addiction Counseling – Family/Couple without Recipient Present (Individual Setting)
Service Definition (Scope)*:*	

Family/Couple Addiction Counseling without the recipient present is a series of time-limited, structured, face-to-face or telehealth according to Indiana Administrative Code. Sessions that work toward the goals of the recipient identified in the individualized integrated care plan. Skills training and education is for the family/couple to assist the beneficiary more effectively in learning/implementing these skills. The face-to-face or telehealth according to Indiana Administrative Code. Interaction may be with family members or non-professional caregivers in an individual setting.
Family/Couple Counseling and Therapy must be provided at home (living environment) or other locations outside the clinic setting.

Service Requirements include:

- The Medicaid identified recipient is the focus of the treatment.
- Documentation must support how the service specifically benefits the identified recipient.
- Counseling must demonstrate progress towards and/or achievement of individual treatment goals.
- Referral to available community recovery support programs is available.
- The number of in-person visits and the percentage of time telehealth will be the delivery method of service will be based on what is clinically appropriate and in agreement with the consumer and/or legal guardian.
- The use of telehealth should protect against isolating participants by offering services which are in-person and shall be invoked to prioritize and facilitate community integration.
- As required by 45 CFR § 164.308 (a)(1)(ii), an accurate and thorough risk analysis shall be conducted for any functions utilizing telehealth services to assess the potential risks and vulnerabilities to the confidentiality, integrity, and availability of patient data.
- All telehealth services will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc. Video cameras/monitors are not permitted in bedrooms and bathrooms. Participants are able to turn all telehealth-related devices on/off at their discretion in order to ensure privacy. The provider who is responsible for the treatment of the individual is responsible for training participants on the use of any telehealth-related devices both initially and on-going.
- Telehealth services shall consider and respond to all accessibility needs, including whether hands-on or physical assistance is needed to render the service.

Telehealth services must ensure the health and safety of the individual receiving services by adhering to all abuse, neglect, and exploitation prevention practices that apply to in-person treatment, as well as by providing participants with resources on how to report incidences of abuse, neglect, and exploitation.

Additional needs-based criteria for receiving the service, if applicable *(specify): N/A*

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

☑ Categorically needy *(specify limits):*

The combined total of individual and group Addiction Counseling service may be provided for a maximum of 32 hours (128 15-minute units) per year.

Exclusions:

- Recipients with withdrawal risk/symptoms whose needs cannot be managed at this level of care or who need detoxification services.
- Recipients at risk of harm to self or others.

	• Addiction counseling sessions that consist of only education services are not reimbursed. • Addiction Counseling may not be provided for professional caregivers.
☐	Medically needy *(specify limits): N/A*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional; (B) QBHP.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Service Title:	Addiction Counseling – Group Setting

Service Definition (Scope):

Group Addiction Counseling is a planned and organized face-to-face or telehealth according to Indiana Administrative Code. Service with the recipient where addiction professionals and other clinicians provide counseling intervention in a group setting that works toward the recipient's individualized recovery goals identified in the IICP.

Service Requirements include:

- The Medicaid identified recipient is the focus of the treatment.
- Documentation must support how the service specifically benefits the recipient.
- Treatment consists of regularly scheduled sessions.
- Counseling must demonstrate progress towards and/or achievement of recipient treatment goals.
- Referral to available community recovery support programs is available.
- Services may include the following:
  - Education on addiction disorders.
  - Skills training in communication, anger management, stress management, relapse prevention.
- The number of in-person visits and the percentage of time telehealth will be the delivery method of service will be based on what is clinically appropriate and in agreement with the consumer and/or legal guardian.
- The use of telehealth should protect against isolating participants by offering services which are in-person and shall be invoked to prioritize and facilitate community integration.
- As required by 45 CFR § 164.308 (a)(1)(ii), an accurate and thorough risk analysis shall be conducted for any functions utilizing telehealth services to assess the potential risks and vulnerabilities to the confidentiality, integrity, and availability of patient data.
- All telehealth services will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc. Video cameras/monitors are not permitted in bedrooms and bathrooms. Participants are able to turn all telehealth-related devices on/off at their discretion in order to ensure privacy. The provider who is responsible for the treatment of the individual is responsible for training participants on the use of any telehealth-related devices both initially and on-going.
- Telehealth services shall consider and respond to all accessibility needs, including whether hands-on or physical assistance is needed to render the service.

Telehealth services must ensure the health and safety of the individual receiving services by adhering to all abuse, neglect, and exploitation prevention practices that apply to in-person treatment, as well as by providing participants with resources on how to report incidences of abuse, neglect, and exploitation.

Additional needs-based criteria for receiving the service, if applicable *(specify): N/A*

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

☑	Categorically needy *(specify limits):*
	The combined total of individual and group Addiction Counseling service may be provided for a maximum of 32 hours (128 15-minute units) per year. Exclusions: • Recipients with withdrawal risk/symptoms whose needs cannot be managed at this level of care or who need detoxification services. • Recipients at imminent risk of harm to self or others. • Addiction counseling sessions that consist of only education services are not reimbursed. • Addiction Counseling may not be provided for professional caregivers.
☐	Medically needy *(specify limits): N/A*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements
			defined under 405 IAC 1-5-1 and

			405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional; (B) QBHP.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*	
Service Title:	Addiction Counseling – Family/Couple with Recipient Present (Group Setting)
Service Definition (Scope)*:*	

Group Addiction Counseling with the recipient present is a planned and organized face-to-face or telehealth according to Indiana Administrative Code. Service with the recipient and family members or non-professional caregivers where addiction professionals and other clinicians provide counseling intervention in a group setting that works toward the recipient's individualized recovery goals identified in the IICP. Addiction Counseling must be provided at home (living environment) or other locations outside the clinic setting.

Service Requirements include:

- The Medicaid identified recipient is the focus of the treatment.
- Documentation must support how the service specifically benefits the recipient.
- Treatment consists of regularly scheduled sessions.
- Counseling must demonstrate progress towards and/or achievement of recipient treatment goals.
- Referral to available community recovery support programs is available.
- Services that are included:
    - Education on addiction disorders.
    - Skills training in communication, anger management, stress management, relapse prevention.
- The number of in-person visits and the percentage of time telehealth will be the delivery method of service will be based on what is clinically appropriate and in agreement with the consumer and/or legal guardian.
- The use of telehealth should protect against isolating participants by offering services which are in-person and shall be invoked to prioritize and facilitate community integration.
- As required by 45 CFR § 164.308 (a)(1)(ii), an accurate and thorough risk analysis shall be conducted for any functions utilizing telehealth services to assess the potential risks and vulnerabilities to the confidentiality, integrity, and availability of patient data.
- All telehealth services will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc. Video cameras/monitors are not permitted in bedrooms and bathrooms. Participants are able to turn all telehealth-related devices on/off at their discretion in order to ensure privacy. The provider who is responsible for the treatment of the individual is responsible for training participants on the use of any telehealth-related devices both initially and on-going.
- Telehealth services shall consider and respond to all accessibility needs, including whether hands-on or physical assistance is needed to render the service.

Telehealth services must ensure the health and safety of the individual receiving services by adhering to all abuse, neglect, and exploitation prevention practices that apply to in-person treatment, as well as by providing participants with resources on how to report incidences of abuse, neglect, and exploitation.

Additional needs-based criteria for receiving the service, if applicable *(specify):*	
Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*	
☑	Categorically needy *(specify limits):*
	The combined total of individual and group Addiction Counseling service may be provided for a maximum of 32 hours (128 15-minute units) per year. Exclusions: • Recipients with withdrawal risk/symptoms whose needs cannot be managed at this level of care or who need detoxification services. • Recipients at imminent risk of harm to self or others. • Addiction counseling sessions that consist of only education services are not reimbursed. • Addiction Counseling may not be provided for professional caregivers.
☐	Medically needy *(specify limits): N/A*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA - certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional; (B) QBHP.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*

Agency	DMHA	Initially, and at the time of DMHA certification renewal

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*	
Service Title:	Addiction Counseling – Family/Couple without Recipient Present (Group Setting)
Service Definition (Scope)*:*	

Group Addiction Counseling without the recipient present is a planned and organized face-to-face or telehealth according to Indiana Administrative Code. Service with family members or non-professional caregivers where addiction professionals and other clinicians provide counseling intervention in a group setting that works toward the recipient's individualized recovery goals identified in the IICP. Skills training and education is for the family/couple to assist the beneficiary more effectively in learning/implementing these skills. Addiction Counseling must be provided at home (living environment) or other locations outside the clinic setting.

Service Requirements include:

- The Medicaid identified recipient is the focus of the treatment.
- Documentation must support how the service specifically benefits the recipient.
- Treatment consists of regularly scheduled sessions.
- Counseling must demonstrate progress towards and/or achievement of recipient treatment goals.
- Referral to available community recovery support programs is available.
- Services that are included:
  - Education on addiction disorders.
  - Skills training in communication, anger management, stress management, relapse prevention.
- The number of in-person visits and the percentage of time telehealth will be the delivery method of service will be based on what is clinically appropriate and in agreement with the consumer and/or legal guardian.
- The use of telehealth should protect against isolating participants by offering services which are in-person and shall be invoked to prioritize and facilitate community integration.
- As required by 45 CFR § 164.308 (a)(1)(ii), an accurate and thorough risk analysis shall be conducted for any functions utilizing telehealth services to assess the potential risks and vulnerabilities to the confidentiality, integrity, and availability of patient data.
- All telehealth services will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc. Video cameras/monitors are not permitted in bedrooms and bathrooms. Participants are able to turn all telehealth-related devices on/off at their discretion in order to ensure privacy. The provider who is responsible for the treatment of the individual is responsible for training participants on the use of any telehealth-related devices both initially and on-going.
- Telehealth services shall consider and respond to all accessibility needs, including whether hands-on or physical assistance is needed to render the service.

Telehealth services must ensure the health and safety of the individual receiving services by adhering to all abuse, neglect, and exploitation prevention practices that apply to in-person treatment, as well as by providing participants with resources on how to report incidences of abuse, neglect, and exploitation.

Additional needs-based criteria for receiving the service, if applicable *(specify): N/A*

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

☑	Categorically needy *(specify limits):*
	The combined total of individual and group Addiction Counseling service may be provided for a maximum of 32 hours (128 15-minute units) per year. Exclusions: • Recipients with withdrawal risk/symptoms whose needs cannot be managed at this level of care or who need detoxification services. • Recipients at imminent risk of harm to self or others. • Addiction counseling sessions that consist of only education services are not reimbursed. • Addiction Counseling may not be provided for professional caregivers.
☐	Medically needy *(specify limits): N/A*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*

Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional; (B) QBHP.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Service Title:	Supported Community Engagement Services
Service Definition (Scope)*:*	

Services that engage a recipient in meaningful community involvement in activities such as volunteerism or community service. These include teaching concepts to encourage attendance, task completion, problem solving and safety. Services are aimed at the general result of community engagement. Services are habilitative in nature and shall not include explicit employment objectives.

Service Requirements include:

- Collaboration with the organization to develop an individualized training plan that identifies specific supports required organizational expectations, training strategies, timeframes, and responsibilities.
- Services must be explicitly identified in the IICP and related to goals identified by the recipient.
- Services are provided to members who may benefit from community engagement and are unlikely to achieve this involvement without the provision of support.
- These services shall be provided in a community setting.
- Services include assisting the recipient in developing relationships with community organizations specific to the recipient's interests and needs.
- Allowable activities include teaching the following concepts:
    - Attendance.
    - Task completion; and
    - Problem solving and safety for the purpose of achieving a generalized skill or behavior that may prepare the recipient for an employment setting.

Additional needs-based criteria for receiving the service, if applicable *(specify): N/A*

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

☑	Categorically needy *(specify limits):*
	This service is offered for up to eighteen hours per month (72 15-minute units). Exclusions:

	• If a provider chooses to compensate a recipient for such activities, the provider must use non-Medicaid funding and must be able to document the funding source. • Training in specific job tasks. • Recipients who are currently competitively employed. • Services are not available as vocational rehabilitation services funded under the Rehabilitation Act of 1973.
☐	Medically needy *(specify limits): N/A*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional; (B) QBHP; or (C) OBHP.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal

Service Delivery Method. *(Check each that applies)*:			
☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*	
Service Title:	Care Coordination

Service Definition (Scope)*:*

Care coordination consists of services that help recipients gain access to needed medical, social, educational, and other services. This includes direct assistance in gaining access to services, coordination of care, oversight of the entire case, and linkage to appropriate services. Care coordination includes: (1) assessment of the eligible recipient to determine service needs; (2) development of an individualized integrated care plan (IICP); (3) referral and related activities to help the recipient obtain needed services; (4) monitoring and follow-up; and (5) evaluation. Care coordination does not include direct delivery of medical, clinical, or other direct services. Care coordination is on behalf of the recipient, not to the recipient.

Service Requirements include:

- Care coordination must provide direct assistance in gaining access to needed medical, social, educational, and other services.
- Care coordination includes the development of an individualized integrated care plan, limited referrals to services, and activities or contacts necessary to ensure that the individualized integrated care plan is effectively implemented and adequately addresses the mental health and/or addiction needs of the eligible recipient.
- Care coordination includes:
    - Needs Assessment: focusing on needs identification of the recipient to determine the need for any medical, educational, social, or other services. Specific assessment activities may include: taking recipient history, identifying the needs of the recipient, and completing the related documentation. It also includes the gathering of information from other sources, such as family members or medical providers, to form a complete assessment of the recipient.
    - Individualized Integrated Care Plan Development: the development of a written individualized integrated care plan based upon the information collected through the assessment phase. The individualized integrated care plan identifies the habilitative activities and assistance needed to accomplish the objectives.
    - Referral/Linkage: activities that help link the recipient with medical, social, educational providers, and/or other programs and services that are capable of providing needed habilitative services.
    - Monitoring/Follow-up: Contact must occur at least every 90 days. Contacts and related activities are necessary to ensure the individualized integrated care plan is effectively implemented and adequately addresses the needs of the recipient. The activities and contacts may be with the recipient, family members, non-professional caregivers, providers, and other entities. Monitoring and follow-up are necessary to help determine if services are being furnished in accordance with a service plan of the recipient, the adequacy of the services in the individualized integrated care plan, and

changes in the needs or status of the recipient. This function includes making necessary adjustments in the individualized integrated care plan and service arrangement with providers.

- Evaluation: the care coordinator must periodically reevaluate the recipient's progress toward achieving the individualized integrated care plan's objectives. Based upon the care coordinator's review, a determination would be made on if changes should be made. Time devoted to formal supervision of the case between care coordinator and licensed supervisor are included activities and should be documented accordingly. This must be documented appropriately and billed under one provider only.

Additional needs-based criteria for receiving the service, if applicable *(specify):N/A*

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

☑ Categorically needy *(specify limits):*

Care Coordination service may be provided for a maximum of 400 hours (1600 15- minute units) per year.

Exclusions:

- Activities billed under Behavioral Health Reassessment (by a non-physician).
- The actual or direct provision of medical services or treatment. Examples include, but are not limited to:
  - Training in daily living skills.
  - Training in work skills and social skills.
  - Grooming and other personal services.
  - Training in housekeeping, laundry, cooking.
  - Transportation services.
  - Individual, group, or family therapy services.
  - Crisis intervention services.
  - Services that go beyond assisting the recipient in gaining access to needed services. Examples include:
    - Paying bills and/or balancing the recipient's checkbook.
    - Traveling to and from appointments with recipients.

☐ Medically needy *(specify limits): N/A*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain

			documentation in accordance

			with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Licensed professional; (B) QBHP; or (C) OBHP.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Service Title:	Medication Training and Support – Individual Setting

Service Definition (Scope):
Individual Medication Training and Support involves face-to-face or telehealth according to Indiana Administrative Code, contact with the recipient, in an individual setting, for the purpose of monitoring medication compliance, providing education and training about medications, monitoring medication side effects, and providing other nursing or medical assessments. Medication Training and Support also includes certain related non face-to-face activities. Service Requirements include: • Face-to-face contact in an individual setting that includes monitoring self-administration of prescribed medications and monitoring side effects, including weight, blood glucose level, and blood pressure. • When provided in a clinic setting, Medication Training and Support may compliment, but not duplicate, activities associated with medication management activities available under the Clinic Option. • When provided in residential treatment settings, Medication Training and Support may include components of medication management services.

- The recipient is the focus of the service.
- Documentation must support how the service benefits the recipient.
- Medication Training and Support must demonstrate movement toward and/or achievement of recipient treatment goals identified in the individualized integrated care plan (IICP).
- Medication Training and Support goals are habilitative in nature
- Medication Training and Support may also include the following services that are not required to be provided face-to-face with the recipient:
  - Transcribing physician or AHCP medication orders.
  - Setting or filling medication boxes.
  - Consulting with the attending physician or AHCP regarding medication-related issues.
  - Ensuring linkage that lab and/or other prescribed clinical orders are sent.
  - Ensuring that the recipient follows through and receives lab work and services pursuant to other clinical orders.
  - Follow up reporting of lab and clinical test results to the recipient and physician.
- The number of in-person visits and the percentage of time telehealth will be the delivery method of service will be based on what is clinically appropriate and in agreement with the consumer and/or legal guardian.
- The use of telehealth should protect against isolating participants by offering services which are in-person and shall be invoked to prioritize and facilitate community integration.
- As required by 45 CFR § 164.308 (a)(1)(ii), an accurate and thorough risk analysis shall be conducted for any functions utilizing telehealth services to assess the potential risks and vulnerabilities to the confidentiality, integrity, and availability of patient data.
- All telehealth services will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc. Video cameras/monitors are not permitted in bedrooms and bathrooms. Participants are able to turn all telehealth-related devices on/off at their discretion in order to ensure privacy. The provider who is responsible for the treatment of the individual is responsible for training participants on the use of any telehealth-related devices both initially and on-going.
- Telehealth services shall consider and respond to all accessibility needs, including whether hands-on or physical assistance is needed to render the service.

  Telehealth services must ensure the health and safety of the individual receiving services by adhering to all abuse, neglect, and exploitation prevention practices that apply to in-person treatment, as well as by providing participants with resources on how to report incidences of abuse, neglect, and exploitation.

Additional needs-based criteria for receiving the service, if applicable *(specify): N/A*

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

	Categorically needy *(specify limits):*
	Medication Training and Support service including all subtypes (individual, group, family/couple, with and without recipient present) may be provided for a maximum of 182 hours (728 15- minute units) per year. Exclusions: • If clinic option medication management, counseling, or psychotherapy is provided and medication management is a component, then Medication Training and Support may not be billed separately for the same visit by the same provider. • Coaching and instruction regarding recipient self-administration of medications is not reimbursable under Medication Training and Support but may be billed as Skills Training and Development.
☐	Medically needy *(specify limits): N/A*
Provider Qualifications *(For each type of provider. Copy rows as needed)*:	

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements

			defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (E) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Medication Training and Support is provided within the scope of practice as defined by federal and state law. (B)Agencies certify that individual providing the service meets the following qualifications: • Licensed physician • Authorized health care professional (AHCP) • Licensed registered nurse (RN) • Licensed practical nurse (LPN) • Medical Assistant (MA) who has graduated from a two (2) year clinical program.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*	
Service Title:	Medication Training and Support – Family/Couple with the Recipient Present (Individual Setting)
Service Definition (Scope)*:*	

Family/Couple Medication Training and Support with the recipient present involves face-to-face or telehealth according to Indiana Administrative Code, contact with the recipient and family members or other non-professional caregivers, in an individual
setting, for the purpose of monitoring medication compliance, providing education and training about medications, monitoring medication side effects, and providing other nursing and medical assessments. Medication Training and Support also includes certain non-face-to-face activities.

Service Requirements include:

- Face-to-face contact in an individual setting with family members or non-professional caregivers in support of the recipient.
- May include training of family members or non-professional caregivers to monitor self-administration of prescribed medications and monitoring side effects, including weight, blood glucose level, and blood pressure.
- When provided in the clinic setting, Medication Training and Support may compliment, but not duplicate, activities associated with medication management activities available under the Clinic Option.
- When provided in residential treatment settings, Medication Training and Support may include components of medication management services.
- The recipient is the focus of Medication Training and Support.
- Documentation must support how the service benefits the recipient, including when Medication Training and Support is provided in a group setting.
- Medication Training and Support results in demonstrated movement toward, or achievement of, the recipient's treatment goals identified by the individualized integrated care plan.
- Medication Training and Support goals are habilitative in nature.
- The number of in-person visits and the percentage of time telehealth will be the delivery method of service will be based on what is clinically appropriate and in agreement with the consumer and/or legal guardian.
- The use of telehealth should protect against isolating participants by offering services which are in-person and shall be invoked to prioritize and facilitate community integration.
- As required by 45 CFR § 164.308 (a)(1)(ii), an accurate and thorough risk analysis shall be conducted for any functions utilizing telehealth services to assess the potential risks and vulnerabilities to the confidentiality, integrity, and availability of patient data.
- All telehealth services will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc. Video cameras/monitors are not permitted in bedrooms and bathrooms. Participants are able to turn all telehealth-related devices on/off at their discretion in order to ensure privacy. The provider who is responsible for the treatment of the individual is responsible for training participants on the use of any telehealth-related devices both initially and on-going.
- Telehealth services shall consider and respond to all accessibility needs, including whether hands-on or physical assistance is needed to render the service.

Telehealth services must ensure the health and safety of the individual receiving services by adhering to all abuse, neglect, and exploitation prevention practices that apply to in-person treatment, as well as by providing participants with resources on how to report incidences of abuse, neglect, and exploitation.

Additional needs-based criteria for receiving the service, if applicable *(specify): N/A*

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

☑	Categorically needy *(specify limits):*
	Medication Training and Support service including all subtypes (individual, group, family/couple, with and without recipient present) may be provided for a maximum of 182 hours (728 15-minute units) per year. Exclusions: • If Clinic Option medication management, counseling, or psychotherapy is provided and medication management is a component, then Medication Training and Support may not be billed separately for the same visit by the same provider. • Coaching and instruction regarding recipient self-administration of medications is not reimbursable under Medication Training and Support but may be billed as Skills Training and Development.
☐	Medically needy *(specify limits):N/A*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an

			entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Medication Training and Support is provided within the scope of practice as defined by federal and state law. (B) Agencies certify that individual providing the service meets the following qualifications: • Licensed physician • Authorized health care professional (AHCP) • Licensed registered nurse (RN) • Licensed practical nurse (LPN) • Medical Assistant (MA) who has graduated from a two (2) year clinical program

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*	
Service Title:	Medication Training and Support – Family/Couple without the Recipient Present (Individual Setting)
Service Definition (Scope)*:*	

Family/Couple Medication Training and Support without the recipient present involves face-to-face or telehealth according to Indiana Administrative Code, contact with family members or other non-professional caregivers, in an individual setting, for the purpose of monitoring medication compliance, providing education and training about medications, monitoring medication side effects, and providing other nursing and medical assessments. Skills training and education is for the family/couple to assist the beneficiary more effectively in learning/implementing these skills. Medication Training and Support also includes certain non face-to-face activit
Service Requirements include:

- Face-to-face contact in an individual setting with family members or non-professional caregivers on behalf of the recipient.
- May include training of family members or non-professional caregivers to monitor assist with administration of prescribed medications and monitoring side effects, including weight, blood glucose level, and blood pressure.
- When provided in the clinic setting, Medication Training and Support may compliment, but not duplicate, activities associated with medication management activities available under the Clinic Option.
- When provided in residential treatment settings, Medication Training and Support may include components of medication management services.
- The recipient is the focus of Medication Training and Support.
- Documentation must support how the service benefits the recipient, including when Medication Training and Support is provided in a group setting.
- Medication Training and Support results in demonstrated movement toward, or achievement of, the recipient's treatment goals identified by the individualized integrated care plan.
- Medication Training and Support goals are habilitative in nature.
- The number of in-person visits and the percentage of time telehealth will be the delivery method of service will be based on what is clinically appropriate and in agreement with the consumer and/or legal guardian.
- The use of telehealth should protect against isolating participants by offering services which are in-person and shall be invoked to prioritize and facilitate community integration.
- As required by 45 CFR § 164.308 (a)(1)(ii), an accurate and thorough risk analysis shall be conducted for any functions utilizing telehealth services to assess the potential risks and vulnerabilities to the confidentiality, integrity, and availability of patient data.
- All telehealth services will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc. Video cameras/monitors are not permitted in bedrooms and bathrooms. Participants are able to turn all telehealth-related devices on/off at their discretion in order to ensure privacy. The provider who is responsible for the treatment of the individual is responsible for training participants on the use of any telehealth-related devices both initially and on-going.
- Telehealth services shall consider and respond to all accessibility needs, including whether hands-on or physical assistance is needed to render the service.

Telehealth services must ensure the health and safety of the individual receiving services by adhering to all abuse, neglect, and exploitation prevention practices that apply to in-person treatment, as well as by providing participants with resources on how to report incidences of abuse, neglect, and exploitation.

Additional needs-based criteria for receiving the service, if applicable *(specify): N/A*	
Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*	
☑	Categorically needy *(specify limits):*
	Medication Training and Support service including all subtypes (individual, group, family/couple, with and without recipient present) may be provided for a maximum of 182 hours (728 15-minute units) per year. Exclusions: • If Clinic Option medication management, counseling, or psychotherapy is provided and medication management is a component, then Medication Training and Support may not be billed separately for the same visit by the same provider. • Coaching and instruction regarding recipient self-administration of medications is not reimbursable under Medication Training and Support but may be billed as Skills Training and Development.

☐ Medically needy *(specify limits):N/A*			
Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Medication Training and Support is provided within the scope of practice as defined by federal and state law. (B) Agencies certify that individual providing the service meets the following qualifications: • Licensed physician • Authorized health care professional (AHCP) • Licensed registered nurse (RN) • Licensed practical nurse (LPN) • Medical Assistant (MA) who has graduated from a two (2) year clinical program
Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:			

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*	
Service Title:	Medication Training and Support – Group Setting
Service Definition (Scope)*:*	

Group Medication Training and Support involves face-to-face or telehealth according to Indiana Administrative Code, contact with the recipient, in a group setting, for the purpose of providing education and training about medications and medication side effects.

Service Requirements include:

- Face-to-face contact in a group setting that includes monitoring self-administration of prescribed medications and monitoring side effects, including weight, blood glucose level, and blood pressure.
- When provided in the clinic setting, Medication Training and Support may compliment, but not duplicate, activities associated with medication management activities available under the Clinic Option.
- When provided in residential treatment settings, Medication Training and Support may include components of medication management services.
- The recipient is the focus of Medication Training and Support.
- Documentation must support how the service benefits the recipient, including when services are provided in a group setting.
- Medication Training and Support results in demonstrated movement toward, or achievement of, the recipient's treatment goals identified in the individualized integrated care plan (IICP).
- Medication Training and Support goals are habilitative in nature.
- The number of in-person visits and the percentage of time telehealth will be the delivery method of service will be based on what is clinically appropriate and in agreement with the consumer and/or legal guardian.
- The use of telehealth should protect against isolating participants by offering services which are in-person and shall be invoked to prioritize and facilitate community integration.
- As required by 45 CFR § 164.308 (a)(1)(ii), an accurate and thorough risk analysis shall be conducted for any functions utilizing telehealth services to assess the potential risks and vulnerabilities to the confidentiality, integrity, and availability of patient data.
- All telehealth services will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc. Video cameras/monitors are not permitted in bedrooms and bathrooms. Participants are able to turn all telehealth-related devices on/off at their discretion in order to ensure privacy. The provider who is responsible for the treatment of the individual is responsible for training participants on the use of any telehealth-related devices both initially and on-going.
- Telehealth services shall consider and respond to all accessibility needs, including whether hands-on or physical assistance is needed to render the service.

Telehealth services must ensure the health and safety of the individual receiving services by adhering to all abuse, neglect, and exploitation prevention practices that apply to in-person treatment, as well as by providing participants with resources on how to report incidences of abuse, neglect, and exploitation.

Additional needs-based criteria for receiving the service, if applicable *(specify): N/A*

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

☑	Categorically needy *(specify limits):*
	Medication Training and Support service including all subtypes (individual, group, family/couple, with and without recipient present) may be provided for a maximum of 182 hours (728 15-minute units) per year. Exclusions: • If Clinic Option medication management, counseling, or psychotherapy is provided and medication management is a component, then Medication Training and Support may not be billed separately for the same visit by the same provider. • Coaching and instruction regarding recipient self-administration of medications is not

	reimbursable under Medication Training and Support but may be billed as Skills Training and Development.
☐	Medically needy *(specify limits): N/A*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Medication Training and Support is provided within the scope of practice as defined by federal and state law. (B) Agencies certify that individual providing the service meets the following qualifications: • Licensed physician • Authorized health care professional (AHCP) • Licensed registered nurse (RN) • Licensed practical nurse (LPN) • Medical Assistant (MA) who has graduated from a two (2) year clinical program

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:		
Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal

Service Delivery Method. *(Check each that applies)*:			
☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*	
Service Title:	Medication Training and Support – Family/Couple with the Recipient Present (Group Setting)
Service Definition (Scope)*:*	

Family/Couple Medication Training and Support with the recipient present involves face-to-face or telehealth according to Indiana Administrative Code, contact, in a group setting with the recipient and family members or other non-professional caregivers, for the purpose of providing education and training about medications and medication side effects.

Service Requirements include:

- Face-to-face contact with family members or non-professional caregivers in support of a recipient that includes education and training on the administration of prescribed medications and side effects including weight, blood glucose level, and blood pressure, and/or conducting medication groups or classes.
- When provided in the clinic setting, Medication Training and Support may compliment, but not duplicate, activities associated with medication management activities available under the Clinic Option.
- When provided in residential treatment settings, Medication Training and Support may include components of medication management services.
- The recipient is the focus of Medication Training and Support.
- Documentation must support how the service benefits the recipient, including when services are provided in a group setting.
- Medication Training and Support results in demonstrated movement toward, or achievement of, the recipient's treatment goals identified in the individualized integrated care plan.
- Medication Training and Support goals are habilitative in nature.
- The number of in-person visits and the percentage of time telehealth will be the delivery method of service will be based on what is clinically appropriate and in agreement with the consumer and/or legal guardian.
- The use of telehealth should protect against isolating participants by offering services which are in-person and shall be invoked to prioritize and facilitate community integration.
- As required by 45 CFR § 164.308 (a)(1)(ii), an accurate and thorough risk analysis shall be conducted for any functions utilizing telehealth services to assess the potential risks and vulnerabilities to the confidentiality, integrity, and availability of patient data.
- All telehealth services will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc. Video cameras/monitors are not permitted in bedrooms and bathrooms. Participants are able to turn all telehealth-related devices on/off at their discretion in order to ensure privacy. The provider who is responsible for the treatment of the individual is responsible for training participants on the use of any telehealth-related devices both initially and on-going.
- Telehealth services shall consider and respond to all accessibility needs, including whether hands-on or physical assistance is needed to render the service.

Telehealth services must ensure the health and safety of the individual receiving services by adhering to all abuse, neglect, and exploitation prevention practices that apply to in-person treatment, as well as by providing participants with resources on how to report incidences of abuse, neglect, and exploitation.

Additional needs-based criteria for receiving the service, if applicable *(specify): N/A*

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

☑	Categorically needy *(specify limits):*
	Medication Training and Support service including all subtypes (individual, group, family/couple, with and without recipient present) may be provided for a maximum of 182 hours (728 15-minute units) per year. Exclusions:

	• If Clinic Option medication management, counseling or psychotherapy is provided and medication management is a component, then Medication Training and Support may not be billed separately for the same visit by the same provider. • Coaching and instruction regarding recipient self-administration of medications is not reimbursable under Medication Training and Support but may be billed as Skills Training and Development. • The following non face-to-face services are excluded: o Transcribing physician or AHCP medication orders. o Setting or filling medication boxes. o Consulting with the attending physician or AHCP regarding medication-related issues. o Ensuring linkage that lab and/or other prescribed clinical orders are sent. o Ensuring that the recipient follows through, and receives lab work and other clinical orders. o Follow up reporting of lab and clinical test results to the recipient and physician. • Medication Training and Support may not be provided to professional caregivers.
☐	Medically needy *(specify limits):N/A*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows:

			(A) Training and Support is provided within the scope of practice as defined by federal and state law. (B) Agencies certify that individual providing the service meets the following qualifications: • Licensed physician • Authorized health care professional (AHCP) • Licensed registered nurse (RN) • Licensed practical nurse (LPN) • Medical Assistant (MA) who has graduated from a two (2) year clinical program

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*	
Service Title:	Medication Training and Support – Family/Couple without the Recipient Present (Group Setting)
Service Definition (Scope)*:*	

Family/Couple Medication Training and Support without the recipient present is conducted face-to-face or telehealth according to Indiana Administrative Code, in a group setting with family members or other non-professional caregivers The purpose is to provide skills training and education for the family/couple to more effectively assist the beneficiary in learning/implementing skills about medications and medication side effects. .

Service Requirements include:

- Face-to-face contact with family members or non-professional caregivers on behalf of a recipient that includes education and training on the administration of prescribed medications and side effects including weight, blood glucose level, and blood pressure, and/or conducting medication groups or classes.
- When provided in the clinic setting, Medication Training and Support may compliment, but not duplicate, activities associated with medication management activities available under the Clinic Option.
- When provided in residential treatment settings, Medication Training and Support may include components of medication management services.
- The recipient is the focus of Medication Training and Support.

- Documentation must support how the service benefits the recipient, including when services are provided in a group setting and the recipient is not present.
- Medication Training and Support results in demonstrated movement toward, or achievement of, the recipient's treatment goals identified in the individualized integrated care plan.
- Medication Training and Support goals are habilitative in nature.
- The number of in-person visits and the percentage of time telehealth will be the delivery method of service will be based on what is clinically appropriate and in agreement with the consumer and/or legal guardian.
- The use of telehealth should protect against isolating participants by offering services which are in-person and shall be invoked to prioritize and facilitate community integration.
- As required by 45 CFR § 164.308 (a)(1)(ii), an accurate and thorough risk analysis shall be conducted for any functions utilizing telehealth services to assess the potential risks and vulnerabilities to the confidentiality, integrity, and availability of patient data.
- All telehealth services will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc. Video cameras/monitors are not permitted in bedrooms and bathrooms. Participants are able to turn all telehealth-related devices on/off at their discretion in order to ensure privacy. The provider who is responsible for the treatment of the individual is responsible for training participants on the use of any telehealth-related devices both initially and on-going.
- Telehealth services shall consider and respond to all accessibility needs, including whether hands-on or physical assistance is needed to render the service.

Telehealth services must ensure the health and safety of the individual receiving services by adhering to all abuse, neglect, and exploitation prevention practices that apply to in-person treatment, as well as by providing participants with resources on how to report incidences of abuse, neglect, and exploitation.

Additional needs-based criteria for receiving the service, if applicable *(specify): N/A*

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

☑	Categorically needy *(specify limits):*
	Medication Training and Support service including all subtypes (individual, group, family/couple, with and without recipient present) may be provided for a maximum of 182 hours (728 15-minute units) per year. Exclusions: • If Clinic Option medication management, counseling or psychotherapy is provided and medication management is a component, then Medication Training and Support may not be billed separately for the same visit by the same provider. • Coaching and instruction regarding recipient self-administration of medications is not reimbursable under Medication Training and Support but may be billed as Skills Training and Development. • The following non face-to-face services are excluded: o Transcribing physician or AHCP medication orders. o Setting or filling medication boxes. o Consulting with the attending physician or AHCP regarding medication-related issues. o Ensuring linkage that lab and/or other prescribed clinical orders are sent. o Ensuring that the recipient follows through, and receives lab work and other clinical orders. o Follow up reporting of lab and clinical test results to the recipient and physician. • Medication Training and Support may not be provided to professional caregivers.
☐	Medically needy *(specify limits):N/A*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved AMHH provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: (A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. (B) Provider agency is an enrolled Medicaid provider that offers a full continuum of care. (C) Provider agency must maintain documentation in accordance

			with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. (D) Provider agency must meet all AMHH provider agency criteria, as defined in the benefit and AMHH operating policy. In addition to meeting criteria for a provider agency, the agency must certify that the agency staff providing an AMHH service must meet the following standards for this service, as follows: (A) Medication Training and Support is provided within the scope of practice as defined by federal and state law. (B) Agencies certify that individual providing the service meets the following qualifications: • Licensed physician • Authorized health care professional (AHCP) • Licensed registered nurse (RN) • Licensed practical nurse (LPN) • Medical Assistant (MA) who has graduated from a two (2) year clinical program

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	DMHA	Initially, and at the time of DMHA certification renewal

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

2. ☐ **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the state assures that):* There are policies pertaining to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state*

ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. Election of Participant-Direction. (*Select one):*

☑	The state does not offer opportunity for participant-direction of State plan HCBS.
○	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. *(Specify criteria):*

2. Description of Participant-Direction. (Provide an overview of the opportunities for participant-direction *under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

Indiana does not offer self-directed care.

3. Limited Implementation of Participant-Direction. (*Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewide requirements. Select one):*

○	Participant direction is available in all geographic areas in which State plan HCBS are available.
○	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the state affected by this option)*:

4. Participant-Directed Services. *(Indicate the State plan HCBS that may be participant-directed, and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐

5. Financial Management. (*Select one)* :

○	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
○	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. ☐Participant–Directed Person-Centered Service Plan. *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:

- Specifies the State plan HCBS that the individual will be responsible for directing;
- Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget;
- Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual;
- Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
- Specifies the financial management supports to be provided.

7. Voluntary and Involuntary Termination of Participant-Direction. (*Describe how the state facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

8. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can select, manage, and dismiss State plan HCBS providers). (*Select one):*

○	The state does not offer opportunity for participant-employer authority.	
○	Participants may elect participant-employer Authority *(Check each that applies):*	
	☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
	☐	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. Participant–Budget Authority (individual directs a budget that does not result in payment for medical assistance to the individual). (*Select one):*

○	The state does not offer opportunity for participants to direct a budget.
○	Participants may elect Participant–Budget Authority.

	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):*
	Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.*

Quality Improvement Strategy

Quality Measures

(Describe the state's quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

1. **Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and (c document choice of services and providers.**

Requirement	1a. Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of IICPs that address recipient's needs *N: Total number IICPs reviewed that address recipient needs* *D: Total number of IICPs reviewed*
Discovery Activity *(Source of Data & sample size)*	100% of IICPs are reviewed and approved through the waiver database
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Division of Mental Health and Addiction; The State Evaluation Team (SET) annually reviews 100% of all individualized integrated care plans (IICPs) through both the Data Assessment Registry Mental Health and Addiction (DARMHA) database and the required annual AMHH provider Quality Assurance onsite reviews. During the reviews of the IICPs, the SET ensures they are updated timely and there is documentation that supports the applicant received a choice of services and providers. Analysis and aggregation are ongoing. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Division of Mental Health and Addiction
Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

Requirement	1b. Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of IICPs reviewed and revised as warranted on or before annual review date *N: Total number of IICPs reviewed and revised as warranted on or before the annual review date* *D: Total number of IICPs due*
Discovery Activity	100% of IICPs are reviewed and approved through the waiver database

(Source of Data & sample size)	
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Division of Mental Health and Addiction; The State Evaluation Team (SET) annually reviews 100% of all individualized integrated care plans (IICPs) through both the Data Assessment Registry Mental Health and Addiction (DARMHA) database and the required annual AMHH provider Quality Assurance onsite reviews. During the reviews of the IICPs, the SET ensures they are updated timely and there is documentation that supports the applicant received a choice of services and providers. Analysis and aggregation are ongoing. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Division of Mental Health and Addiction
Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

Requirement	1c. Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.
Discovery	

	Discovery Evidence *(Performance Measure)*	Number and percent of recipients with documentation of choice of eligible services *N: Number and percent of recipients with documentation of choice of eligible services* *D: Total number of recipients reviewed*
	Discovery Activity *(Source of Data & sample size)*	Record Review – on site/off site with 95% confidence level with 5% margin of error
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Division of Mental Health and Addiction; The State Evaluation Team (SET) annually reviews 100% of all individualized integrated care plans (IICPs) through both the Data Assessment Registry Mental Health and Addiction (DARMHA) database and the required annual AMHH provider Quality Assurance onsite reviews. During the reviews of the IICPs, the SET ensures they are updated timely and there is documentation that supports the applicant received a choice of services and providers. Analysis and aggregation are ongoing. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.
	Frequency	Ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Division of Mental Health and Addiction
	Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

Requirement	1d. Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.
Discovery	

	Discovery Evidence *(Performance Measure)*	Number and percent of recipients with documentation of choice of providers *N: Total number of recipients reviewed who had documentation of choice of providers* *D: Total number of recipients reviewed*
	Discovery Activity *(Source of Data & sample size)*	Record Review – on site/off site with 95% confidence level with 5% margin of error
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Division of Mental Health and Addiction; The State Evaluation Team (SET) annually reviews 100% of all individualized integrated care plans (IICPs) through both the Data Assessment Registry Mental Health and Addiction (DARMHA) database and the required annual AMHH provider Quality Assurance onsite reviews. During the reviews of the IICPs, the SET ensures they are updated timely and there is documentation that supports the applicant received a choice of services and providers. Analysis and aggregation are ongoing. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.
	Frequency	Ongoing
Remediation		

	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Division of Mental Health and Addiction
	Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

2. Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.

Requirement	2a. An evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of new enrollees who had an evaluation for AMHH eligibility prior to enrollment *N=The number of new enrollees who had an evaluation for AMHH eligibility prior to enrollment* *D=The total number of new enrollees*
Discovery Activity *(Source of Data & sample size)*	Record Review – on site/off site with 95% confidence level with 5% margin of error
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Division of Mental Health and Addiction; For each application for AMHH that is submitted to the SET, providers are required to complete a face- to-face or telehealth according to Indiana Administrative Code AMHH evaluation and Adult Needs Strengths Assessment for each applicant. Information from the evaluation assessment is submitted along with an IICP with other supporting documentation to the SET for review for eligibility. The process is the same for the AMHH renewal as it is for an initial AMHH service request. The SET conducts annual QA review to verify compliance of eligibility requirements.
Frequency	Ongoing

Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Division of Mental Health and Addiction
Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

Requirement	2b. The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of *Adult Needs and Strengths Assessment (ANSA)s* that were completed according to policy *N: Total number of applicants that had an up-to-date ANSA at time of submission of IICP according to policy* *D: Total number applicants that required an ANSA*
Discovery Activity *(Source of Data & sample size)*	Record Review – on site/off site with 95% confidence level with 5% margin of error
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Division of Mental Health and Addiction; For each application for AMHH that is submitted to the SET, providers are required to complete a face- to-face or telehealth according to Indiana Administrative Code AMHH evaluation and Adult Needs Strengths Assessment for each applicant. Information from the evaluation assessment is submitted along with an IICP with other supporting documentation to the SET for review for eligibility. The process is the same for the AMHH renewal as it is for an initial AMHH service request. The SET conducts annual QA review to verify compliance of eligibility requirements.
Frequency	Ongoing
Remediation	

	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Division of Mental Health and Addiction
	Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.
Requirement		2c. The 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of AMHH re-evaluations conducted *N: Number of AMHH evaluations documented as face-to-face* or telehealth according to Indiana Administrative Code *in a progress note at least annually* *D: Number of AMHH evaluations required*
	Discovery Activity *(Source of Data & sample size)*	Record Review – on site/off site with 95% confidence level with 5% margin of error
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Division of Mental Health and Addiction; For each application for AMHH that is submitted to the SET, providers are required to complete a face- to-face or telehealth according to Indiana Administrative Code AMHH evaluation and Adult Needs Strengths Assessment for each applicant. Information from the evaluation assessment is submitted along with an IICP with other supporting documentation to the SET for review for eligibility. The process is the same for the AMHH renewal as it is for an initial AMHH service request. The SET conducts annual QA review to verify compliance of eligibility requirements.
	Frequency	Ongoing

Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Division of Mental Health and Addiction
Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

3. Providers meet required qualifications.

Requirement	3a. Providers meet required qualifications.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of provider agencies that meet qualifications at time of enrollment *N: Total number of providers enrolled that met qualifications at the time of enrollment* *D: Total number of providers enrolled*
Discovery Activity *(Source of Data & sample size)*	100% of provider agency applications are reviewed prior to approval
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Division of Mental Health and Addiction; FSSA's Division of Mental Health and Addiction (DMHA) certified Community Mental Health Centers (CMHCs) are permitted by Indiana's State Medicaid agency (OMPP) to be approved to by DMHA provide AMHH services according to the standards and expectations outlined in the 1915(i) State Plan Benefit. CMHCs approved by DMHA to provide AMHH services must meet all provider agency standards documented in the State Plan Benefit and ensure that all direct care agency staff members providing AMHH services to a recipient meet all standards required for the service being provided. Analysis and aggregation are ongoing. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.
Frequency	Ongoing
Remediation	

	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Division of Mental Health and Addiction
	Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

Requirement		3b. Providers meet required qualifications.
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of provider agencies recertified timely. *N: Total number of agencies recertified timely* *D: Total number of agencies recertified*
	Discovery Activity *(Source of Data & sample size)*	100% of provider agency applications are reviewed prior to approval
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Division of Mental Health and Addiction; FSSA's Division of Mental Health and Addiction (DMHA) certified Community Mental Health Centers (CMHCs) are permitted by Indiana's State Medicaid agency (OMPP) to be approved to by DMHA provide AMHH services according to the standards and expectations outlined in the 1915(i) State Plan Benefit. CMHCs approved by DMHA to provide AMHH services must meet all provider agency standards documented in the State Plan Benefit and ensure that all direct care agency staff members providing AMHH services to a recipient meet all standards required for the service being provided. Analysis and aggregation are ongoing. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.
	Frequency	Every three years or at time of reaccreditation
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Division of Mental Health and Addiction
	Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

4. Settings meet the home and community-based setting requirements as specified in this benefit and in accordance with 42 CFR 441.710(a)(1) and (2).

Requirement	4a. Settings meet the home and community-based setting requirements as specified in this benefit and in accordance with 42 CFR 441.710(a)(1) and (2).
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of settings in compliance with criteria that meets standards for community living *N: Total number of IICPs with compliant HCBS settings* *D: Total number of IICPs reviewed*
Discovery Activity *(Source of Data & sample size)*	100% of IICPs will be reviewed to ensure members reside in HCBS compliant settings

Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Division of Mental Health and Addiction; The State assures that the settings transition plan included with this SPA renewal will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. The State will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its SPA when it submits the next amendment or renewal. HCBS surveys are to be completed by the provider and every member that resided in the setting and then returned to the SET for compliance determinations. Settings are determined to be either Fully Compliant, Needs Modifications and/or Potential Presumed Institutional. Once the provider is informed of the assigned setting compliance designations, the provider determines if they wanted to pursue HCBS compliance or to opt out of providing HCBS services. The Setting Action Plan (SAP) requires the provider to identify action steps for the setting to come into compliance. Once the SAP is returned to the SET and the action steps meet the intent of the final rule, the settings listed under the provider are then determined to be fully compliant with the HCBS requirements. The provider has a total of 180 days, with a possible additional 180 day extension, to have their setting come into compliance. Once a determination is made by the SET, the provider is notified of this decision. DMHA-approved CMHCs receive assistance provided by the State via webinars, onsite trainings and technical assistance calls to increase the understanding of HCBS requirements for providers to successfully implement the HCBS standards.
Frequency	Ongoing
Remediation	

	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Division of Mental Health and Addiction
	Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. IICPs that list a non-HCBS setting as a residence will be returned by the State for additional information within 5 business days with requirement that updated plan is resubmitted within 5 business days for a total of 10 business days.

5. The SMA retains authority and responsibility for program operations and oversight.

Requirement	5a. The SMA retains authority and responsibility for program operations and oversight.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of performance measure data reports from DMHA and contracted entities reviewed to ensure administrative oversight. *N=Number of data reports provided timely and in format.* *D=Number of data reports due.*
Discovery Activity *(Source of Data & sample size)*	100% review of DMHA Administrative Authority Quality Management Report
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	OMPP
Frequency	Quarterly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA and OMPP
Frequency *(of Analysis and Aggregation)*	Quarterly

6. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.

Requirement	6a. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.
Discovery	

	Discovery Evidence *(Performance (Measure)*	Number and percent of 1915(i) claims paid during the review period according to the published rate. *N: Total number of claims paid according to the published rate* *D: Total number of claims submitted*
	Discovery Activity *(Source of Data & sample size)*	Medicaid Management Information System (MMIS) claims data reports 100% review
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	OMPP and Medicaid Fiscal Contractor
	Frequency	Monthly
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	OMPP & DMHA 45 days
	Frequency *(of Analysis and Aggregation)*	Monthly

Requirement	6b. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.
Discovery	

	Discovery Evidence *(Performance Measure)*	Number and percent of 1915(i) claims paid during the review period for recipients enrolled in the 1915(i) program on the date the service was delivered. *N: Total number of claims paid during the review period for recipients enrolled in the AMHH on the date of service delivery* *D: Total number of claims paid during the review period*
	Discovery Activity *(Source of Data & (sample size)*	OMPP & Medicaid Management Information System (MMIS) claims data reports 100% review
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	OMPP and Medicaid Fiscal Contractor
	Frequency	Monthly
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	OMPP & DMHA 45 days
	Frequency *(of Analysis and Aggregation)*	Quarterly

7. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation; medication errors; and the use of restraints.

Requirement	7a. The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation; medication errors; and use of restraints.
Discovery	

Discovery Evidence *(Performance Measure)*	Number and percent of IICPs that address health and welfare needs of the recipient. *N: Total number of IICPs reviewed that addressed the health and welfare needs of a recipient* *D: Total number of IICPs reviewed*
Discovery Activity *(Source of Data & sample size)*	100% of IICPs reviewed to ensure health and welfare needs are addressed
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Division of Mental Health and Addiction; The State will review 100% of all IICPs to ensure health and welfare needs are addressed as well as review 100% of all submitted incident reports to monitor if the incident report is submitted within the required timeframe. Analysis and aggregation are ongoing. Incomplete IICPs will be returned by the State for additional information within 5 business days with requirement that updated plan is resubmitted within 5 business days for a total of 10 business days.
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Division of Mental Health and Addiction
Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. Incomplete IICP will be returned by the State for additional information within 5 business days with requirement that updated plan is resubmitted within 5 business days for a total of 10 business days.

Requirement	7b. The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation; medication errors; and use of restraints.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of incidents reported within required timeframe. *N: Total number of incident reports submitted within the required timeframe* *D: Total number of incident reports submitted*
Discovery Activity *(Source of Data & sample size)*	100% review of incident reports submitted

	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Division of Mental Health and Addiction
	Frequency	Ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Division of Mental Health and Addiction; The State will review 100% of all IICPs to ensure health and welfare needs are addressed as well as review 100% of all submitted incident reports to monitor if the incident report is submitted within the required timeframe. Analysis and aggregation are ongoing. Incomplete IICPs will be returned by the State for additional information within 5 business days with requirement that updated plan is resubmitted within 5 business days for a total of 10 business days.
	Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. Report submitted to State within 72 hours. State will review plan and respond within 5 business days. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

Requirement		7c. The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation; medication errors; and use of restraints.
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of reports for medication errors resolved according to policy *N: Total number of medication errors that were resolved according to policy* *D: Total number of reports for medication errors*
	Discovery Activity *(Source of Data & sample size)*	100% review of incident reports submitted
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Division of Mental Health and Addiction; The State will review 100% of all IICPs to ensure health and welfare needs are addressed as well as review 100% of all submitted incident reports to monitor if the incident report is submitted within the required timeframe. Analysis and aggregation are ongoing. Incomplete IICPs will be returned by the State for additional information within 5 business days with requirement that updated plan is resubmitted within 5 business days for a total of 10 business days.
	Frequency	Ongoing
Remediation		

	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Division of Mental Health and Addiction

Requirement		7d. The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation; medication errors; and use of restraints.
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of reports of seclusions and restraints resolved according to policy *N: Total number of reports for seclusion and restraint that were resolved according to policy* *D: Total number of reports for seclusion and restraint*
	Discovery Activity *(Source of Data & sample size)*	100% review of incident reports submitted
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Division of Mental Health and Addiction; The State will review 100% of all IICPs to ensure health and welfare needs are addressed as well as review 100% of all submitted incident reports to monitor if the incident report is submitted within the required timeframe. Analysis and aggregation are ongoing. Incomplete IICPs will be returned by the State for additional information within 5 business days with requirement that updated plan is resubmitted within 5 business days for a total of 10 business days.
	Frequency	Ongoing
Remediation		

	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Division of Mental Health and Addiction
	Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. Report submitted to State within 72 hours. State will review plan and respond within 5 business days. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

Requirement	7e. The State identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation; medication errors; and use of restraints.
Discovery	

	Discovery Evidence *(Performance Measure)*	Number and percent of reports for abuse, neglect and exploitation resolved according to policy *N: Total number of reports submitted for abuse, neglect and exploitation that were resolved according to policy* *D: Total number of reports for abuse, neglect, and exploitation*
	Discovery Activity *(Source of Data & sample size)*	100% review of reports submitted
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Division of Mental Health and Addiction; The State will review 100% of all IICPs to ensure health and welfare needs are addressed as well as review 100% of all submitted incident reports to monitor if the incident report is submitted within the required timeframe. Analysis and aggregation are ongoing. Incomplete IICPs will be returned by the State for additional information within 5 business days with requirement that updated plan is resubmitted within 5 business days for a total of 10 business days.
	Frequency	Ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Division of Mental Health and Addiction
	Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. Report submitted to State within 72 hours. State will review plan and respond within 5 business days. A corrective action plan is required to be submitted within 30 business days and the State will respond in 30 business days for a total of 60 business days.

Requirement	7f. The State identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation; medication errors; and use of restraints.
Discovery	

	Discovery Evidence *(Performance Measure)*	Number and percent of incident for abuse, neglect and exploitation that required a corrective action plan *N: Total number of CAPs associated with complaints that were implemented within prescribed time period.* *D: Total number of CAPs associated with complaints with implementation timeframes due.*
	Discovery Activity *(Source of Data & sample size)*	100% review of incident reports submitted

	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Division of Mental Health and Addiction; The State will review 100% of all IICPs to ensure health and welfare needs are addressed as well as review 100% of all submitted incident reports to monitor if the incident report is submitted within the required timeframe. Analysis and aggregation are ongoing. Incomplete IICPs will be returned by the State for additional information within 5 business days with requirement that updated plan is resubmitted within 5 business days for a total of 10 business days.
	Frequency	Ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Division of Mental Health and Addiction
	Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a corrective action plan is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days

System Improvement

(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. Methods for Analyzing Data and Prioritizing Need for System Improvement

1. DMHA collects and tracks complaints related to implementation, providers and services offered through the 1915(i). Complaints could be received from recipients, family members, concerned citizens, providers, or advocates. Complaints are categorized as an individual issue or a system challenge/barrier. The system challenge/barrier complaints are discussed during bimonthly strategy meetings between DMHA and OMPP. System issues identified in the complaints are prioritized with solutions discussed for highest priority items.

2. Roles and Responsibilities

2. DMHA reviews and analyzes individual issues related to performance measures to identify any system level trends. DMHA and OMPP monitor trends to identify the need for system changes.

3. Frequency

Monthly, Quarterly, and Annually

4. Method for Evaluating Effectiveness of System Ch

1. During the monthly meeting between DMHA and OMPP, the need for new system changes as well as the effectiveness of previous system changes will be discussed and evaluated. Additional changes will be made as necessary, including changes in provider agency training, bulletins, policy changes, and refinements.

1915(i) State plan Home and Community-Based Services

Administration and Operation

The state implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit *for elderly and disabled individuals as set forth below.*

1. Services. *(Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):*

Behavioral and Primary Healthcare Coordination

2. Concurrent Operation with Other Programs. (*Indicate whether this benefit will operate concurrently with another Medicaid authority)*:

***Select one*:**

○	**Not applicable**
☑	**Applicable**

Check the applicable authority or authorities:

☐	**Services furnished under the provisions of §1915(a)(1)(a) of the Act.** The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. *Specify:* *(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);* *(b) the geographic areas served by these plans;* *(c) the specific 1915(i) State plan HCBS furnished by these plans;* *(d) how payments are made to the health plans; and* *(e) whether the 1915(a) contract has been submitted or previously approved.*
☑	**Waiver(s) authorized under §1915(b) of the Act.** *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*

This § 1915(i) State Plan benefit operates concurrently with an approved fee-for-service selective contracting waiver authorized under §1915(b)(4) of the Act, and was effective on 10/01/2018.

Specify the §1915(b) authorities under which this program operates (*check each that applies*):

☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
☐	§1915(b)(2) (central broker)	☑	§1915(b)(4) (selective contracting/limit number of providers)

☐	**A program operated under §1932(a) of the Act.** *Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:*
☐	**A program authorized under §1115 of the Act.** *Specify the program*:

3. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit. *(Select one)*:

☑	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:		
	○	The Medical Assistance Unit *(name of unit)*:	
	☑	Another division/unit within the SMA that is separate from the Medical Assistance Unit	
		(name of division/unit) This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.	The Division of Mental Health & Addiction (DMHA) is the operating agency under the umbrella of Indiana's SMA. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State Plan HCBS benefit.
	The State plan HCBS benefit is operated by *(name of agency)*		

4. Distribution of State plan HCBS Operational and Administrative Functions.

☑ *(By checking this box the state assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State Plan HCBS enrollment	☑	☐	☐	☐
2 Eligibility evaluation	☑	☐	☐	
3 Review of participant service plans	☑	☐	☐	☐
4 Prior authorization of State Plan HCBS	☑	☐	☐	☐
5 Utilization management	☑	☐	☑	☐
6 Qualified provider enrollment	☑	☐	☑	☐
7 Execution of Medicaid provider agreement	☑	☐	☑	☐
8 Establishment of a consistent rate methodology for each State plan HCBS	☑	☐	☑	☐
9 Rules, policies, procedures, and information development governing the State Plan HCBS benefit	☑	☐	☐	☐
10Quality assurance and quality improvement activities	☑	☐	☐	

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

Function 4 - Prior Authorization On behalf of the Family and Social Services Administration (FSSA), the State Evaluation Team (SET) reviews all Adult Mental Health Habilitation Prior Authorization requests for Indiana Health Coverage Programs (IHCP) members on a case-by- case basis through the Data Assessment Registry Mental Health and Addiction (DARMHA) system.

Function 5 - Utilization Management The contracted entity is the Medicaid Surveillance Utilization Review Contractors. The benefit auditing function is incorporated into the Surveillance Utilization Review (SUR) functions of the contract between the OMPP and SUR Contractor. OMPP has expanded its program integrity activities by using a multi-pronged approach to SUR activity that includes provider self-audit, contractor desk audit and full on-site audit functions. The SUR Contractor sifts and analyzes claims data and identifies providers/claims that indicate aberrant billing patterns and/or other risk factors. The audit process utilizes data mining, research, identification of outliers, problematic billing patterns, aberrant providers and issues that are referred by DMHA and OMPP. The SUR Unit meets with DMHA and OMPP at least quarterly to discuss audits and outstanding issues. The SUR Contractor is a Subject Matter Expert (SME) responsible for directly coordinating with the DMHA and OMPP. This individual also analyzes data to identify potential areas of program risk and identify providers that appear to be outliers warranting review. The contractor may also perform desk or on-site audits and be directly involved in review of the benefit program and providers. Throughout the entire SUR process, oversight is maintained by OMPP. The SUR Unit offers education regarding key program initiatives and audit issues at provider meetings to promote ongoing compliance with Federal and State guidelines, including all Indiana Health Coverage Programs (IHCP) and benefit requirements.

Function 6 - Qualified Provider Enrollment The contracted entity is DMHA and Medicaid Fiscal Agent Providers interested in providing AMHH services must first apply for certification through DMHA. Next, the provider must enroll as a Medicaid provider with Indiana Health Coverage Programs (IHCP). OMPP contracts with a fiscal agent to process IHCP provider enrollments. The fiscal agent processes the applications, verifies licensure and certification requirements are met, maintains the provider master file, assigns provider ID numbers, and stores National Provider Identifier and taxonomy information. Upon successful completion of the provider enrollment process an enrollment confirmation letter is mailed to the new provider.

Function 7 - Execution of Medicaid Provider Agreement (Medicaid Fiscal Agent): The contracted entity is the Medicaid Fiscal Agent OMPP has a fiscal agent under contract which is obligated to assist OMPP in processing approved Medicaid Provider Agreement to enroll approved eligible providers in the Medicaid MMIS for claims processing. This includes the enrollment of DMHA-approved 1915(i) providers. The fiscal agent also conducts provider training and provides technical assistance concerning claims processing. The Medicaid Fiscal Agent contract defines the roles and responsibilities of the Medicaid fiscal contractor. DMHA tracks all provider enrollment requests and receives information directly from the MMIS Fiscal Agent contractor regarding provider enrollment activities as they occur for monitoring of completion, timeliness, accuracy, and to identify issues. Issues are shared with OMPP. DMHA and/or OMPP attend the MMIS Fiscal Agent's scheduled provider training sessions required in OMPP's contract with the fiscal agent. DMHA may also participate in the fiscal agent's individualized provider training for providers having problems.

Function 8 - Establishment of a consistent rate methodology for each State Plan HCBS (Medicaid Actuarial Contractor): The contracted entity is an actuarial service. OMPP has an actuarial service under contract to develop and assess rate methodology for HCBS. The rate methodology for AMHH services is assessed and reviewed at least every five years. The actuarial contractor completes the cost surveys and calculates rate adjustments. OMPP reviews and approves the fee schedule to ensure consistency, efficiency, economy, quality of care, and sufficient access to providers for AMHH services.

(By checking the following boxes the State assures that):

5. ☑ **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual, or any paid caregiver of the individual
- financially responsible for the individual
- empowered to make financial or health-related decisions on behalf of the individual
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*

The Independent State Evaluation Team (SET) is responsible for determining the 1915(i) eligibility and approving the individualized services requested in the proposed care plan. The members of the SET are prohibited from having any financial relationships with the applicant/recipient requesting services, their families, or the entity selected to provide services. Assessments are completed and proposed plans of care (Individualized Integrated Care Plan – IICP) are submitted by a qualified provider entity to the SET for final eligibility determination and care plan approval. Responsibility for 1915(i) program eligibility determination and approval of the IICP proposed services in all cases is retained by the SET to ensure no conflict of interest in the final determinations. The DMHA-approved AMHH provider agency submits the results from the face-to-face or telehealth according to the Indiana Administrative Code assessment, required supporting documentation, and a proposed care plan to SET for independent review. The SET determines eligibility for 1915(i) services based upon their review of the clinical documentation of the applicant's identified needs and alignment of needs, goals, and recommended services. The State also requires documentation, signed by the applicant/recipient that attests to the following: 1) The recipient and/or legal guardian is an active participant in the planning and development of the 1915(i) IICP. 2) The recipient is the person requesting 1915(i) services on the IICP. 3) The recipient received a randomized list of eligible 1915(i) service provider agencies in his/her community; and has selected the provider(s) of his or her choice to deliver the 1915(i) service on the IICP. 4) The recipient and/or legal guardian was offered a copy of the completed IICP In addition, AMHH provider agencies are required to have written policies and procedures available for review by the State that clearly define and describe how conflict of interest requirements are implemented and monitored. The State ensures compliance through policies designed to be consistent with CMS conflict of interest assurances and through quality assurance activities.

6. ☑ **Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. ☑ **No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. ☑ **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. Projected Number of Unduplicated Individuals To Be Served Annually.
(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	6/1/2024	5/31/2025	3000
Year 2			
Year 3			
Year 4			
Year 5			

2. ☑ **Annual Reporting.** *(By checking this box the state agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

Financial Eligibility

1. ☑ **Medicaid Eligible.** *(By checking this box the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

2. **Medically Needy** (*Select one*):

☑ The State does not provide State plan HCBS to the medically needy.
☐ The State provides State plan HCBS to the medically needy. (*Select one*):
☐ The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services. ☐ The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

3. ☑ In addition to providing State Plan HCBS to individuals described in item 1 above, the state is **also** covering the optional categorically needy eligibility group of individuals under 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the federal poverty level, or who are eligible for HCBS under a waiver approved for the state under section 1915(c), (d) or (e) or section 1115 to provide such services to individuals whose income does not exceed 300% of the supplemental security income benefit rate.

Evaluation/Reevaluation of Eligibility

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*Select one*):

☑	Directly by the Medicaid agency
○	By Other (*specify State agency or entity under contract with the State Medicaid agency*):

2. **Qualifications of Individuals Performing Evaluation/Reevaluation**. The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

Individuals conducting the state evaluation for eligibility determination and approval of plans of care hold a least a bachelor's degree in social work, counseling, psychology, or similar field.

3. **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

Information about 1915(i) services is posted on the DMHA and Office of Medicaid Policy and Planning (OMPP) public websites. These websites summarize the eligibility criteria and note the available services, service provider agencies, locations where potential enrollees may go to apply, and how to access assessments and services. Any provider may identify a potential enrollee who meets the 1915(i) eligibility criteria or individuals may notify their provider of an interest in the 1915(i) service.
Any individual may contact the State for information about BPHC eligibility and the process to apply. The individual is given a list of BPHC-eligible provider agencies that may be chosen to assist in the application process. The agency staff reviews the program information with the applicant, together discuss the options under the program, and determines whether to complete an application.

Each person referred for 1915(i) services will receive a bio-psychosocial needs assessment via face to face or via telehealth, according to Indiana Administrative Code and Federal policies and regulations, by the referring provider including, but not limited to the Adult Needs and Strengths Assessment (ANSA) tool and completion of the 1915(i) referral form developed by OMPP/DMHA.

The ANSA tool consists of items that are rated as:
'0' no evidence or no need for action
'1' need for watchful waiting to see whether action is needed
'2' need for action
'3' need for either immediate or intensive action due to a serious or disabling need

The items are grouped into categories or domains. Once the assessment has been completed, the

agency staff receives a level of need (LON) recommendation based on the individual item ratings.

The number of in-person visits and the percentage of time telehealth will be the delivery method of service will be based on what is clinically appropriate and in agreement with the consumer and/or legal guardian. The use of telehealth should protect against isolating participants by offering services that are in-person and shall be invoked to prioritize and facilitate community integration. As required by 45 CFR 164.308(a)(1)(ii), an accurate and thorough risk analysis shall be conducted for any functions using telehealth services to assess the potential risks and vulnerabilities to the confidentiality, integrity, and availability of patient data. Telehealth services will be delivered in a way that respects the privacy of the individual, especially in instances of toileting, dressing, etc. Video cameras/monitors are not permitted in bedrooms and bathrooms. Participants can turn all telehealth-related devices on/off at their discretion to ensure privacy. The provider responsible for the treatment of the individual is responsible for training participants on the use of any telehealth-related devices both initial and ongoing. Telehealth services shall consider and respond to all accessibility needs, including whether hands-on or physical assistance is needed to render the service. Telehealth services must ensure the health and safety of the individual receiving services by adhering to all abuse, neglect, and exploitation prevention practices that apply to in-person treatment, as well as by providing participants with resources on how to report incidences of abuse, neglect, and exploitation and Federal policies and regulations.

The LON recommendation from the ANSA is not intended to be a mandate for the level of services that an individual receives. There are many factors, including individual preference and choice, which influence the actual intensity of treatment services.

The user's manual for the ANSA may be found on-line at:
https://dmha.fssa.in.gov/DARMHA/mainDocuments.aspx

The referral form and supporting documentation provide specific information about the person's health status, current living situation, family dynamic, vocational/employment status, social functioning, living skills, self-care skills, capacity for decision making, potential for self-injury or harm to others, substance use/abuse, need for assistance managing a medical condition, and medication adherence.

The agency staff and the applicant jointly develop a proposed plan of care [Individualized Integrated Care Plan (IICP)] that includes desired goals and services requested and deemed necessary to address the goals. Upon completion of the referral packet (including but not limited to the ANSA, referral form, and proposed plan of care (IICP)), the agency staff submits the documents to DMHA through a secure electronic file transfer process.

The State Evaluation Team (SET) is a special team of state employees who are part of DMHA. Upon receipt of the referral packet, the SET reviews all submitted documentation and determines whether the applicant meets the needs-based criteria for 1915(i).

Time spent for the initial evaluation, and IICP cannot be billed or reimbursed under the 1915(i) benefit before eligibility for this benefit has been determined. The eligibility determination process completed by the SET is billed as administrative activities.

If determined eligible for the 1915(i) service, an eligibility determination and care plan service approval letter is sent to the applicant and the agency staff. Once eligible, the approved service may begin immediately.

If determined ineligible for the 1915(i) benefit, a denial letter, generated from DMHA, is sent to the applicant and the agency staff member informing them that the application for the program and service has been denied. The letters will include the reason for denial, appeal rights and process.

Re-evaluations for continued 1915(i) services follow the same process.

4. ☑ **Reevaluation Schedule**. *(By checking this box the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

5. ☑ **Needs-based HCBS Eligibility Criteria.** *(By checking this box the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

All of the following needs-based criteria must be met for BPHC eligibility:
1. The recipient must demonstrate needs related to management of his/her behavioral and physical health.*
2. The recipient must demonstrate impairment in self-management of physical and behavioral health services.**
3. The recipient has received a recommendation for intensive community-based care on ANSA with a Level of 3 or higher).
4. The recipient demonstrates a health need which requires assistance and support in coordinating behavioral and physical health treatment.

*The evaluation for BPHC eligibility will include an assessment to manage a prescription medication regimen and the impact on health symptoms and functioning. Additionally, an individual will be assessed for awareness of co-occurring behavioral and physical healthcare needs and the ability to manage both.
**Impairment in self-management of physical and behavioral health is operationally defined as limited or impaired ability to carry out routine healthcare regimens, including but not limited to, taking medicine as prescribed, keeping medical appointments, maintaining linkage with a primary medical provider, diet, exercise and management of symptoms.

6. ☑ **Needs-based Institutional and Waiver Criteria.** *(By checking this box the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)

Needs-based eligibility criteria are specified in Item 5 above.	Indiana Law allows reimbursement to NFs for eligible persons who require skilled or intermediate nursing care as defined in 405 IAC 1-3-1 and 1-3-2. 405 IAC 1-3-1(a) Skilled nursing services, as ordered by a physician, must be required and provided on a daily basis, essentially 7 days a week. 405 IAC 1-3-2 (a)	Indiana Law allows reimbursement to ICF/IIDs for eligible persons as defined in 405 IAC 1-1-11. A person may be functionally eligible for an ICF/IID LOC waiver when documentation shows the individual meets the following conditions: 1. Has a diagnosis of intellectual disability, cerebral palsy, epilepsy, autism, or	Dangerous to self or others or gravely disabled. (IC-12-26-1)

	Intermediate nursing care includes care for patients with long term illnesses or disabilities which are relatively stable, or care for patients nearing recovery and discharge who continue to require some professional medical or nursing supervision and attention. A person is functionally eligible for either NF or an NF level of care waiver if the need for medical or nursing supervision and attention is determined by any of the following findings from the functional screening: 1. Need for direct assistance at least 5 days per week due to unstable, complex medical conditions. 2. Need for direct assistance for 3 or more substantial medical conditions including activities of daily living.	condition similar to intellectual disability. 2. Condition identified in #1 is expected to continue. 3. Condition identified in #1 had an age of onset prior to age 22. 4. Individual needs a combination or sequence of services 5. Has 3 of 6 substantial functional limitations as defined in 42 CFR 435.1010 in areas of (1) self-care, (2) learning, (3) self-direction, (4) capacity for independent living, (5) language, and (6) mobility.	

*Long Term Care/Chronic Care Hospital

**LOC= level of care

7. ☑ **Target Group(s).** The State elects to target this 1915(i) State Plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

The BPHC Program Eligibility, 405 IAC 5-21.8:

- Age 19 or over
- Approved BPHC eligible primary diagnosis; Eligible diagnoses

ICD-10 Code	ICD-10 Description

F10.10	Alcohol abuse, uncomplicated	
F10.120	Alcohol abuse with intoxication, uncomplicated	
F10.150	Alcohol abuse with alcohol-induced psychotic disorder with delusions	
F10.151	Alcohol abuse with alcohol-induced psychotic disorder with hallucinations	
F10.188	Alcohol abuse with other alcohol-induced disorder	
F10.19	Alcohol abuse with unspecified alcohol-induced disorder	
F10.20	Alcohol dependence, uncomplicated	
F10.21	Alcohol dependence, in remission	
F10.220	Alcohol dependence with intoxication, uncomplicated	
F10.230	Alcohol dependence with withdrawal, uncomplicated	
F10.250	Alcohol dependence with alcohol-induced psychotic disorder with delusions	
F10.251	Alcohol dependence with alcohol-induced psychotic disorder with hallucinations	
F10.29	Alcohol dependence with unspecified alcohol-induced disorder	
F11.10	Opioid abuse, uncomplicated	
F11.120	Opioid abuse with intoxication, uncomplicated	
F11.150	Opioid abuse with opioid-induced psychotic disorder with delusions	
F11.151	Opioid abuse with opioid-induced psychotic disorder with hallucinations	
F11.159	Opioid abuse with opioid-induced psychotic disorder, unspecified	
F11.19	Opioid abuse with unspecified opioid-induced disorder	
F11.20	Opioid dependence, uncomplicated	
F11.21	Opioid dependence in remission	
F11.220	Opioid dependence with intoxication, uncomplicated	
F11.250	Opioid dependence with opioid-induced psychotic disorder with delusions	
F11.251	Opioid dependence with opioid-induced psychotic disorder with hallucinations	
F11.259	Opioid dependence with opioid-induced psychotic disorder, unspecified	
F11.29	Opioid dependence with unspecified opioid-induced disorder	
F12.10	Cannabis abuse, uncomplicated	
F12.120	Cannabis abuse with intoxication, uncomplicated	
F12.150	Cannabis abuse with psychotic disorder with delusions	
F12.151	Cannabis abuse with psychotic disorder with hallucinations	
F12.19	Cannabis abuse with unspecified cannabis-induced disorder	
F12.20	Cannabis dependence, uncomplicated	
F12.21	Cannabis dependence, in remission	
F12.220	Cannabis dependence with intoxication, uncomplicated	
F12.250	Cannabis dependence with psychotic disorder with delusions	
F12.251	Cannabis dependence with psychotic disorder with hallucinations	
F12.29	Cannabis dependence with unspecified cannabis-induced disorder	
F13.10	Sedative, hypnotic or anxiolytic abuse, uncomplicated	
F13.120	Sedative, hypnotic or anxiolytic abuse with intoxication, uncomplicated	
F13.150	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions	

F13.151	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations	
F13.188	Sedative, hypnotic or anxiolytic abuse with other sedative, hypnotic or anxiolytic-induced disorder	
F13.19	Sedative, hypnotic or anxiolytic abuse with unspecified sedative, hypnotic or anxiolytic-induced disorder	
F13.20	Sedative, hypnotic or anxiolytic dependence, uncomplicated	
F13.21	Sedative, hypnotic or anxiolytic dependence, in remission	
F13.220	Sedative, hypnotic or anxiolytic dependence with intoxication, uncomplicated	
F13.230	Sedative, hypnotic or anxiolytic dependence with withdrawal, uncomplicated	
F13.250	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions	
F13.251	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations	
F13.26	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting amnestic disorder	
F13.29	Sedative, hypnotic or anxiolytic dependence with unspecified sedative, hypnotic or anxiolytic-induced disorder	
F14.10	Cocaine abuse, uncomplicated	
F14.120	Cocaine abuse with intoxication, uncomplicated	
F14.150	Cocaine abuse with cocaine-induced psychotic disorder with delusions	
F14.151	Cocaine abuse with cocaine-induced psychotic disorder with hallucinations	
F14.19	Cocaine abuse with unspecified cocaine-induced disorder	
F14.20	Cocaine dependence, uncomplicated	
F14.21	Cocaine dependence, in remission	
F14.220	Cocaine dependence with intoxication, uncomplicated	
F14.250	Cocaine dependence with cocaine-induced psychotic disorder with delusions	
F14.251	Cocaine dependence with cocaine-induced psychotic disorder with hallucinations	
F14.29	Cocaine dependence with unspecified cocaine-induced disorder	
F15.10	Other stimulant abuse, uncomplicated	
F15.120	Other stimulant abuse with intoxication, uncomplicated	
F15.19	Other stimulant abuse with unspecified stimulant-induced disorder	
F15.20	Other stimulant dependence, uncomplicated	
F15.21	Other stimulant dependence, in remission	
F15.220	Other stimulant dependence with intoxication, uncomplicated	
F15.29	Other stimulant dependence with unspecified stimulant-induced disorder	
F16.10	Hallucinogen abuse, uncomplicated	
F16.120	Hallucinogen abuse with intoxication, uncomplicated	
F16.183	Hallucinogen abuse with hallucinogen persisting perception disorder (flashbacks)	
F16.188	Hallucinogen abuse with other hallucinogen-induced disorder	
F16.19	Hallucinogen abuse with unspecified hallucinogen-induced disorder	
F16.20	Hallucinogen dependence, uncomplicated	

F16.21	Hallucinogen dependence, in remission	
F16.220	Hallucinogen dependence with intoxication, uncomplicated	
F16.250	Hallucinogen dependence with hallucinogen-induced psychotic disorder with delusions	
F16.251	Hallucinogen dependence with hallucinogen-induced psychotic disorder with hallucinations	
F16.283	Hallucinogen dependence with hallucinogen persisting perception disorder (flashbacks)	
F16.288	Hallucinogen dependence with other hallucinogen-induced disorder	
F16.29	Hallucinogen dependence with unspecified hallucinogen-induced disorder	
F18.10	Inhalant abuse, uncomplicated	
F18.120	Inhalant abuse with intoxication, uncomplicated	
F18.150	Inhalant abuse with inhalant-induced psychotic disorder with delusions	
F18.151	Inhalant abuse with inhalant-induced psychotic disorder with hallucinations	
F18.19	Inhalant abuse with unspecified inhalant-induced disorder	
F18.20	Inhalant dependence, uncomplicated	
F18.21	Inhalant dependence, in remission	
F18.220	Inhalant dependence with intoxication, uncomplicated	
F18.250	Inhalant dependence with inhalant-induced psychotic disorder with delusions	
F18.251	Inhalant dependence with inhalant-induced psychotic disorder with hallucinations	
F18.29	Inhalant dependence with unspecified inhalant-induced disorder	
F19.10	Other psychoactive substance abuse, uncomplicated	
F19.120	Other psychoactive substance abuse with intoxication, uncomplicated	
F19.122	Other psychoactive substance abuse with intoxication with perceptual disturbances	
F19.150	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with delusions	
F19.151	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with hallucinations	
F19.16	Other psychoactive substance abuse with psychoactive substance-induced persisting amnestic disorder	
F19.19	Other psychoactive substance abuse with unspecified psychoactive substance-induced disorder	
F19.20	Other psychoactive substance dependence, uncomplicated	
F19.21	Other psychoactive substance dependence, in remission	
F19.220	Other psychoactive substance dependence with intoxication, uncomplicated	
F19.222	Other psychoactive substance dependence with intoxication with perceptual disturbance	
F19.230	Other psychoactive substance dependence with withdrawal, uncomplicated	
F19.232	Other psychoactive substance dependence with withdrawal with perceptual disturbance	
F19.250	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with delusions	

F19.251	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with hallucinations	
F19.26	Other psychoactive substance dependence with psychoactive substance-induced persisting amnestic disorder	
F19.29	Other psychoactive substance dependence with unspecified psychoactive substance-induced disorder	
F20.0	Paranoid schizophrenia	
F20.1	Disorganized schizophrenia	
F20.2	Catatonic schizophrenia	
F20.3	Undifferentiated schizophrenia	
F20.5	Residual schizophrenia	
F20.81	Schizophreniform disorder	
F20.89	Other schizophrenia	
F20.9	Schizophrenia, unspecified	
F22	Delusional disorders	
F24	Shared psychotic disorder	
F25.0	Schizoaffective disorder, bipolar type	
F25.1	Schizoaffective disorder, depressive type	
F25.8	Other schizoaffective disorders	
F25.9	Schizoaffective disorder, unspecified	
F28	Other psychotic disorder not due to a substance or known physiological condition	
F29	Unspecified psychosis not due to a substance or known physiological condition	
F30.10	Manic episode without psychotic symptoms, unspecified	
F30.12	Manic episode without psychotic symptoms, moderate	
F30.13	Manic episode, severe, without psychotic symptoms	
F30.2	Manic episode, severe with psychotic symptoms	
F30.3	Manic episode in partial remission	
F30.9	Manic episode, unspecified	
F31.0	Bipolar disorder, current episode hypomanic	
F31.10	Bipolar disorder, current episode manic without psychotic features, unspecified	
F31.12	Bipolar disorder, current episode manic without psychotic features, moderate	
F31.13	Bipolar disorder, current episode manic without psychotic features, severe	
F31.2	Bipolar disorder, current episode manic severe with psychotic features	
F31.30	Bipolar disorder, current episode depressed, mild or moderate severity, unspecified	
F31.32	Bipolar disorder, current episode depressed, moderate	
F31.4	Bipolar disorder, current episode depressed, severe, without psychotic features	
F31.5	Bipolar disorder, current episode depressed, severe, with psychotic features	
F31.60	Bipolar disorder, current episode mixed, unspecified	
F31.62	Bipolar disorder, current episode mixed, moderate	
F31.63	Bipolar disorder, current episode mixed, severe, without psychotic features	
F31.64	Bipolar disorder, current episode mixed, severe, with psychotic features	

F31.71	Bipolar disorder, in partial remission, most recent episode hypomanic	
F31.73	Bipolar disorder, in partial remission, most recent episode manic	
F31.75	Bipolar disorder, in partial remission, most recent episode depressed	
F31.77	Bipolar disorder, in partial remission, most recent episode mixed	
F31.81	Bipolar II disorder	
F31.89	Other bipolar disorder	
F31.9	Bipolar disorder, unspecified	
F32.1	Major depressive disorder, single episode, moderate	
F32.2	Major depressive disorder, single episode, severe without psychotic features	
F32.3	Major depressive disorder, single episode, severe with psychotic features	
F32.4	Major depressive disorder, single episode, in partial remission	
F33.1	Major depressive disorder, recurrent, moderate	
F33.2	Major depressive disorder, recurrent severe without psychotic features	
F33.3	Major depressive disorder, recurrent, severe with psychotic symptoms	
F33.41	Major depressive disorder, recurrent, in partial remission	
F33.9	Major depressive disorder, recurrent, unspecified	
F34.0	Cyclothymic disorder	
F34.1	Dysthymic disorder	
F40.00	Agoraphobia, unspecified	
F40.01	Agoraphobia with panic disorder	
F40.02	Agoraphobia without panic disorder	
F40.10	Social phobia, unspecified	
F41.0	Panic disorder [episodic paroxysmal anxiety]	
F41.1	Generalized anxiety disorder	
F42.2	Mixed obsessional thoughts and acts	
F42.3	Hoarding disorder	
F43.10	Post-traumatic stress disorder, unspecified	
F43.11	Post-traumatic stress disorder, acute	
F43.12	Post-traumatic stress disorder, chronic	
F44.81	Dissociative identity disorder	
F45.41	Pain disorder exclusively related to psychological factors	
F50.00	Anorexia nervosa, unspecified	
F50.01	Anorexia nervosa, restricting type	
F50.02	Anorexia nervosa, binge eating/purging type	
F50.2	Bulimia nervosa	
F50.81	Binge eating disorder	
F50.82	Avoidant/restrictive food intake disorder	
F50.89	Other specified eating disorder	
F50.9	Eating disorder, unspecified	
F51.4	Sleep terrors [night terrors]	
F60.0	Paranoid personality disorder	

F60.3	Borderline personality disorder

☐ **Option for Phase-in of Services and Eligibility.** If the State elects to target this 1915(i) State Plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. (Specify the phase-in plan):

(By checking the following box the State assures that):

8. ☑ **Adjustment Authority**. The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

9. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	**Minimum number of services**. The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is*:* 1	
ii.	**Frequency of services**. The State requires (select one):	
	○	**The provision of 1915(i) services at least monthly**
	☑	**Monthly monitoring of the individual when services are furnished on a less than monthly basis** If the State also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency: Three (3) instances of the BPHC service must be provided to each eligible member every 180 days and documented in progress notes.

Home and Community-Based Settings

(By checking the following box the State assures that):

1. ☑ **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (*Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):*

(Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)

The state assures that this 1915(i) state plan HCBS benefit will be subject to any provisions or requirements included in HCBS Final Rule.

An ongoing monitoring phase in the state fiscal year (SFY) 2023 due to the fulfillment and completion of State Transition Plan activities in SFY 2022. The State Evaluation Team (SET) will conduct on-site visits to a percentage of each agency's POCO settings that have been identified as a setting that provides HCBS services. In addition to the site visits, CMS requires a supplemental provider self-assessment. The provider self-assessment document will only be completed for the sites identified in the annual Ongoing Monitoring notification letter. The Division of Mental Health and Addiction is collaborating on a shared Corrective Action Plan (CAP) with the Division of Aging, the Division of Disability and Rehabilitation Services, and the Office of Medicaid Policy and Planning to ensure fidelity to HCBS Final Rule across all FSSA agencies implementing Home and Community Based Services.

Person-Centered Planning & Service Delivery

(By checking the following boxes the state assures that):

1. ☑ There is an independent assessment of individuals determined to be eligible for the State Plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

2. ☑ Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State Plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

3. ☑ The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

4. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.** There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):*

The agency staff member conducting the assessment must be a certified user of the State required standardized assessment tool, with supervision by a certified super user of the tool. Minimum qualification for the person conducting the independent evaluation are: (1): bachelor's degree in social sciences or related field with two or more years of clinical experience; (2) completion of DMHA and OMPP approved training and orientation for 1915(i) eligibility and determination; and (3) completion of assessment tool Certification training**. The assessment must be completed face to face or via telehealth, according to Indiana Administrative Code. The use of telehealth must achieve the following:**

- The number of in-person visits and the percentage of time telehealth will be the delivery method of service will be based on what is clinically appropriate and in agreement with the consumer and/or legal guardian. The use of telehealth should protect against isolating participants by offering services which are in-person and shall be invoked to prioritize and facilitate community integration.
- As required by 45 CFR § 164.308 (a)(1)(ii), an accurate and thorough risk analysis shall be conducted for any functions utilizing telehealth services to assess the potential risks and vulnerabilities to the confidentiality, integrity, and availability of patient data.
- All telehealth services will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc. Video cameras/monitors are not permitted in bedrooms and bathrooms. Participants are able to turn all telehealth-related devices on/off at their discretion in order to ensure privacy. The provider who is responsible for the treatment of the individual is responsible for training participants on the use of any telehealth-related devices both initially and on-going.
- Telehealth services shall consider and respond to all accessibility needs, including whether hands-on or physical assistance is needed to render the service.
- Telehealth services must ensure for the health and safety of the individual receiving services by adhering to assessment and abuse, neglect, and exploitation prevention and response practices that apply to in-person treatment.

5. Responsibility for Development of Person-Centered Service Plan. There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*

Licensed professional means any of the following persons:

- a licensed psychiatrist;
- a licensed physician;
- a licensed psychologist or a psychologist endorsed as a health service provider in psychology
- (HSPP);
- a licensed clinical social worker (LCSW);

- a licensed mental health counselor (LMHC);
- a licensed marriage and family therapist (LMFT); or
- a licensed clinical addiction counselor, as defined under IC 25-23.6-10.5.

Qualified behavioral health professional (QBHP) means any of the following persons:

- an individual who has had at least two (2) years of clinical experience treating persons with mental illness under the supervision of a licensed professional, as defined above, such experience occurring after the completion of a master's degree or doctoral degree, or both, in any of the following disciplines:
  - in psychiatric or mental health nursing from an accredited university, plus a license as a registered nurse in Indiana;
  - in pastoral counseling from an accredited university; or
  - in rehabilitation counseling from an accredited university.
- an individual who is under the supervision of a licensed professional, as defined above, is eligible for and working toward licensure, and has completed a master's or doctoral degree, or both, in any of the following disciplines:
  - in social work from a university accredited by the Council on Social Work Education;
  - in psychology from an accredited university;
  - in mental health counseling from an accredited university; or
  - in marital and family therapy from an accredited university.
- a licensed independent practice school psychologist under the supervision of a licensed
- professional, as defined above.
- an authorized health care professional (AHCP), defined as follows:
  - a physician assistant with the authority to prescribe, dispense and administer drugs and medical devices or services under an agreement with a supervising physician and subject to the requirements of IC 25-27.5-5.
  - a nurse practitioner or a clinical nurse specialist, with prescriptive authority and performing duties within the scope of that person's license and under the supervision of, or under a supervisory agreement with, a licensed physician pursuant to IC 25-23-1.

Other behavioral health professional (OBHP) means any of the following persons:

- an individual with an associate or bachelor's degree, and/or equivalent behavioral health experience, meeting minimum competency standards set forth by the behavioral health service provider and supervised by a licensed professional, as defined above, or QBHP, as defined above; or
- a licensed addiction counselor, as defined under IC 25-23.6-10.5 supervised by a licensed professional, as defined above, or QBHP, as defined under above.

6. Supporting the Participant in Development of Person-Centered Service Plan. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

Person centered planning is an existing requirement for DMHA approved provider agencies in Indiana. This requirement is covered via certification rules, requirement for national accreditation, and contracts connected to DMHA funding. All IICPs are to be developed with the recipient leading the care. The recipient has authority to determine who is included in the process. IICPs require staff and recipient signatures as well as clinical documentation of recipient participation. A copy of the IICP is offered to the client and/or legal guardian.

The Independent State Evaluation Team (SET) reviews and approves or denies all proposed BPHC services submitted for consideration to ensure the applicant/recipient participated in the IICP development and to prevent a conflict of interest. The following process and expectations are adhered to by provider agencies assisting recipients in developing the IICP:

The IICP is developed through a collaboration that includes the applicant/recipient, identified community supports (family/nonprofessional caregivers), and all individuals/agency staff involved in assessing and/or providing care for the applicant/recipient. The IICP is a person-centered service plan that integrates all components and aspects of care that are deemed medically necessary, needs based, are clinically indicated, and are provided in the most appropriate setting in order to achieve the recipient's goals. An IICP must be developed with each applicant/recipient. The IICP must include all indicated medical and support service coordination needed by the applicant/recipient in order to reside in the community, to function at the highest level of independence possible, and to achieve his/her goals. The IICP is developed after completing a holistic clinical and bio-psychosocial assessment. The holistic assessment includes documentation in the applicant/recipient's medical record of the following:

- Review, discussion and documentation of the applicant/recipient's desires, needs, and goals.
- Goals and recovery, habilitative or rehabilitative based in nature with outcomes specific to the applicant/recipient's needs.
- Goals are identified by the applicant/recipient.
- Review of psychiatric symptoms and how they affect the applicant/recipient's functioning, ability to attain desires and goals, as well as the applicant's ability to self-manage mental and physical healthcare services.
- Applicant/recipient's ability to attain desires, needs and goals and to self-manage health services.
- Review of the applicant/recipient's skills and the support needed for the applicant/recipient to attain desires, needs and goals toward self-managing mental and physical healthcare in order to remain in the community.
- Applicant/recipient's ability to manage his or her health condition and services.

A member of the treatment team involved in assessing the applicant/recipients needs and desires fulfills the role of care coordinator and is responsible for documenting the IICP with the applicant/recipient's participation. In addition to driving the IICP development, the applicant/recipient of BPHC services is given a list of eligible provider agencies and services offered in his/her geographic area. The applicant/recipient is asked to select the provider agency of choice. The referring provider agency is responsible for linking the recipient to his/her selected provider. The provider agencies are required to have mechanisms in place to support the applicant/recipient's choice.

The IICP must reflect the applicant/recipient's desires and choices. The applicant/recipient's signature which demonstrates his/her participation in the development of an ongoing IICP review is required in the clinical record and subject to State audit. The applicant must attest to participation in the development of the IICP on the BPHC application. Infrequently, an applicant/recipient may request services but refuse to sign the IICP for various reasons (i.e. thought disorder, paranoia, etc.). If a recipient refuses to sign the IICP, the agency staff member is required to document on the plan of care (POC) that the recipient agreed to the plan but refused to sign the plan. The agency staff member must also document in the clinical record progress notes that a planning meeting with the recipient did occur and that the IICP reflects the recipient's choice of services and agreement to participate in the services identified in the IICP. The progress note must further explain any known reasons why the recipient refused to sign the plan and how those will be addressed in the future.

Each eligible BPHC provider agency is required to ensure a written statement of rights is provided to each recipient. The statement shall include:

(1) The toll-free consumer service line number and the telephone number for Indiana protection and advocacy.

(2) Document that agency staff provides both a written and an oral explanation of these rights to each applicant/recipient.

In addition, all Approval/Denial Notification letters include an explanation of the action to be taken and the appeal rights. Applicants/recipients/authorized representatives may file a complaint or grievance with the State. All complaints/grievances regarding BPHC provider agencies are accepted by the following means:

(1) The "Office of Family and Consumer Affairs" on the DMHA website;
(2) The "Consumer Service Line" (800-901-1133)
(3) Indiana Disability Rights (800-622-4845)
(4) In-person to a DMHA staff member; or
(5) Via written complaint or email that is submitted to DMHA.

7. Informed Choice of Providers. *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

The State maintains a network of Community Mental Health Centers (CMHCs). As a DMHA approved BPHC provider agency, each CMHC is an enrolled Medicaid provider that offers a full continuum of behavioral healthcare services, as is mandated by DMHA for all CMHCs, in addition to providing BPHC services as documented in this State Plan benefit. The care coordinator explains the process for making an informed choice of provider(s) and answers questions. The applicant/recipient is also advised that the choice of providers and provider agencies is ongoing for the duration of the program. Therefore, providers within an agency and provider agencies themselves can be changed upon request from the enrollee. A list of qualified BPHC agency providers in randomized sequence is presented by the care coordinator. A listing of approved BPHC provider agencies is also posted on the Indiana Medicaid website at www.in.gov/medicaid. When accessing in.gov/medicaidwebsite, the individual has a choice of a "Member" tab and "Provider" tab. The Member tab notes: *If you are an Indiana Medicaid Member or are interested in applying to becoming a Member, please click the "Member" tab.*

Selection of the Member tab provides an array of information to individuals applying for or eligible for Medicaid services, including a "Find a Provider" link. This link allows the individual to target the search by selecting types of providers by city, county or state. The resulting lists include the provider's name, address, telephone number and a link to the map for each provider location.

Applicants/recipients and family members may interview potential service providers and make a choice.

This 1915(i) State Plan benefit runs concurrently with the 1915(b)(4) fee-for-service selective contracting waiver (IN.02.R01).

8. Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency. *(Describe the process by which the person-centered service plan is made subject to the approval of the Medicaid agency):*

The Indiana Office of Medicaid Policy and Planning (OMPP) retains responsibility for service plan approvals made by the Division of Mental Health and Addiction (DMHA). OMPP reviews and approves the policies, processes and standards for developing and approving BPHC plans of care (POC). Based on the terms and conditions of the 1915(i) benefit, OMPP may review and overrule the approval or disapproval of any specific plan of care acted upon by DMHA serving in its capacity as the operating agency. In the instance of a complaint from a 1915(i) provider or applicant/recipient, the IICP submitted to DMHA may be reviewed by OMPP.

9. Maintenance of Person-Centered Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

☐	Medicaid agency	☑	Operating agency	☐	Case manager
☐	Other (*specify):*				

Services

1. State plan HCBS. *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Behavioral & Primary Healthcare Coordination (BPHC)
Service Definition (Scope):	

Behavioral & Primary Healthcare Coordination (BPHC) consists of coordination of healthcare services to manage the healthcare needs of the individual.
The BPHC service includes the following.

- Logistical support, advocacy and education to assist individuals in navigating the healthcare system
  - Activities that help recipients gain access to needed health (physical and behavioral health) services
  - Manage health conditions such as adhering to health regimens
  - Scheduling and keeping medical appointments
  - Obtaining and maintaining a primary medical provider
  - Coordination of care within and across systems
- Assessment of the eligible recipient to determine service needs
- Development of an individualized integrated care plan (IICP)
- Referral and related activities to help the recipient obtain needed services
- Monitoring and follow-up
- Evaluation

The number of in-person visits and the percentage of time telehealth will be the delivery method of service will be based on what is clinically appropriate and in agreement with the consumer and/or legal guardian. The use of telehealth should protect against isolating participants by offering services that are in-person and shall be invoked to prioritize and facilitate community integration.

As required by 45 CFR § 164.308 (a)(1)(ii), an accurate and thorough risk analysis shall be conducted for any functions utilizing telehealth services to assess the potential risks and vulnerabilities to the confidentiality, integrity, and availability of patient data.

All telehealth services will be delivered in a way that respects the privacy of the individual, especially in instances of toileting, dressing, etc. Video cameras/monitors are not permitted in bedrooms and bathrooms. Participants can turn all telehealth-related devices on/off at their discretion to ensure privacy. The provider who is responsible for the treatment of the individual is responsible for training participants on the use of any telehealth-related devices both initial and on-going.

Telehealth services shall consider and respond to all accessibility needs, including whether hands-on or physical assistance is needed to render the service.
Telehealth services must ensure the health and safety of the individual receiving services by adhering to all abuse, neglect, and exploitation prevention practices that apply to in-person treatment, as well as by providing participants with resources on how to report incidences of abuse, neglect, and exploitation and Federal policies and regulations.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

N/A

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑ Categorically needy *(specify limits):*

The BPHC service is initially offered in 15-minute units up to 48 units/12 hours per 180 days. Additional units are available upon request.

Exclusions:

- Time spent on the initial assessment, referral form and IICP Activities which are billed under MRO Case Management or AMHH Care Coordination
- Direct delivery of medical, clinical, or other direct services

-

☐ Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	N/A	DMHA-certified Community Mental Health Center (CMHC)	DMHA-approved BPHC provider agencies must meet DMHA and OMPP-defined criteria and standards, including the following: A) Provider agency has acquired a National Accreditation by an entity approved by DMHA. B) Provider agency is an enrolled Medicaid provider that offers a full-continuum of care. C) Provider agency must maintain documentation in accordance with the Medicaid requirements defined under 405 IAC 1-5-1 and 405 IAC 1-5-3. D) Provider agency must meet all BPHC provider agency criteria, as defined in the 1915(i) benefit and BPHC operating policy. In addition to meeting criteria for a provider agency, the agency must certify the staff providing a BPHC needs assessment, development and adjustments to the IICP, referral and linkage activities, and physician consults must meet the following standards: A) Licensed professional; B) QBHP; or C) OBHP. The agency must certify the staff providing all other BPHC services including coordination across health systems, monitoring and follow-up activities, and re-evaluation of the recipients progress meet the following standards: A) Licensed professional B) QBHP C) OBHP D) Certified Recovery Specialist; or E) Certified Integrated Health Technician (IHT). A Certified Recovery Specialist (CRS) refers to an individual who meets all of the following criteria:

			1. Is maintaining healthy recovery from mental illness; 2. Has completed the CRS Indiana Division of Mental Health and Addiction (DMHA) state-approved training program; 3. Receives a passing score on the certification exam; and 4. Is supervised by a licensed professional or QBHP. A Certified IHT refers to an individual who meets all of the following criteria: 1. Has completed the IHT job specific training from the community mental health center employing the IHT; 2. Receives a passing score on the certification exam; and 3. Is supervised by a licensed professional or Qualified Behavioral Health Professional.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:		
Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency	**DMHA**	Initially, and at the time of DMHA certification and renewal.

Service Delivery Method. *(Check each that applies)*:			
☐	Participant-directed	☑	Provider managed

2. ☐ **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the state assures that):* There are policies pertaining to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. Election of Participant-Direction. (*Select one):*

☑	The state does not offer opportunity for participant-direction of State plan HCBS.
○	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. *(Specify criteria):*

2. Description of Participant-Direction. (Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):

Indiana does not offer self-directed care.

3. Limited Implementation of Participant-Direction. (*Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

○	Participant direction is available in all geographic areas in which State plan HCBS are available.
○	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the state affected by this option)*:

4. Participant-Directed Services. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐

5. Financial Management. (*Select one)* :

○	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
○	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. ☐Participant–Directed Person-Centered Service Plan. *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:

- Specifies the State plan HCBS that the individual will be responsible for directing;
- Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget;
- Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual;
- Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
- Specifies the financial management supports to be provided.

7. Voluntary and Involuntary Termination of Participant-Direction. *(Describe how the state facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

8. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can select, manage, and dismiss State plan HCBS providers). (*Select one):*

○	The state does not offer opportunity for participant-employer authority.	
○	Participants may elect participant-employer Authority *(Check each that applies):*	
	☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
	☐	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. Participant–Budget Authority (individual directs a budget that does not result in payment for medical assistance to the individual). (*Select one):*

○	The state does not offer opportunity for participants to direct a budget.
○	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):*
	Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.*

Quality Improvement Strategy

Quality Measures

(Describe the state's quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

(Table repeats for each measure for each requirement and lettered sub-requirement above.)

1. Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and c) document choice of services and providers.

Requirement	1a) Service plans address assessed needs of 1915(i) participants
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of IICPs that address recipient needs *N: Total number of IICPs reviewed that address recipient needs* *D: Total number of IICPs reviewed*
Discovery Activity *(Source of Data & sample size)*	100% of IICPs are reviewed and approved through the State's database
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The Division of Mental Health and Addiction (DMHA) reviews 100% of all Individualized Integrated Care Plans (IICPs) submitted through the Data Assessment Registry Mental Health and Addiction (DARMHA) database. During the review of the IICPs, DMHA ensures the needs of the participants are addressed, the IICP is updated timely, and documentation supports the applicant received a choice of services and providers.
Frequency	Ongoing

Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA

	Frequency (of Analysis and Aggregation)	Analysis and aggregation are ongoing. If a corrective action plan (CAP) is needed, it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

Requirement	1b) Service plans are updated, at least, every 180 days
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of IICPs reviewed and revised within the past 180 days *N: Total number of IICPs reviewed and revised within the past 180 days* *D: Total number of IICPs reviewed*
Discovery Activity *(Source of Data & sample size)*	100% of IICPs are reviewed and approved through the State's database
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA
Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a CAP is needed, it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

Requirement	1c) Service plans document choice of services
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of recipients with documentation of choice of eligible services *N: Total number of IICPs reviewed with recipient's documented choice of eligible services* *D: Total number of IICPs reviewed*

Discovery Activity *(Source of Data & sample size)*	Record Review – onsite/off site Sample with 95% confidence level with 5% margin of error
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA
Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a CAP is needed, it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

Requirement	1d) Service plans address choice of providers
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of recipients with documentation of choice of providers *N: Total number of IICPs reviewed with recipient's documented choice of providers* *D: Total number of IICPs reviewed*
Discovery Activity *(Source of Data & sample size)*	Record Review - onsite/off site Sample with 95% confidence level with 5% margin of error
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
Frequency	Ongoing
Remediation	

Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA
Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a CAP is needed, it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

Requirement	1e. Client and/or legal guardian offered a copy of the IICP
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of clients or legal guardians that were offered a copy of the completed IICP *N: Total number of attestations reviewed with documentation of offered IICP* *D: Total number of attestations reviewed*
Discovery Activity *(Source of Data & sample size)*	Record Review – onsite/off site Sample with 95% confidence level with 5% margin of error
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA
Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a CAP is needed, it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

2. Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.

Requirement	2a) An evaluation for eligibility is provided to all applicants
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of new applicants who had anevaluation for BPHC eligibility prior to enrollment that was face to face or telehealth, according to Indiana Administrative Code. *N: Number of new applicants who had a face-to-face or telehealth evaluation for BPHC eligibility prior to enrollment* *D: Total number of new applicants who had a BPHC evaluation prior to enrollment*
Discovery Activity *(Source of Data & sample size)*	Record Review - onsite/off site Sample with 95% confidence level with 5% margin of error
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	. For each BPHC application submitted, providers are required to complete a BPHC evaluation and Adult Needs Strengths Assessment (ANSA), which should be completed face to face or via telehealth, according to Indiana Administrative Code. Information from the evaluation and assessment is submitted along with an IICP with other supporting documentation to DMHA for review for eligibility. The process is the same for the BPHC renewal application, as it is for the initial application. DMHA conducts an annual quality assurance review for each BPHC provider to ensure compliance with all eligibility requirements. DMHA will review the services provided during a package period to ensure the services provided are included in the IICP.
Frequency	Ongoing

Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA

Frequency	Analysis and aggregation are ongoing. If a CAP is needed, it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

(of Analysis and Aggregation)	

Requirement	2b) The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of Adult Needs and Strengths Assessments (ANSA) completed according to policy *N: Number of applicants who had anANSA completed face to face or via telehealth, according to Indiana Administrative Code (within 60 days of application submission) for BPHC eligibility prior to enrollment* *D: Total number of new applicants who had an ANSA completed prior to enrollment*
Discovery Activity *(Source of Data & sample size)*	Record Review - onsite/off site Sample with 95% confidence level with 5% margin of error
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA
Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a CAP is needed, it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

Requirement	2c) The 1915(i) benefit eligibility of enrolled individuals is re-evaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS

Discovery

Discovery Evidence *(Performance Measure)*	Number and percent of enrolled individuals re-evaluated at least every 180 daysas specified in the approved 1915(i) benefit *N: Number of BPHC re-evaluations completed for enrolled individuals during the past 180 days* *D: Total number of enrolled individuals due for re-evaluation during the past 180 days*
Discovery Activity *(Source of Data & sample size)*	Record Review - onsite/off site Sample with 95% confidence level with 5% margin of error
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA
Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a CAP is needed, it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

Requirement	2d) Service activities are linked to goals, objectives, and/or strategies identified in the IICP.
Discovery	

	Discovery Evidence *(Performance Measure)*	*Number and percent of completed BPHC services linked to goals, objectives, and/or strategies identified in the IICP.* ***N: Number of completed BPHC services linked to goals, objectives, and/or strategies identified in the IICP.*** ***D: Total number of completed BPHC services during the review period.***
	Discovery Activity *(Source of Data & sample size)*	Record Review - onsite/off site Sample with 95% confidence level with 5% margin of error
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
	Frequency	Ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA
	Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a CAP is needed, it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

3. Providers meet required qualifications.

Requirement	3a) Providers meet required qualifications
Discovery	

Discovery Evidence *(Performance Measure)*	Number and percent of provider agencies who meet qualifications *N: Number of BPHC provider agencies who meet qualifications at re-certification* *D: Total number of BPHC provider agencies due for recertification*
Discovery Activity *(Source of Data & sample size)*	100% of provider agency applications are reviewed prior to approval
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	. DMHA approves all providers for the BPHC program. The State's 24 DMHA-certified Community Mental Health Centers (CMHCs) are the exclusive providers for the BPHC program. CMHC's must meet all provider agency standards documented in the State Plan benefit and ensure that all direct care agency staff members providing services meet all required qualifications. The services are provided according to the standards and expectations outlined in the State Plan benefit. All providers must be re-certified by DMHA to provide services. The re-certification is required every three (3) years or at the time of re-accreditation.
Frequency	Ongoing

Remediation

Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA
Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a CAP is needed, it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

Requirement	3b) Providers meet required qualifications

Discovery

Discovery Evidence	Number and percent of provider agencies re-certified timely *N: Number of BPHC provider agencies recertified timely*

(Performance Measure)	*D: Total number of BPHC provider agencies recertified*
Discovery Activity *(Source of Data & sample size)*	100% of provider agency re-certification applications are reviewed prior to approval
Monitoring Responsibilities	DMHA

	(Agency or entity that conducts discovery activities)	
	Frequency	Every 3 years or at a time of reaccreditation
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA
	Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are quarterly. If a CAP is needed, it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

4. Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).

Requirement	4) Provider owned, controlled, and operated residential settings meet the home and community-based setting requirements as specified in the benefit and in accordance with 42 CFR 441.710(a)(1)-(2)
Discovery	

	Discovery Evidence *(Performance Measure)*	Number and percent of provider owned, controlled, and operated residential settings in compliance with criteria that meets standards for community living *N: Number of provider-owned, controlled, and operated residential settings in compliance with HCBS Settings final rule* *D: Total number of provider-owned, controlled, and operated residential settings*
	Discovery Activity *(Source of Data & sample size)*	100% of provider owned, controlled, and operated residential settings are reviewed to ensure applicants reside in HCBS compliant settings
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	. CMHC's receive assistance provided through DMHA webinars, onsite trainings, and technical assistance calls to increase the understanding of HCBS requirements for providers to successfully implement standards.

Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA
Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a CAP is needed, it must be provided to the State within 30 business days. The State will respond in 30 business days for a total of 60 business days.

5. The SMA retains authority and responsibility for program operations and oversight.

Requirement	5a) The SMA retains authority and responsibility for program operations and oversight
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of performance measure data reports from DMHA and contracted entities reviewed to ensure administrative oversight. *N: Number of data reports provided timely* *D: Total number of data reports due*
Discovery Activity *(Source of Data & sample size)*	100% review of DMHA Quality Management Reports
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	OMPP
Frequency	Quarterly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates*	DMHA and OMPP

	remediation activities; required timeframes for remediation)	
	Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are completed annually. If a CAP is needed from DMHA it must be provided within 30 business days and OMPP will respond in 30 business days for a total of 60 business days.

Requirement		5b) The SMA retains authority and responsibility for program operations and oversight
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of performance measure data reports from DMHA and contracted entities reviewed to ensure administrative oversight. *N: Number of data reports provided in correct format* *D: Total number of data reports due*
	Discovery Activity *(Source of Data & sample size)*	100% review of DMHA Quality Management Reports
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	OMPP
	Frequency	Quarterly
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA and OMPP
	Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are completed annually. If a CAP is needed from DMHA it must be provided within 30 business days and OMPP will respond in 30 business days for a total of 60 business days.

6. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.

Requirement	6a) The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of claims paid according to the published rate during the review period *N: Number of claims paid according to the published rate during the review period* *D: Total number of claims submitted during the review period*
Discovery Activity *(Source of Data & sample size)*	Medicaid Management Information System (MMIS) 100% review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	OMPP and Medicaid Fiscal Contractor
Frequency	Monthly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	OMPP
Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are completed annually. Corrective Action will follow the process identified in the contract between OMPP and MMIS vendor.

Requirement	6b) The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of paid during the review period for recipients enrolled in the program on the date the service was delivered *N: Number of claims paid during the review period for recipients enrolled in the program on the date the service was delivered* *D: Total number of claims submitted for recipients enrolled in the) program on the date the service was delivered*
Discovery Activity	Medicaid Management Information System (MMIS) 100% review

(Source of Data & sample size)	
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	OMPP and Medicaid Fiscal Contractor
Frequency	Monthly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	OMPP
Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are completed annually. Corrective Action will follow the process identified in the contract between OMPP and MMIS vendor.

7. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.

Requirement	7a) The State identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints and medication errors.
Discovery	

Discovery Evidence *(Performance Measure)*	Number and percent of provider agencies who have policies and procedures to prevent incidents of abuse, neglect, exploitation *N: Number of provider agencies with policies and procedures to prevent incidents of abuse, neglect, exploitation* *D: Total number of provider agencies with policies and procedures reviewed*
Discovery Activity *(Source of Data & sample size)*	100% of provider agencies policies and procedures reviewed to ensure health and welfare needs are addressed.
Monitoring Responsibilities	. DMHA reviews policies and procedures for all approved providers for the program to ensure health and welfare needs are addressed. Additionally, DMHA reviews 100% of all incident reports required to be and ensures the incident report is submitted within the required timeframe.

(Agency or entity that conducts discovery activities)	
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA
Frequency *(of Analysis and Aggregation)*	Review of policies and procedures occurs annually. If policies and procedures are not in compliance, revised policies must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

Requirement	7b) The State identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints and medication errors.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of incidents reported within required timeframe *N: Number of incident reports submitted within required timeframe* *D: Total number of incident reports submitted*
Discovery Activity *(Source of Data & sample size)*	100% review of submitted incident reports
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation*	DMHA

activities; required timeframes for remediation)	
Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. Report submitted to State within 72 hours. State will review plan and respond within 5 business days. If CAP is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

Requirement	7c) The State identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints, and medication errors.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of incident reports involving medication errors resolved according to policy *N: Number of incident reports including medication errors resolved according to policy* *D: Total number of incident reports including medication errors submitted*
Discovery Activity *(Source of Data & sample size)*	100% review of submitted incident reports
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA
Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. Report submitted to State within 72 hours State will review plan and respond within 5 business days. If a CAP is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

Requirement	7d) The State identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.

Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of incident reports involving seclusions and restraints resolved according to policy *N: Number of incident reports including seclusion and restraints resolved according to policy* *D: Total number of incident reports including seclusion and restraints submitted*
Discovery Activity *(Source of Data & sample size)*	100% review of submitted incident reports
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA
Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. Report submitted to State within 72 hours State will review plan and respond within 5 business days. If a CAP is needed it must be provided within 30 business days and the State will respond in 30 business days for a total of 60 business days.

Requirement	7e) The State identifies and addresses incident reports involving death
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of incident reports involving death resolved according to policy *N: Number of incident reports involving death where the participant's health, safety, and welfare were met by the provider* *D: Total number of incident reports involving death*
Discovery Activity *(Source of Data & sample size)*	100% review of provider agencies' critical incident reports involving death
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMHA
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMHA
Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. Incident report submitted to State within 24 hours for residential settings and within 72 hours for participants in a private/independent home setting. State will review submitted report and respond within 5 business days. If a CAP is needed, it must be submitted to the State within 30 business days. The State will respond in 30 business days for a total of 60 business days.

System Improvement
(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. Methods for Analyzing Data and Prioritizing Need for System Improvement

1) DMHA collects and tracks complaints related to the BPHC service offered through the 1915(i). Complaints could be received from recipients, family members, concerned citizens, providers, or advocates. Complaints are categorized as individual issue or system challenges. All complaints are discussed during monthly strategy meetings between DMHA and OMPP.
System challenge/barrier issues identified in the complaints are prioritized with solutions discussed for highest priority items.

2. Roles and Responsibilities

DMHA reviews and analyzes individual issues related to performance measures to identify any system trends. DMHA and OMPP monitor trends to identify the need for system changes.

3. Frequency

Monthly, Quarterly, and Annually

4. Method for Evaluating Effectiveness of System Changes

During the monthly meeting between DMHA and OMPP, the need for new system changes as well as the effectiveness of previous system changes will be discussed and evaluated. Additional changes will be made as necessary, including changes in provider agency training, bulletins, policy changes and refinements.

STANDARD-SETTING AUTHORITY FOR INSTITUTIONS

The state authority(ies) responsible for establishing and maintaining health standards, and standards other than those relating to health, for public or private institutions in which recipients of medical assistance under the plan may receive care or services are:

1. State Board of Health - Legal Base: Chapter 346, Acts of 1945 as amended

   The legal citation quoted above resulted in promulgation of State Board of Health General Regulations for Hospitals HHL-1 through HHL-41.

   Legal Base: Chapter 239, Acts of 1963 as amended

   The legal citation listed above resulted in promulgation of State Board of Health Health Facilities Regulations HHF 20 through HHF 38, effective June 3, 1970.

   These documents are on file in the Office of the State Board of Health, 1330 West Michigan Street, Indianapolis, Indiana.

2. Fire Marshal Department - The 1970 edition of the Federal Life Safety Code has been adopted and is used as the standards required by the State Fire Marshal Department.

   These standards are maintained on file in the State Fire Marshal Department, 502 State Office Building, Indianapolis, Indiana.

3. Administrative Building Council-

   Rules and Regulations of the Administrative Building Council:

Construction	- Volume I
Electrical	- Volume II
Plumbing	- Volume III
Mechanical	- Volume IV

   It is required that the above rules and regulations, on file in the Administrative Building Council Office, 215 North Senate Avenue, be followed completely. However, there are instances where the requirements of the State Fire Marshal Department exceed those of the Administrative Building Council. In order to qualify for Federal funds, the State Fire Marshal Department requirements are followed in each such instance.

Interagency Agreement between Family and Social Services Administration's Office of Medicaid Policy and Planning and the State Department of Health

I. PURPOSE

This Agreement is entered into by the Office of Medicaid Policy and Planning, Family and Social Services Administration, hereinafter referred to as OMPP, and the Indiana State Department of Health, hereinafter referred to as Health, for the purpose of defining interrelationships and responsibilities as well as providing for coordination between the parties in the certification of nursing facilities and intermediate care facilities for the mentally retarded (hereinafter jointly referred to as "long term care facilities"), psychiatric residential treatment facilities, home health and hospice service providers for participation in the Indiana Medical Assistance Program (Medicaid).

It is acknowledged by the parties hereto that Health is also responsible for survey and certification of certain Medicaid providers under Title XVIII (Medicare).

II. AUTHORITY

This Agreement is written in accordance with and pursuant to 42 USC 1396a(a)(5); 42 USC 1396a(a)(9); 42 USC 1396a(a)(33); 42 CFR Part 431, Subparts A and M; 42 CFR Part 442; 42 CFR 483, Subpart G; 42 CFR 418; 42 CFR 484; Section 1902(a)(33)(B) of the Social Security Act; the Indiana State Plan for Medicaid Assistance required under 42 USC 1396 *et seq*; and the Indiana State Health Plan required under section 42 USC 246 *et seq*.

III. RESPONSIBILITIES OF OMPP

A. OMPP shall administer its responsibilities regarding the Medicaid program for long term care facilities in accordance with federal law and regulation, specifically 42 CFR Parts 431 and 442, and in accordance with state law and promulgated rules to include IC 12-15-1-1 *et seq*.; IC 16-28 *et seq*.; and 410 IAC 16.2.

B. OMPP shall administer its responsibilities regarding the Medicaid program for psychiatric residential treatment facilities in accordance with federal law and regulation, specifically 42 CFR 483, Subpart G, and in accordance with state law and promulgated rules to include 405 IAC 5-20.

C. OMPP shall administer its responsibilities regarding the Medicaid program for home health agencies in accordance with federal law and regulation, specifically 42 CFR Part 484, and in accordance with state law and promulgated rules to include IC 16-27 *et seq*. and 410 IAC 17.

D. OMPP shall administer its responsibilities regarding the Medicaid program for hospice agencies in accordance with federal law and regulation, specifically 42 CFR Part 418, and in accordance with state law and promulgated rules to include 405 IAC 5-2-10; 405 IAC 1-16; 405 IAC 5-5-1; 405 IAC 5-34; IC 16-25; and 410 IAC 17.1.

E. OMPP shall perform the following duties specifically relating to the survey and certification process for psychiatric residential treatment facilities, home health agencies, hospice agencies and for long term care facilities as mentioned in Section I above which are certified under Title XVIII:

1. OMPP shall maintain and supply to Health upon request all rules and regulations pertaining to Medicaid long term care facilities, psychiatric residential treatment facilities, home health agencies and hospice agencies and inform Health of changes thereto.
2. OMPP shall issue, renew, cancel, or terminate provider agreements in accordance with certification findings issued by Health (or in the case of a Medicare participating facility, the Department of Health and Human Services, hereinafter referred to as DHHS).
3. OMPP shall notify Health on a timely basis of all provider agreement issuances, assignments, amendments, expirations and denials.
4. OMPP shall refer to Health any information regarding alleged violations of federal regulations and hazards to the health and safety of patients residing in long term care facilities and psychiatric residential treatment facilities participating in the Medicaid program. The OMPP shall also refer to Health any information regarding alleged violations and hazards to the health and safety of patients enrolled in either the Medicaid home health program or the Medicaid hospice program.

F. In exchange for services rendered in accordance with Section IV of this agreement, OMPP shall reimburse Health for actual costs allowable under appropriate federal regulations and guidelines, associated with the performance of Health's duties and responsibilities. OMPP shall reimburse Health for only those costs for which federal financial participation is available. Such reimbursement shall be subject to the following conditions:

1. Health shall forward copies of quarterly expenditure reports CMS 435, CMS 435A, and CMS 434 to OMPP. Health shall also provide a written request stating the total amount of funds to be reimbursed, designating the appropriate fund object center to which funds are to be transferred. OMPP shall transfer to Health Title XIX federal funds to cover Medicaid Certification and Nurse Aide Registry expenditures within thirty (30) days from receipt of documentation.

2. Full reimbursement shall be for expenditures incurred during the survey and certification of psychiatric residential treatment facilities, long term care facilities, home health agencies, and hospice agencies including providers and suppliers that are defined and certified under Title XVIII (Medicare), which are consistent with a budget that has received prior approval from OMPP and DHHS.

3. Expenditures for which reimbursement is claimed under this agreement shall not include any expenditures that are attributable to Health's overall responsibilities under State law and regulations for establishing and maintaining standards pertaining to State licensure of health facilities.

4. The state share of expenditures under this section shall be paid by Health.

IV. RESPONSIBILITIES OF HEALTH

A. In accordance with 42 USC 1396a(a)(9) and (33) and the Indiana State Plan for Medical Assistance, Health has been designated as the state health standard setting authority and state survey agency responsible for surveying institutional providers to certify that they meet standards for participation in the Medicaid program under the State Plan.

B. Health, as the designated state survey agency, shall perform the following duties specifically relating to the survey and certification of providers and suppliers defined and certified under Title XVIII (Medicare):

1. Utilizing qualified personnel, Health will conduct on-site surveys of Intermediate Care Facilities for the Mentally Retarded/Developmentally Disabled (MR/DD) at least annually, or more frequently if there is a question of compliance; conduct on-site surveys of Nursing Facilities in accordance with 42 USC 1396r(g); and, in accordance with applicable federal guidelines, conduct on-site reviews to validate psychiatric residential treatment facility attestations of compliance with federal restraint and seclusion standards, including any necessary follow up, enforcement and appeals activities.

2. Health will use federal standards and the forms, methods and procedures designated by DHHS to determine provider eligibility and certification under Medicaid as defined by 42 CFR 442.

3. Health will document findings and complete reports regarding a facility's compliance or noncompliance with each standard or requirement, including a listing of deficiencies. Upon determining the certification status and appropriate remedy(ies), Health will notify OMPP and the provider of certification status and any remedy(ies) imposed by Health in accordance with applicable federal rules and transmittals.

4. Health will notify the provider and OMPP of any action to discontinue remedy(ies).

5. Health will make available to nursing facilities, in accordance with 42 CFR 488.331, an informal dispute resolution process upon request of the nursing facility after the nursing facility receives notice of certification of noncompliance.

6. Health will conduct provider appeals of determinations of long term care facilities, psychiatric residential treatment facilities, home health agencies and hospice agencies compliance so long as the scope of the appeal is limited as set forth in Federal Regulations 42 CFR 431.

7. Hearing decisions will be forwarded to OMPP.

8. Health will report findings and notify OMPP of final determinations or any changes in the status of certification in a timely manner. The notification to OMPP must include:

   a. The type and term of certification, recertification or decertification;
   b. Total number of certified beds and location if distinct part certification; and
   c. Relevant materials supporting the certification decision, including ownership information.

9. Health will maintain on file all information and reports used in determining each long term care facility's, psychiatric resident treatment facility's, home health agency's and hospice agency's compliance with federal requirements, as maintained in the normal course of business, for a period of at least three (3) years or such longer periods of time as may be required by OMPP, and make such information and reports readily accessible to OMPP, DHHS, or their respective agents upon request. Such requests may be made:

(i) For meeting other requirements under the Plan; and
(ii) For purposes consistent with the Medicaid agency's effective administration of the program.

10. Health will retain in the state survey agency office for a period determined by agency records retention policy accurate ownership information, survey reports, findings, and deficiency statements, all of which shall become public information pursuant to State and Federal law.

11. Health will obtain annually and promptly furnish to OMPP, ownership and control information for each participating long term care facility, psychiatric residential treatment facility, home health agency and hospice agency.

12. Health will investigate complaints regarding long term care facilities, psychiatric residential treatment facilities, home health agencies and hospice agencies allegedly violating certification standards or otherwise jeopardizing the health and safety of patients. Also, Health will respond timely to OMPP following referral of alleged violations in accordance with section III, part E, paragraph 4 of this agreement.

13. Health will submit budget requests, expenditure estimates, and requests for reimbursement and expenditure reports at such times and in such manner as required by OMPP or DHHS, including the following:

    a. The above submittals shall be in accordance with federal guidelines unless otherwise specified in writing by OMPP.

    b. Health shall furnish or make available on request such supplemental accounts, records, or other information as may be required by OMPP, DHHS, or their agents, to substantiate any estimate, expenditure, or report as may be necessary for auditing purposes to verify the permissibility of expenditures under the agreement. This will include a separate accounting of Nurse Aide Registry and Training costs for OMPP's use in CMS 64 reporting.

    c. Each submittal shall include only those expenditures that are allowable under applicable federal regulations and guidelines; necessary and proper for carrying out Health's duties and responsibilities (including subcontract costs) under this agreement; and which are not attributable to Health's overall responsibilities under State law and regulations for establishing and maintaining standards pertaining to State licensure of health facilities.

    d. Documentation supporting expenditures reimbursed pursuant to Section III, part F shall be retained for a period of three (3) years with the following qualifications.

        1. If an audit is in progress, or if audit findings have not been resolved, the above-described records shall be retained until final resolution occurs.
        2. The three- (3) year retention period shall begin as of the date that the final payment is delivered to Health, or the date of expiration of this agreement, whichever is later.

14. Pursuant to Indiana Code § 16-28-12-2, Health will administer the dedicated fund for collection of civil money penalties in accordance with 42 U.S.C. 1396r(h)(2)(A)(ii) and provide information to OMPP about the administration of the fund upon request.

V. GENERAL PROVISIONS

A. The certification authority of Health shall not be delegated to any other governmental or private agency. However, Health may subcontract for and utilize the services, facilities and records of any State agency or local governmental agency to assist Health in performing its survey-related duties and responsibilities. Any subcontracts entered into by Health shall be written in accordance with this Agreement. No subcontract provision shall supersede any provision of this Agreement.

B. If a final disallowance is assessed the State due to Health's failure to abide by the provisions of this agreement and the governing federal regulations, the disallowance shall be assessed to Health in the following manner:

1. If the disallowance is the result of a fiscal audit, Health shall make restitution to OMPP, with assistance from the State Budget Agency, within a reasonable time frame.

2. If the disallowance is the result of a program or performance audit/review, Health shall repay all identified funds (federal and state) expended in relation to the invalid or incorrect action within a reasonable time period after the federal adjustment to the state account. The identified funds shall include the direct and indirect costs associated with the administrative, survey, and support personnel involved in the certification and decision making process which resulted in assessment of the disallowance.

C. Any property purchased with funds paid to Health under the provision of this and previous agreements shall be accounted for in accordance with standards established by OMPP governing the disposition of such property. OMPP shall provide Health with a copy of such standards.

D. The parties agree that this Agreement may be modified or amended by written amendments signed by both parties or their designated representatives.

E. This Agreement may be terminated by either party upon ninety- (90) days advance written notice to the other party. Termination of this Agreement shall be without prejudice to any obligation or liability of either party already accrued prior to such termination.

F. The foregoing constitutes the final written expression of agreement between the parties. Prior inconsistent oral and written agreements are hereby superseded.

G. Each of the parties hereto acknowledges and presents that such party has carefully read and fully understands the terms, conditions, and effect of this agreement and is entering into this agreement freely and voluntarily.

H. Multiple copies of this agreement may be executed in counterpart in lieu of a fully executed original. This agreement shall be deemed executed upon the date that both parties have signed a counterpart and delivered the signed counterpart to the other party. All of the counterparts, collectively, shall constitute the original agreement so that each of the parties shall be bound by the mutual promises and obligations of this agreement in full.

I. This agreement cannot be amended, modified, or supplemented in any respect except by subsequent written agreement signed by both parties.

J. This agreement shall be governed by the laws of the State of Indiana.

K. This agreement shall be binding upon the parties hereto, and their personal representatives, heirs, assigns, and successors in interest.

This agreement constitutes the terms or conditions agreed upon this 1st day of March, 2005, by the Indiana State Department of Health and Office of Medicaid Policy and Planning.

The parties having read and understood the foregoing terms of the contract do by their respective signatures dated below hereby agree to the terms thereof:

Jeanne LaBrecque
Director of Health Policy and Medicaid

Judith Monroe, M.D., Commissioner
State Department of Health

Charles Schalliol, Director
Office of Management and Budget

TN No. 05-003
Supersedes
TN No. 00-003

Approval Date SEP 22 2005

Effective Date ~~April~~ March 1, 2005

MEMORANDUM OF UNDERSTANDING
BETWEEN THE OFFICE OF MEDICAID POLICY AND PLANNING
AND
THE DIVISION OF DISABILITY, AGING, AND REHABILITATIVE SERVICES

I. PURPOSE

This Memorandum of Understanding is entered into by the Office of Medicaid Policy and Planning (hereinafter "Office") and the Division of Disability, Aging, and Rehabilitative Services (hereinafter "Division") in order to define the administrative and fiscal responsibility of the respective agencies in the Division's administration of the Indiana Vocation Rehabilitation Services.

II. AUTHORITY

This Memorandum is written in accordance with and pursuant to IC 12-15 et seq., IC 12-10-1 et seq.; 12-12-1 et seq.; 29 U.S.C. § 701; 29 U.S.C. § 721 and 42 U.S.C. § 1396a et seq.

III. PROGRAM RESPONSIBILITY

Both the Office and the Division recognize the responsibilities imposed upon the Office as the Single State Medicaid Agency and the importance of ensuring that the Office retain the authority to discharge its responsibilities in providing health benefits coverage under the Indiana State Medicaid Plan. Simultaneously, both the Office and the Division recognize that the Division is responsible for planning, establishing and operating programs, facilities and services relating to vocational rehabilitation. Consequently, the Office and the Division agree to the following division of responsibilities.

IV. RESPONSIBILITIES OF THE OFFICE

The Office shall:

A. Pursuant to IC 12-8-6-3, administer Medicaid as the designated single state agency.
B. Pursuant to IC 12-8-6-4, develop and coordinate Medicaid policy for the State of Indiana.
C. Pay claims made under Medicaid.
D. Draft and maintain the State Medicaid Plan for the medical assistance program.
E. Pursuant to IC 12-15-1-2, IC 12-15-1-4, and other applicable federal regulations, coordinate with state agencies and private contractors involved in the provision of Medicaid services.
F. Pursuant to IC 12-15-1-10, adopt rules and standards affecting services, programs and providers of medical services for recipients of Medicaid.
G. Respond to inquiries from interested parties that relate to areas under OMPP's administrative control.

H. Develop and maintain the appropriate Medicaid policy guidelines for the county offices of the Division of Family and Children and a manual for the medical provider community.
I. Accept Medicaid eligibility determinations made by the Division of Family and Children through its county offices.
J. Educate and inform providers about the proper billing procedures.
K. Be responsible for the fiscal and quality accountability and audits for services made under Medicaid.
L. Process provider claims for Medicaid payment and issue payment to providers in accordance with Medicaid procedures.
M. Process requests for prior authorization for services requiring prior authorization in accordance with state regulations.
N. The Office shall provide reimbursement for any necessary medical service covered by the Indiana Medicaid Program when an eligible customer of the Indiana Vocational Rehabilitation Services is dually eligible for Medicaid services.

V. RESPONSIBILITIES OF THE DIVISION

A. Pursuant to IC 12-9-1-3 and 12-12-1-1, establish the rehabilitation services bureau within the division.
B. Pursuant to IC 12-12-1-2, organize the rehabilitation services bureau to include the unit of vocational rehabilitation, referred to as Indiana Vocational Rehabilitation Services.
C. Pursuant to IC 12-9-2-3(a)(6), adopt rules necessary to carry out the functions of the Division.
D. Pursuant to IC 12-9-2-3(a)(7), establish and implement the policies and procedures necessary to carry out the functions of the Division.
E. Pursuant to IC 12-12-1-3(1), through the rehabilitation services bureau, plan, establish and operate programs, facilities and services relating to vocational rehabilitation.
F. Pursuant to IC 12-12-1-3(2), through the rehabilitation services bureau, design all necessary state plans for rehabilitation services required for receipt and disbursement of any money available to the state from the federal government.
G. Pursuant to IC 12-12-1-5, through the rehabilitation services bureau, provide job placement services and increase employment opportunities for persons with disabilities by encouraging and authorizing direct job placement into any job that is chosen by the vocational rehabilitation client.
H. Maintain the sole responsibility for determining the eligibility of all vocational rehabilitation applicants for vocational rehabilitation services.
I. Through Indiana Vocational Rehabilitation Services, provide vocational rehabilitation services to eligible persons consistent with the Division's mission, state plan, and current program guidelines.
J. Through Indiana Vocational Rehabilitation Services, coordinate with the vocational rehabilitation customer and other professionals to determine what vocational rehabilitation services are required and the manner of service provision.

K. Through Indiana Vocational Rehabilitation Services, coordinate appropriate vocation rehabilitation case-management services, including, pursuant to 29 U.S.C. § 721(A)(1), referrals to the Division of Family and Children's county offices for eligibility determinations for services available through that agency, including Medicaid services.

L. The Indiana Vocational Rehabilitation Services will be responsible for working directly with the Division of Family and Children caseworkers in order to share information, coordinate planning and services as appropriate in order to prevent duplication of services and to maximize the benefits received by mutual recipients/customers.

M. Pursuant to 29 U.S.C. § 721(A)(i) and 29 U.S.C. § 721(B)(i), the Indiana Vocational Rehabilitation Services will not be held financially responsible for services and benefits to an eligible individual when it is determined that comparable services and benefits are available to the individual under the Indiana Medicaid Program, unless such a determination would interrupt or delay the process of the individual toward achieving the employment outcome identified in the individualized plan for employment, or an immediate job placement, or the provision of such services at any individual at extreme medical risk and seek reimbursement from the Office in accordance with Section VI.

VI. MUTUAL RESPONSIBILITIES

A. The Office and the Division will coordinate reimbursing the Division for any payment of Medicaid covered services directly by the Division when the Division is required to pay to Medicaid providers in advance of payment to the providers by the Office as follows:

1. Pursuant to the EDS Provider Manual, Section 2-23, payments for covered Medicaid services made by the Indiana Vocational Rehabilitation Services to a provider shall be refunded in full by the provider.
2. The Medicaid provider must then bill the Office for reimbursement of the Medicaid covered service.
3. The Office and the Division will develop procedures for verifying vocational rehabilitation customers' eligibility status as Medicaid recipients in order to facilitate reimbursement of payments made by the Indiana Vocational Rehabilitation Services to Medicaid providers.

VII. COMMUNICATION AND INTRAAGENCY DISPUTES

A. To ensure that issues arising under this Memorandum are resolved expeditiously, the Office and the Division shall designate a liaison. The liaison shall coordinate execution of the functions and responsibilities encompassed in this Memorandum.

B. The liaisons of the Office and the Division shall attempt to resolve all disagreements. If a disagreement is not resolved by the liaisons, a formal meeting between the Office and Division's administrative staff may be requested by either party.

VIII. MODIFICATION

This Memorandum may be modified at any time by a written modification mutually agreed upon by both the Office and the Division.

IX. TERMINATION

This Memorandum may be terminated at any time with the mutual consent of both the Office and the Division.

X. SIGNATURES

This Memorandum is signed and entered into on the date indicated below.

For the Office:

Kathleen D. Gifford
Assistant Secretary
Office of Medicaid Policy and Planning

Date: 6/29/2000

For the Division:

Alex Braitman
Acting Director
Division of Disability, Aging and Rehabilitative Services

Date: 6/30/00

MEMORANDUM OF UNDERSTANDING
BETWEEN
INDIANA STATE DEPARTMENT OF HEALTH
AND
INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION

This Agreement is made and entered into by and between the Indiana State Department of Health, hereinafter referred to as ISDH, and the Indiana Family and Social Services Administration, hereinafter referred to as IFSSA, specifically the Office of Medicaid Policy and Planning (OMPP) and Division of Family and Children (DFC).

WHEREAS, ISDH and IFSSA enter into a Memorandum of Understanding for the intent and purpose to promote high quality health care and service for recipients under the Medicaid Program; to comply with state and federal statutes, regulations and guidelines requiring the proper expenditures of public funds for the administration of the Medicaid Program including but not limited to the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program.

WHEREAS, the ISDH is the State government agency responsible for administering the Title V program that includes Maternal and Child Health Services (MCH) and Children's Special Health Care Services (CSHCS); and the Supplemental Food Program for Women, Infants, and Children (WIC) in Indiana.

WHEREAS, it is the desire of the ISDH to enter into memoranda of understanding with other agencies for the purpose of obtaining assurance to deliver maternal and child health services, nutritional services, and services for children with special health care needs.

WITNESSETH, in consideration of the mutual promises herein contained, the ISDH and IFSSA have agreed and do hereby enter into this cooperative agreement according to the provisions set out herein:

I. Scope of Services

ISDH agrees to:
A. Coordination

1. Refer MCH, CSHCS, and WIC program Participants who may be eligible for Medicaid to the nearest county office of the Division of Family and Children and inform participants of the current hours of service.

2. Coordinate activities with the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) (Healthwatch) Program under

Section 1905 (a) (B) (Social Security Act) and other Medicaid program initiatives to ensure that the ISDH carries out Title V programs without duplicating efforts. These activities shall include: the development of policies, similar periodicity schedules, special programs, and provision of outreach services.

3. Review with Medicaid the periodicity schedules and content standards for health care services including EPSDT.

4. Provide care coordination services and access to CSHCN program's approved providers, and Regional Diagnostic and Treatment Centers to children dually enrolled in Medicaid and the CSHCS program.

5. Facilitate on-site Medicaid eligibility determinations in WIC and Title V sites.

6. Facilitate administrative support of on-site placement of Medicaid staff and/or training of local provider staff including MCH, WIC, and CSHCS program staff to determine Medicaid eligibility or refer clients to the county office of the Division of Family and Children.

7. Mandate that qualified Title V funded MCH providers delivering health services be Medicaid providers and participate in the EPSDT (Healthwatch) program.

8. Inform local MCH, WIC, and CSHCS offices of this Agreement and of the responsibilities of the local program staff affected by this Agreement.

9. Enroll in the Indiana Health Coverage Programs (IHCP) as a family member transportation provider and submit claims for the travel expenses of IHCP-eligible CSHCS enrollees that are reimbursed under 410 IAC 3.2-9-1.

10. Contract with the IHCP Managed Care Organizations (MCO) to receive reimbursement for the mileage of members enrolled in the Medicaid Risk-Based Managed Care program.

11. Verify that families whose travel expenses are reimbursed comply with the requirements of 405 IAC 5-4-3(1) through (3), and maintain records of families' licenses, vehicle registration, and insurance in accordance with the requirements of 405 IAC 5-4-3.

INSERT * (after IFSSA contributes the first $50,000.00 of required state share not for the initial two years) wsk

12. Reimburse the IHCP monthly for the state share of CSHCS family member transportation expenditures. OMPP shall forward copies of monthly MAR expenditure reports. OMPP shall also

provide a written request stating the total amount of funds to be reimbursed, designating the appropriate fund object center to which funds are to be transferred. ISDH shall transfer to OMPP CSHCS funds to cover the state share of the family member transportation expenditures within thirty (30) days from receipt of documentation.

B. Outreach

1. Develop outreach materials with input from IFSSA that promote information about the Medicaid/EPSDT program, the toll-free Helpline number, and information concerning sources of health care financing options for children with long-term special health care needs.

2. Maintain the toll-free telephone number (Indiana Family Helpline, and TTY/TDD) to provide information about relevant health and social services including services funded through Social Services Block Grant, Title V, WIC, and Title XIX.

3. Incorporate Medicaid/EPSDT (HealthWatch) providers into the database of information for the toll-free Helpline no less frequently than provided by OMPP or its contractor.

4. Provide outreach materials to IFSSA, the Division of Family and Children and the Office of Medicaid Policy and Planning for dissemination to the county offices of the Division of Family and Children.

5. Provide the addresses, telephone numbers, and hours of service of the local WIC clinics, MCH clinics, the CSHCS treatment centers, and immunization service sites to IFSSA, Division of Family and Children and the Office of Medicaid Policy and Planning no less frequently than on a quarterly basis.

C. Data Collection and Transmittal

1. Cross match, through the WIC Data System, computerized participant files from Medicaid and WIC to generate a monthly list of newly enrolled Medicaid prenatal clients and children under 5 years of age who are not on the WIC Program to increase outreach efforts.

2. Provide Office of Medicaid Policy and Planning with data and information on Indiana population-based health care assessments on access, health status and progress in meeting the Department of Health and Human Services' Healthy People 2010: National Health

Promotion and Disease Prevention Objectives; annually or as frequently as they are available.

IFSSA agrees to:

A. Coordination

1. Refer appropriate Medicaid applicants in each county office of the Division of Family and Children to WIC Services, Title V funded or non-Title V funded providers of maternal and child health services, Children's Special Health Care Services, and immunization services.

2. Accept referrals of persons from Title V funded and non-Title V funded MCH providers and process applications for persons who are referred, enroll applicants in the Medicaid payment system who are found to be eligible, and redetermine Medicaid eligibility, via the county offices of the Division of Family and Children.

3. Accept and process applications for the Children's Special Health Care Services Program.

4. Provide for enrollment of qualified Title V funded and non-Title V funded MCH providers as Medicaid providers.

5. Provide ISDH with a copy of provider bulletins, a provider manual, and an updated list of enrolled Medicaid and EPSDT (Healthwatch) providers no less frequently than quarterly.

6. Inform the county office of the Division of Family and Children of this Agreement and of the responsibilities of the county department personnel as affected by this agreement.

7. Accept and process Primary Care Case Management and Fee for Service family member transportation claims from ISDH.

8. Facilitate discussions with the MCO's regarding ISDH reimbursement under the capitation payments.

B. Outreach

1. Disseminate MCH, CSHCS, WIC and immunization outreach materials to the Division of Family and Children's county offices and the Office of Medicaid Policy and Planning.

C. Data Collection and Transmittal

1. Provide ISDH with demographic data and program activity summary on prenatal, EPSDT (HealthWatch) eligible, and persons served by IFSSA, necessary to fulfill Title V federal reporting requirements and to track MCH-related U.S. Department of Health and Human Services Healthy People 2010: Health Promotion and Disease Prevention Objectives within time frames established by the ISDH and IFSSA.

2. Make available each month to the WIC contracted computer firm the names of pregnant women and children under age five newly certified for Medicaid to be used for outreach and eligibility determination.

3. Share information and collaborate to develop a process to make available each month the names of children enrolled in the Medicaid Program who are also CSHCS recipients.

ISDH and IFSSA mutually agree to:

A. Coordination

1. Work collaboratively to improve the availability and quality of comprehensive health care and nutritional services provided for women, infants, children, adolescents, and families served by both agencies.

2. Assist and promote information to resolve issues relating to provider relations, client eligibility, or reimbursement.

3. Share and review results of any study or analysis based on shared Medicaid, Title V, or WIC participant data on shared clientele with designated staffs prior to release, within mutually acceptable time frames.

4. Provide jointly developed training sessions for the purpose of implementing this Agreement and promoting high quality health and medical services for eligible families.

5. Meet on a regular basis to institute common standards of care to be used by WIC, Title V, and Title XIX, including but not limited to EPSDT, and document results and progress of meetings.

6. Meet on a regular basis for the purpose of evaluating and exploring other alternatives for increasing cooperation, maximizing

resources and services delivery, and exchanging data. Document progress and results of meetings.

7. Assure that Title XIX, Title V services and WIC services are consistent with the needs of participants and the three programs' objectives and requirements.

8. Work collaboratively in the development and implementation of Medicaid managed care arrangements for Clients receiving Title V services including pregnant women, children, adolescents or children with special health care needs.

B. Data Collection and Transmittal

1. Assign specific agency designees to accept and coordinate all data requests from each respective agency.

2. Work collaboratively by jointly providing necessary client data files on a mutally acceptable schedule to facilitate client care administration and to permit matching of population-based and other programmatic data files for evaluation purposes.

3. Be in compliance with applicable state and federal laws regarding confidentiality of participation information.

4. Assure that each program will restrict the use or disclosure of information obtained from program applicants or participants to persons directly connected with the administration and of the enforcement of the respective program and the Comptroller General of the United States for audit and examination authorized by law.

II. Essential Terms and Conditions

A. Liaison Responsibilities:

The State Health Commissioner and the Secretary of Family and Social Services Administration shall designate appropriate liaisons whose responsibilities shall include regular and periodic communication about the programs and operations described in the Agreement.

The liaisons shall be responsible for the joint planning of relationships between the two agencies. They shall oversee the investigation of any problems that arise from the operation of the Agreement. They shall periodically review the effectiveness of the working relationship

defined in this agreement, and shall initiate jointly any amendments to the agreement.

B. Amendment and Termination:

This cooperative agreement may be modified only by written amendment executed by the parties hereto and approved by the appropriate state officials (s). This cooperative agreement may be terminated by either party through written notice to the other, at least 30 days before the effective date of such termination.

C. Agreement Period:

The term of this Agreement shall begin on the first day of JULY 2002, and will continue thereafter until termination by either party upon 30 days advance written notice to the other.

Gregory Wilson, MD

GREGORY WILSON, M.D.
STATE HEALTH COMMISSIONER.

JOHN HAMILTON, SECRETARY
FAMILY & SOCIAL SERVICES
ADMINISTRATION

Melanie Bella

MELANIE BELLA,
ASST. SECRETARY
OFFICE OF MEDICAID POLICY
AND PLANNING

JOHN BOYCE, DIRECTOR
DIVISION OF FAMILY &
CHILDREN

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I. INTERAGENCY AGREEMENT

1. This agreement is made and entered into by and between the Office of Medicaid Policy and Planning, having a mailing address of 402 West Washington Street, W382, Indianapolis, Indiana 46204, hereinafter referred to as OMPP, and the Division of Mental Health, having a mailing address of 402 West Washington Street, W353, Indianapolis, Indiana 46024, hereinafter referred to as DMH, and the Division of Aging and Rehabilitative Services, having a mailing address of 402 West Washington Street, W451, Indianapolis, Indiana 46024, hereinafter referred to as DARS.

2. WHEREAS, OMPP is the single state agency responsible for the administration of the Indiana Medicaid Program under the provisions of IC 12-15-1-1 and Title XIX of the Social Security Act; and

3. WHEREAS, DMH operates certain state inpatient psychiatric institutions and certain state institutional intermediate care facilities for the mentally retarded (ICF's/MR); and

4. WHEREAS, DARS operates certain state institutional intermediate care facilities for the mentally retarded; and

5. WHEREAS, IC 12-15-5 provides for Medicaid payment for services to patients who have been found eligible for Medicaid under IC 12-15-5 for inpatient services provided by inpatient psychiatric institutions for patients under age twenty-one (21) [those in treatment immediately preceding their twenty-first (21st) birthday may continue in treatment until age twenty-two (22)], and for patients who are age sixty-five (65) or over; and for patients residing in Medicaid certified institutions for the intermediate care for the mentally retarded, and

6. WHEREAS, Title XIX of the Social Security Act and the related federal regulations place precise and strict requirements on the payment for psychiatric hospital inpatient care for eligible Medicaid recipients in order for the State of Indiana to claim its proper and appropriate share of Federal Financial Participation (FFP) under its Medicaid Plan; and

7. WHEREAS, 42 CFR 431.620 requires that an interagency agreement be executed which will maximize cooperation between the parties to this agreement to carry out the objectives of the respective programs which they administer;

8. NOW, THEREFORE, the parties hereby agree to the following terms and conditions and the parties further agree to actively promote the cooperative relationships this agreement is intended to create. This agreement shall insure that the parties hereto have a functional relationship effectuated through an interagency agreement which:

    a) provides for maximum utilization of care and services available under the programs; and

    b) utilizes these programs to develop more effective use of Medicaid resources, and to develop joint planning to determine alternative methods of care.

II. DUTIES OF OMPP

1. OMPP shall reimburse each provider for which there is a current active Medicaid provider agreement in accordance with applicable state and federal reimbursement criteria.

2. With respect to referrals from DMH, OMPP assures that referrals of individuals with psychiatric impairments from providers or from DMH are processed, that applicants found to be eligible will be enrolled, and continued Medicaid eligibility determined.

3. With respect to referrals from DARS, OMPP assures that referrals of individuals with developmental delays are processed, that applicants found to be eligible will be enrolled, and continued Medicaid eligibility determined.

4. OMPP will cooperate with the staff of any provider and DMH or DARS in assisting Medicaid enrolled patients or the patients' families in obtaining community-based services and resources needed by the patient in order to facilitate his earliest possible release from inpatient psychiatric care or institutional ICF/MR care.

5. OMPP agrees to provide to DMH and DARS the following upon request:

    1) access to the Medicaid State Plan;

    2) a list of enrolled providers and suppliers of care and services, when necessary for interagency coordination in administration of the program.

6. It shall be the responsibility of OMPP to communicate with County Offices of the Division of Family and Children (aka County Departments of Public Welfare) regarding this agreement.

III. DUTIES OF DMH

1. It shall be the duty of DMH to refer for authorization for Medicaid reimbursement of services only those persons:

   a) who require inpatient psychiatric hospital services on a continuous twenty-four (24) hour a day basis by a provider who meets Medicaid certification requirements as a psychiatric facility to provide inpatient psychiatric services for Medicaid recipients under age twenty-one (21); or

   b) who require inpatient psychiatric hospital services on a continuous twenty-four (24) hour a day basis by a provider who meets Medicaid certification requirements as a psychiatric facility to provide inpatient psychiatric services for Medicaid recipients over age sixty-five (65); or

   c) who require services provided by a Medicaid-certified ICF/MR.

   If the recipients described in a) through c) above have been admitted to a provider facility, they must have been admitted in accordance with the laws of Indiana which control voluntary and involuntary admission to such facilities.

2. DMH agrees to maintain such records as are necessary to carry out Medicaid-related functions and responsibilities with regard to Medicaid provider certification and rate setting, Medicaid recipient eligibility, and services provided to eligible Medicaid recipients for which payment is claimed.

3. DMH further agrees to furnish any such records as mentioned above at any and all reasonable times to OMPP, the Medicaid Fiscal Agent, the State Department of Health in its role as State Survey Agency, and any other OMPP designees.

4. DMH agrees to abide by and to require the state-operated intermediate care facilities for the mentally retarded it operates to abide by all applicable state and federal statutes and regulations, state administrative directives, policies, and procedures of the Medicaid Program, including but not

limited to requirements for admission, on-going treatment, tracking medical care for patients under twenty-one (21) years of age, plan of discharge, utilization review committee functions, and independent medical review.

5. DMH agrees to maintain procedures for the immediate readmission to an inpatient facility, when necessary, of Medicaid patients who have been discharged, are on leave, or are otherwise not receiving inpatient psychiatric services or institutional ICF/MR services; provided, however, that it is understood that this agreement in no way obligates or authorizes DMH or any provider to readmit any person involuntarily, except in accordance with IC 12-26-4; IC 12-26-5; IC 12-26-6; or IC 12-26-7.

IV. DUTIES OF DARS

1. It shall be the duty of DARS to refer for authorization for Medicaid reimbursement of services only those persons:

    a) who require services provided by a Medicaid-certified ICF/MR.

    If the recipients described in a) above have been admitted to a provider facility, they must have been admitted to a provider facility in accordance with the laws of Indiana which control voluntary and involuntary admission to such facilities.

2. DARS agrees to maintain such records as are necessary to carry out Medicaid-related functions and responsibilities with regard to Medicaid provider certification and rate setting, Medicaid recipient eligibility, and services provided to eligible Medicaid recipients for which payment is claimed.

3. DARS further agrees to furnish any such records as mentioned above at any and all reasonable times to OMPP, the Medicaid Fiscal Agent, the State Department of Health in its role as State Survey Agency, and any other OMPP designees.

4. DARS agrees to abide by and to require the state-operated intermediate care facilities for the mentally retarded it operates to abide by all applicable state and federal statutes and regulations, state administrative directives, policies, and procedures of the Medicaid Program, including but not limited to requirements for admission, on-going treatment, tracking medical care for patients under twenty-one (21) years of age, plan of discharge, utilization review committee functions, and independent medical review.

5. DARS agrees to maintain procedures for the immediate readmission, when necessary, to an intermediate care facility for the mentally retarded of Medicaid patients who have been discharged, are on leave, or are otherwise not receiving ICF/MR services; provided, however, that it is understood that this agreement in no way obligates or authorized DARS or any provider to readmit any person involuntarily, except in accordance with IC 12-26-4; IC 12-26-5; IC 12-26-6; or IC 12-26-7.

6. It shall be the duty of DARS to provide an initial diagnosis and evaluation for each developmentally disabled Medicaid recipient who could be appropriately placed in an ICF/MR. DARS shall communicate the results of the diagnosis and evaluation to OMPP as expeditiously as possible in order to facilitate prompt, proper placement in an ICF/MR. DARS shall also make available upon request any records pertaining to the initial diagnosis and evaluation of any Medicaid recipient to OMPP or its designee.

V. MUTUAL DUTIES AND OBJECTIVES

1. For Medicaid recipients in psychiatric hospitals who are under age twenty-one (21) the requirements of 42 CFR 456.480-482 must be met. For Medicaid recipients in mental hospitals who are over age sixty-five (65), the requirements of 42 CFR 456.160 and 42 CFR 456.180 must be met, and for Medicaid recipients in ICF's/MR, the requirements of 42 CFR Part 483, and 42 CFR 456.360-381 must be met.

2. The parties agree that an effort should be made to place patients returning to community living in their natural homes or in individualized integrated settings.

3. Each Medicaid enrolled patient must receive active, ongoing treatment as evidenced by an established written and regularly updated individual plan of care. The plan of care must include information regarding the potential for patient discharge from an inpatient treatment.

4. For Medicaid recipients in psychiatric hospitals who are under age twenty-one (21), the individual plan of care shall set forth treatment objectives and describe an integrated program of appropriate therapies, activities, and experiences designed to meet those objectives. The plan shall be formulated in consultation with the recipient and parents, legal guardians, or others to whose care or custody the recipient may be released following discharge. The plan shall be based upon

diagnostic evaluation which includes an examination of the medical, psychological, social, behavioral, and developmental aspects of the recipient's situation. The plan shall include at an appropriate time a post-discharge treatment plan and plan for coordination of inpatient services for Medicaid patients under age twenty-one (21), with partial discharge plans and appropriate related services in the patient's community, to insure continuity of care when the patient is returned to his family, school, or community.

5. For Medicaid recipients in mental hospitals who are over age sixty-five (65), the individual plan of care shall include an initial review of the recipient's medical, psychiatric and social needs; periodic review of the recipient's medical, psychiatric and social needs; a determination, at least quarterly, of the recipient's need for continued institutional care and for alternative care arrangements; appropriate medical care in the institution, and appropriate social services.

6. Each Medicaid patient's plan of care shall be reviewed and updated every ninety (90) days for Medicaid recipients residing in ICF's/MR and recipients over age sixty-five (65) residing in institutions for mental diseases, and every thirty (30) days for recipients under age twenty-one (21) receiving services in a psychiatric hospital. Such review will be by an interdisciplinary team and shall consist of a determination that the services provided were and continue to be required on an inpatient basis, and for recommendations as to necessary adjustments in the plan as indicated by the patient's overall adjustment as an inpatient. This periodic update of the plan of care must be in writing and made a part of the patient's record.

7. The psychiatric hospital's utilization review committee shall review the appropriateness of admissions and continued stay by applying criteria contained in the approved utilization review plan. Such criteria shall be developed or adapted from appropriate regional norms. In any case, the initial review date shall be not longer than thirty (30) days after admission. Subsequent reviews must occur at least every ninety (90) days thereafter for patients over age sixty-five (65), and at least every thirty (30) days for patients under age twenty-one (21). Assigned review dates shall be recorded in the patient's record. All utilization review activities shall be conducted according to applicable federal regulations. Evidence of the utilization review committee action on admissions and patient plans of care are to be made a matter of record and shall be available for review by OMPP or any designee of OMPP.

8. This agreement will be reviewed after the date of signing on any occasion requested by the parties to the agreement. Further, this agreement may be amended at any time upon written agreement of all of the parties to the agreement.

This agreement is entered into this 15th day of April, 1993.

James Verdier, Asst. Secretary
Office of Medicaid Policy
and Planning

Robert Dyer, Ph.D., Director
Division of Mental Health

Bobby Conner, Director
Division of Aging and
Rehabilitative Services

INTERAGENCY AGREEMENT
BETWEEN
INDIANA STATE DEPARTMENT OF PUBLIC WELFARE
EARLY PERIODIC SCREENING,
DIAGNOSIS AND TREATMENT PROGRAM
AND
THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN, YOUTH AND FAMILIES
HEAD START PROGRAM

I. Purpose of the Agreement

This agreement intends to increase the number of children participating in the Early Periodic Screening Diagnosis and Treatment (EPSDT) Program through the referral of Medicaid eligible children by local Head Start Agencies to EPSDT providers for services, and, to provide the local Head Start Agencies with screening and treatment services for Medicaid eligible Head Start children.

II. Mutual Objectives and Agency Responsibilities

Listed below are the responsibilities that the Indiana State Department of Public Welfare and Head Start Programs agree to assume when jointly serving EPSDT/Head Start children:

A. Eligibility

The Head Start Program shall:

1. Determine the Medicaid status of all Head Start children.
2. Refer potentially Medicaid eligible children and their families to the County Department of Public Welfare for eligibility determination.
3. Provide Medicaid eligible enrollees with brochures explaining available services.
4. Ensure confidentiality in the exchange of information by first obtaining a signed authorization from the parent or guardian.
5. Determine if children are presently participating in the EPSDT Program.
6. Determine from the parent or guardian of all Medicaid eligible enrollees whether an EPSDT screening was received by the child within the past year. If so, the parent's copy of the EPSDT Screening Form could be shared with Head Start to help satisfy program requirements or;

-continued-

Effective Date 4/1/86
Approval Date 4-1-86

7. Request the health records of enrollees from EPSDT providers who have been identified by the parents and/or the EPSDT Program, following appropriate authorization.

The Indiana State Department of Public Welfare shall:

1. Ensure that an explanation and offer of EPSDT services are given on the local level to every Medicaid eligible enrollee of appropriate age.

2. Furnish local Head Start Programs with EPSDT brochures which outline EPSDT services.

Joint Responsibilities

1. Inform each other of any changes in the EPSDT and/or Head Start Programs which may affect eligibility.

B. Arrangement for Screening Services

The Head Start Program shall:

1. Explain the value of EPSDT services to Medicaid eligible enrollees and their families and encourage them to schedule appointments with an EPSDT Provider.

2. Request from the Indiana State Department of Public Welfare a current listing of EPSDT Screening Providers within each geographical target area.

3. Act as facilitator between Head Start parents and the Indiana State Department of Public Welfare or designated representative in arranging EPSDT screening and supportive services, such as transportation.

4. Encourage the scheduling of group screening appointments with local EPSDT Screening Providers for Head Start enrollees and their families whenever possible.

The Indiana State Department of Public Welfare shall:

1. Assume primary responsibilities in scheduling EPSDT screening services for those Head Start participants who are Medicaid eligible and meet the criteria for participation in the EPSDT program, within the constraints of availability of services.

2. Provide current listings of all EPSDT screening providers (by county) to the Indiana Specialist, Resource Access Project, University of Illinois, with periodic update as needed.

Joint Responsibilities

1. Protect the family's rights to freedom of choice in selecting medical and dental providers.

C. Case Management

The Head Start Program shall:

1. Act as facilitator between Head Start parents and the Indiana State Department of Public Welfare or designate in arranging referrals for diagnostic and treatment services, when indicated. Possible activities include:

   - Provision of supportive services to families of Head Start children who are scheduled for EPSDT services.

   - Reminding the parents or guardians of enrolled children of scheduled EPSDT appointments.

   - Provision of follow-up to Head Start families when scheduled appointments have been missed.

2. Encourage the family of such a child leaving Head Start to continue a preventive health schedule.

The Indiana State Department of Public Welfare shall:

1. Assume case management responsibilities for all EPSDT eligible children who leave the Head Start Program and shall be ultimately responsible for all case management activities for all EPSDT children including those enrolled in the Head Start Program.

D. Provider Recruitment

The Head Start Program shall:

1. Refer interested providers who are not participating in the EPSDT Program to the Indiana State Department of Public Welfare for enrollment as an EPSDT provider.

The Indiana State Department of Public Welfare shall:

1. Pursue the enrollment of eligible providers identified by the Head Start Program.

E. Outreach and Health Education

The Head Start Program shall:

1. Include information on the EPSDT Program in its health education curricula for enrolled children and their families, emphasizing the value of routine preventive health care.

2. Expand community education and outreach efforts as needed to increase participation of Medicaid-eligibles in the Head Start and EPSDT Programs.

3. Supply the Indiana State Department of Public Welfare with Head Start educational materials.

The Indiana State Department of Public Welfare shall:

1. Distribute educational material on the EPSDT Program to the Indiana Specialist, Resource Access Project, University of Illinois.

2. Provide annual, written notification of available services to eligible families who have not participated in the EPSDT Program.

3. Make Head Start educational materials available to Medicaid eligible families.

Joint Responsibilities

1. Coordinate training sessions for respective outreach staff to maximize mutual understanding of the EPSDT and Head Start Programs.

2. Review written materials for appropriateness and consistency and update as needed.

F. Confidentiality

This Agreement shall contain the assurance that all information obtained by either party to this Agreement from mutual participants shall constitute privileged communications, shall be held confidential and shall not be divulged to anyone except the patient or parent or guardian of the patient without written permission. Information pertaining to individual participants shall be released only for purposes directly connected to the efficient administration of the EPSDT Program or the Head Start Program after obtaining consent for such disclosure. Information may otherwise be disclosed only in summary, statistical or other form which does not identify particular individuals.

G. Exchange of Program Information

The Head Start Program shall supply the following information to Indiana State Department of Public Welfare:

1. Head Start Program Performance Standards and related policy memoranda.

2. Pertinent educational materials developed by the Head Start Program.

3. A list of all Head Start grantees, including addresses, telephone numbers, names of current directors and health coordinators and counties served.

4. Other evaluation reports as appropriate.

The Indiana State Department of Public Welfare shall supply the following information to Head Start:

1. EPSDT posters and brochures, as well as educational materials developed by the Indiana State Department of Public Welfare.

2. Names and addresses of certified EPSDT Screening Providers by county.

3. Locations of County Department of Public Welfare Offices, and State EPSDT Staff.

4. Other evaluation reports as appropriate.

I. Management of Collaborative Activities

To facilitate implementation of this Agreement, both parties agree to the following:

Both parties will invite mutual participation in relevant training sessions and seminars and will jointly arrange special sessions as necessary.

J. Continuous Liaison

The following staff have been appointed to act as interagency liaison for all matters concerning this Agreement:

Regional ACYF/Head Start

GERMAN WHITE, JR.
REGIONAL PROGRAM DIRECTOR
ADMINISTRATION FOR CHILDREN, YOUTH AND FAMILIES
DEPARTMENT OF HUMAN SERVICES
REGION V OFFICE
300 SOUTH WACKER DRIVE
CHICAGO, ILLINOIS 60606

Resource Access Project

NIURKA MASTRAPA
ASSOCIATE COORDINATOR
INDIANA SPECIALIST
UNIVERSITY OF ILLINOIS
403 EAST HEALEY STREET
CHAMPAIGN, ILLINOIS 61820

Indiana EPSDT:

IVAN SUMNER AND JUDY RENSCHLER
INDIANA DEPARTMENT OF PUBLIC WELFARE
MEDICAID DIVISION, ROOM 701
100 NORTH SENATE AVENUE
INDIANAPOLIS, INDIANA 46204

K. Periodic Review and Update of Agreement

This Agreement shall be in effect for a period of one (1) year from the original date of approval and shall be reviewed annually, two months prior to the anniversary date of its execution, by all the responsible parties. Liaison staff identified herein shall arrange for its review. Such review shall be for the purposes of discussing its implementation and for modification, clarification or redefinition of any provision as deemed necessary.

This Agreement shall automatically renew on the anniversary date of its approval. Any modification shall require the signatures of the authorized parties.

IV. Signatures

This Agreement is signed and entered into on the date indicated below.

FOR: RESOURCE ACCESS PROJECT

BY: _____
Merle B. Karnes
Project Director
Resource Access Project

DATE: 2-24-86

FOR: INDIANA STATE DEPARTMENT OF PUBLIC WELFARE

BY: _____
Donald L. Blinzinger
Director
Indiana State Department of Public Welfare - Medicaid Division

The provisions of this Agreement have been reviewed and are endorsed by the parties indicated below.

FOR: INDIANA HEAD START ASSOCIATION

BY: _____
SherrieBell, President
Indiana Handicapped Services Advocate

DATE: 2/26/86

COOPERATION AGREEMENT BETWEEN INDIANA FAMILY & SOCIAL SERVICES ADMINISTRATION, OFFICE OF MEDICAID POLICY & PLANNING AND THE OFFICE OF THE ATTORNEY GENERAL

THIS AGREEMENT is entered into between the Office of the Indiana Family and Social Services Administration, Medicaid Policy and Planning, hereinafter referred to as the "Office", and the Office of the Attorney General, State of Indiana, hereinafter referred to as "OAG".

THIS AGREEMENT in no way is intended to inhibit or relieve the Office from its management responsibilities of prevention, detection, and elimination of abusive and improper or fraudulent practices in the Medicaid program.

WHEREAS, Public Law 95-142,91 Stat.1175, was enacted by the U.S. Congress on October 25, 1977, to strengthen the capability of the government to detect, prosecute, and punish fraudulent activities under the Medicare and Medicaid programs; and

WHEREAS, Section 17 of P.L. 95-142 authorized the Secretary of the U.S. Department of Health and Human Services to certify a state Medicaid Fraud Control Unit for which the federal government will fund a percentage of the costs for establishment and operation thereof up to a maximum specified in the law; and

WHEREAS, P.L. 95-142 requires that a state Medicaid Fraud Control Unit be an entity separate and distinct from the single state agency that administers or supervises the administration of the state Medicaid program; and

WHEREAS, pursuant to the requirements of P.L. 95-142, the Secretary of the U.S. Department of Health and Human Services has promulgated regulations (42 CFR 1007.9) pertaining to the establishment of state Medicaid Fraud Control Units which require that an entity applying for certification as a Medicaid Fraud Control Unit have an agreement with the single state agency administering the Medicaid program whereby the Medicaid agency agrees to comply with the conditions established in 42 CFR 455.21(a)(2).

AGREEMENT:

IT IS AGREED between the Office and the OAG that each shall comply fully with the following provisions in order for the State of Indiana to receive federal funding for the establishment and operation of a Medicaid Fraud Control Unit within the OAG as defined and authorized by Public Law 95-142;

THE OFFICE AGREES TO:

(1) Promptly refer to the Indiana Medicaid Fraud Control Unit, hereinafter referred to as "IMFCU", of the OAG:

a) all cases of suspected fraud in the administration of the Medicaid program. For the purposes of this agreement, "fraud" has the definition used in 42 CFR 455.2: "an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to

himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law";

b) all cases of suspected abuse in the administration of the Medicaid program. For the purposes of this agreement, "abuse" has the definition used in 42 CFR 455.2: "provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care";

c) all cases of suspected fraud and abuse by providers of service under the Indiana Medicaid program;

d) all cases of suspected misappropriation of patients' private funds in facilities receiving payments under the Indiana Medicaid program;

e) all cases of suspected patient abuse in facilities receiving payments under the Indiana Medicaid program.

(2) Inform the IMFCU, through routine case coordination, of proposed actions by the Office. If the Office does not receive a response from the IMFCU within ten business days, the Office may proceed with the proposed action;

(3) Make contact with providers of service under the Indiana Medicaid Program through routine SUR activity unless the IMFCU has placed the provider on hold and notified the Office to suspend routine SUR activity for the provider;

(4) Include in each case referral to the IMFCU all relevant documentation, including a complaint referral report which summarizes the facts, and copies of applicable state and/or federal regulations, procedures, policy statements, and directives. The Office will provide information on all contact between the suspected wrongdoer and Office staff and/or contractors;

(5) Comply promptly with a written request from the IMFCU for access to, and a free copy of, any records or information in the possession of the Office or its contractors, if the IMFCU determines that it may be useful in carrying out its responsibilities;

(6) Comply promptly, and without charge, with written requests from the IMFCU for computerized data stored by the Office or its contractors in such form as the IMFCU may request, limited to the capabilities of IndianaAIM, if the IMFCU determines that these data may be useful in carrying out its responsibilities;

(7) Arrange for the IMFCU to have access to any records of information kept by the providers of services under the state Medicaid program to which the Office is authorized access by section 1396a(a)(27) of the Social Security Act and 42 CFR 431.107 if the IMFCU determines that this access may be necessary in carrying out its responsibilities;

(8) Promptly forward to the IMFCU copies of all audit reports which indicate suspected Medicaid provider fraud and abuse and, upon written request, one copy of work papers relative to such audits. This includes audits performed by the Office or its contractors;

(9) Provide for the needs of the IMFCU of copies of claims, other documents, equipment, etc when negotiating with the Office's fiscal contractors, computer systems contractors, and audit contractors;

(10) Allow coordination of operations between the Office and the IMFCU when conducting on-site audits or other SUR related activities;

(11) Make available to the IMFCU details of any plans to undertake decertification against a Medicaid program provider, and;

(12) Meet with the IMFCU on a scheduled basis to discuss cases or other matters concerning fraud or abuse of the Medicaid program.

OAG AGREES THAT THE INDIANA MEDICAID FRAUD CONTROL UNIT (IMFCU) WILL:

(1) Perform the duties and responsibilities as required of a Medicaid Fraud Control Unit under Federal regulations 42 CFR 1007.11, as authorized by Indiana law;

(2) Protect the privacy rights of individual recipients in its collection and use of any such records and information received from the Office;

(3) Submit all requests for computerized data stored by the Office or its contractors directly to the Office for prioritization;

(4) Advise the Office within ten business days of the necessity to place any proposed actions received through routine case coordination on hold. An IMFCU hold is defined as the request that no Office staff initiate audit related contacts with the identified provider without receiving prior approval from the IMFCU;

(5) Review all referrals of Medicaid fraud or abuse received from the Office, as well as from other sources pursuant to federal regulations. IMFCU will determine whether the matter requires further investigation for potential criminal or civil prosecution, and shall take such action as deemed warranted in its discretion;

(6) Make reasonable efforts to inform, in writing within thirty (30) days of receipt, if the IMFCU accepts or rejects a referral from the Office for investigation;

(7) Provide the Office with reports that summarize the investigative findings, including data collected during investigations relative to provider eligibility, fraud, abuse, or other inappropriate practices, regardless of whether the case is referred for prosecution;

(8) Allow the Office to review the case files of those cases IMFCU might close without taking any adverse action against a provider in order that the Office might

be more fully informed in determining what administrative actions, if any, are appropriate;

(9) Provide the Office, when appropriate, with data collected during investigations that may have a bearing on recipient eligibility, abuse or services or other aberrant practices;

(10) Inform the Office of released cases, which were previously placed on IMFCU hold or accepted, in a timely manner so the Office may coordinate referrals to other appropriate agencies;

(11) Make IMFCU personnel available for testimonial purposes in administrative hearings brought by the Office, if necessary, and;

(12) Develop and implement training programs in conjunction with the Office for each other as necessary to assist in their mutually cooperative efforts.

EFFECTIVE DATE:

THIS AGREEMENT shall become effective and binding when signed and shall continue in force as long as the Indiana Medicaid Fraud Control Unit remains certified by the U.S. Department of Health and Human Services, or until it is replaced by a subsequent agreement.

IN WITNESS WHEREOF, the parties hereto have caused this agreement to be executed by their officials hereunto duly authorized.

OFFICE OF MEDICAID POLICY & PLANNING

By: _____ Date: 7/29/2005
Jeanne M. LaBrecque
Director of Health Policy and Medicaid

OFFICE OF THE ATTORNEY GENERAL

By: _____ Date: 8/13/05
Allen K. Pope, Director
Indiana Medicaid Fraud Control Unit

State of Indiana

Interagency Agreement
between the Division of Mental Health
and the Office of Medicaid Policy and Planning

A. Purpose

This Interagency Agreement is entered into by the Division of Mental Health (DMH) and the Office of Medicaid Policy and Planning (OMPP) to define the administrative responsibilities and fiscal accountability of the respective parties relative to Medicaid administrative activities performed by DMH-contracted Managed Care Providers under the Hoosier Assurance Plan. Parties to this agreement recognize that state and federal statutes and regulations place shared responsibility and authority for certain programs upon each party.

B. Program Responsibility

Parties to this agreement recognize the responsibilities imposed upon the OMPP as the Single State Medicaid Agency and the importance of ensuring that OMPP retains the authority to discharge its responsibilities. Additionally, the parties recognize that DMH has the responsibility and authority to provide, through contracts with certified managed care providers, a comprehensive community mental health system to the populations it serves. Consequently, the parties agree to cooperate and assist each other in carrying out their respective responsibilities.

C. Responsibilities of the Division of Mental Health

The Division of Mental Health (DMH) shall:

1. certify each of its Managed Care Providers, based on the entity's accreditation as either a network or behavioral health services provider, and ensure that each entity has the capability to perform the functions of a managed care provider, including provision or contracting for provision of services within the continuum of care pursuant to 440 IAC 4.3-1-1(8) and IC 12-7-2-40.6;

2. maintain contracts with Hoosier Assurance Plan Managed Care Providers, or a contract with an entity representing said Managed Care Providers, for purposes of claiming Medicaid administrative matching funds for allowable Medicaid administrative activities performed by the Managed Care Providers;

3. monitor the administrative activities of DMH-contracted Managed Care Providers and review, for accuracy and reasonableness, the providers' claims for Medicaid administrative matching funds prior to submitting the claims to the Office of Medicaid Policy and Planning; in support of such claims, DMH shall require Managed Care Providers to retain sufficient data to substantiate the providers' claims for Medicaid administrative matching funds and demonstrate that adequate quality assurance controls are in place;

4. provide to OMPP assistance with research, budget preparation, financial reporting and account reconciliation, as needed;

5. cooperate and assist OMPP in conducting financial recoveries that may be necessitated by fraudulent or unallowable practices by DMH-contracted Managed Care Providers;

6. certify that state matching funds are available for reimbursement of Medicaid administrative activities performed by DMH-contracted Managed Care Providers;

7. review and approve the methodology for distributing federal matching funds among DMH-contracted providers;

8. repay upon written demand by OMPP all sums paid to DMH by OMPP, which are identified as the result of an audit exception or cost disallowance, pending resolution of any disputed amount.

D. Responsibilities of the Office of Medicaid Policy and Planning

The Office of Medicaid Policy and Planning (OMPP) shall:

1. seek review and comment from DMH prior to adopting any rules or policies that may affect services, programs or providers under the Hoosier Assurance Plan;

2. make recommendations to DMH regarding compliance with federal statutes and regulations;

3. review and submit to the Health Care Financing Administration (HCFA) Medicaid administrative claims for activities performed by DMH-contracted Managed Care Providers;

4. demand in writing repayment by DMH of all sums paid to DMH by OMPP, which are identified as the result of an audit exception or cost disallowance; OMPP shall offset such amounts against current or future allowable claims, demand cash repayment, or withhold payment of current claims in a like amount pending resolution of any disputed amount.

E. Mutual Responsibilities

1. DMH and OMPP shall provide each other with such information or reports that may be necessary to fulfill their respective responsibilities under this agreement;

2. DMH and OMPP shall comply with all applicable federal and state statutes, regulations, promulgated rules, standards, methods and procedures as designated by the Department of Health and Human Services and Title XIX of the Social Security Act;

3. DMH and OMPP shall cooperate in establishing a Cost Allocation Plan for purposes of claiming Medicaid administrative matching funds;

4. DMH and OMPP shall cooperate in seeking State Budget Agency review and approval of methods and procedures for certifying state matching funds, claiming federal administrative funds, and distributing funds received under this agreement.

F. Communication

To assure that problems and issues arising under this agreement are resolved expeditiously, each party shall designate a representative to coordinate the execution of the functions and responsibilities encompassed by this agreement and who shall be the recipient of correspondence or communication relevant to issues, understandings or processes encompassed by this agreement.

In recognition of the critical role clear communication plays, the parties further agree that:

1. OMPP shall be responsible for formal communications with the federal government regarding the administrative claims, procedures and responsibilities referenced in this agreement;

2. OMPP and DMH shall involve the designated representative from each agency in all meetings relevant to the administrative claims, procedures and responsibilities referenced in this agreement;

3. Every effort shall be made by the parties' designated representatives to resolve any disputes relating to this agreement; disputes that cannot be so resolved shall be referred to the Director of the Division of Mental Health and the Assistant Secretary of the Office of Medicaid Policy and Planning. Failing resolution at that level, disputes shall be presented to the Secretary of the Family and Social Services Administration, and the Secretary's decision shall be final. All parties agree to seek the most rapid dispute resolution possible.

G. Successor Agency/Official

The successor agencies of the Division of Mental Health and Office of Policy and Planning, and all successor officials of said parties, are hereby bound to the terms and conditions set forth in this agreement.

H. Modification

This agreement may be modified at any time by written modification agreed upon by the parties to this agreement.

I. Termination

The term of this agreement shall begin on the first day of January, 1999, and will continue thereafter until termination by one of the undersigned parties upon thirty (30) days advance written notice to the others. This agreement may be terminated at any time by written authorization of all of the duly appointed representatives of the undersigned parties, or their successors.

State of Indiana

In witness whereof, the Office of Medicaid Policy and Planning, the Division of Mental Health, the Indiana Family and Social Services Administration, and the State Budget Agency have, by duly authorized representatives, entered into this agreement.

By: Janet S. Corson Date: 10/13/99
Janet Corson, Director
Division of Mental Health

By: Kathleen D. Gifford Date: 10/15/99
Kathleen D. Gifford, Assistant Secretary
Office of Medicaid Policy and Planning

By: [signature] Date: 10/20/99
Peter A. Sybinsky, Ph.D., Secretary
Family and Social Services Administration

By: Roger E. Sill Date: 12/13/99
Peggy Boehm, Director
State Budget Agency

State Plan Under Title XIX of the Social Security Act
State/ Territory: INDIANA

Liens and Adjustments or Recoveries

1. The State uses the following process to determine that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home.

The State requests verification from the attending physician of the institutionalized individual's status immediately preceding giving notice of the State's intent to file a lien on the recipient's real property.

2. The following criteria are used for establishing that a permanently institutionalized individual's son or daughter provided care as specified under regulations at 42 CFR § 433.36 (f).

A written statement from the son or daughter describing the type and amount of care provided to the parent by the son or daughter and the effect such care may have had on the parent's ability to remain at home. The statement should include appropriate documentation to substantiate that the care was necessary and provided. Such documentation may include doctor's statements, statements of neighbors or other relatives, copies of cancelled checks, bank statements, credit card statements, income tax returns or other documents or correspondence evidencing the extent and type of care provided.

3. The State defines the terms below as follows:

- Estate

All real and personal property and other assets included within an individual's probate estate;
Any interest in real property owned by the individual at the time of death that was conveyed to the individual's survivor through joint tenancy with right of survivorship, if the joint tenancy was created after June 30, 2002 and;
Any real or personal property conveyed through a non-probate transfer.
Nonprobate transfer means a valid transfer, effective at death, by a transferor:
Whose last domicile was in Indiana; and
Who immediately before death had the power, acting alone, to prevent transfer of the property by revocation or withdrawal and;
-Use the property for the benefit of the transferor; or
-Apply the property to discharge claims against the transferor's probate estate.
The term does not include transfer of survivorship interest in a tenancy by the entireties real estate, or payment of death proceeds of a life insurance policy.

State Plan Under Title XIX of the Social Security Act
State/ Territory: INDIANA

Any sum due after June 30, 2005, to a person after the death of a Medicaid recipient that is under the terms of an annuity contract purchased after May 1, 2005, with the assets of:

A) the Medicaid recipient; or

B) *the Medicaid recipient's spouse*

Assets included in the estate of the Medicaid recipient's surviving spouse are included after the death of the surviving spouse. If the surviving spouse has remarried, assets that are attributable to the surviving spouse's subsequent spouse are not included.

- Individual's home

  The recipient's place of residence prior to institutionalization

- Equity interest in the home

  Any equitable right, title, or interest in real property.

- Residing in the home for at least two years on a continuous basis

  Using the home as the principal place of residence.

- Discharge from the medical institution and return home

  Discharge from a medical institution is actual discharge to the recipient's home, which is not a medical institution. Discharge does not include medical leave days or therapeutic leave days, or visitation to home as per a plan of treatment.

- Lawfully residing

  Residing in the recipient's place of residence with the permission of the owners, or if under guardianship, the owner's legal guardian.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Indiana

4. THE STATE DEFINES UNDUE HARDSHIP AS FOLLOWS:

(1) causing an heir to become eligible for public assistance
(2) causing an heir who is currently eligible for public assistance to remain dependent on that public assistance
(3) the complete loss of sole income-producing asset of the heir when the heir's income does not exceed 100% of the federal poverty level
(4) other compelling circumstances as determined on a case-by-case basis by the State

5. THE FOLLOWING STANDARDS AND PROCEDURES ARE USED BY THE STATE FOR WAIVING ESTATE RECOVERIES WHEN RECOVERY WOULD CAUSE AN UNDUE HARDSHIP, AND WHEN RECOVERY IS NOT COST EFFECTIVE:

Applications for undue hardship waivers shall be filed with the Medicaid agency within 90 calendar days of the date that the executor or personal representative of the deceased's estate receives notification of the State's claim. The Medicaid agency shall review and rule on an application for waiver of the State's claim within 45 calendar days of the receipt of a properly completed waiver application. The agency may not grant an undue hardship waiver if the granting of such waiver will result in the payment of claims to other creditors with a lower priority standing in accordance with IC 29-1-14-9.

6. THE STATE DEFINES COST-EFFECTIVE AS FOLLOWS (INCLUDE METHODOLOGY/THRESHOLDS USED TO DETERMINE COST-EFFECTIVENESS):

Recovery is not cost-effective when OMPP determines that attorneys' fees and other expenses of collection equal or exceed the amount that OMPP expects to collect. If the agency determines that it is most cost-effective to compromise the State's claim, the compromise must be approved by the Attorney General and the Governor.

7. THE STATE USES THE FOLLOWING COLLECTION PROCEDURES (INCLUDE SPECIFIC ELEMENTS CONTAINED IN THE ADVANCE NOTICE REQUIREMENT, THE METHOD FOR APPLYING FOR A WAIVER, HEARING AND APPEALS PROCEDURES, AND TIME FRAMES INVOLVED):

When the agency receives notice of the death of a recipient, former recipient, or a deceased recipient's spouse, the agency will file a claim against the estate in probate court. If the estate is valued at under $25,000 and no probate estate is opened, the agency will file an affidavit in support of its claim with any entity that holds funds or property belonging to the deceased. The agency shall notify the executor or personal representative of the deceased recipient's estate of the State's claim and the affected heir's right to apply for an undue hardship waiver. If the agency reviews such an application and determines that an undue hardship does not exist, the agency shall notify the applicant in writing and inform the applicant of his right to request an administrative hearing within 30 days of receipt of the agency's decision that an undue hardship waiver has been denied.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of Indiana

A. The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act:

Service	Type of Charge: Deductible	Coinsurance	Copay	Amount and Basis for Determination
Transportation			X	$0.50 for transportation services for which Medicaid pays $10.00 or less
				$1.00 for transportation services for which Medicaid pays $10.01 to $50.00
				$2.00 for transportation services for which Medicaid pays $50.01 or more
Pharmacy			X	$3.00 for each covered drug dispensed.
Emergency Room			X	$3.00 for nonemergency services (procedures billed outside a designated emergency procedure code range) when provided in a hospital emergency room

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Indiana

B. The method used to collect cost sharing charges for the categorically needy individuals:

■ Providers are responsible for collecting the cost sharing charges from individuals.

□ The agency reimburses providers the full Medicaid rate for a service and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

It is the recipient's responsibility to inform the provider that he or she cannot afford to pay the copayment. Providers and recipients have been notified in writing that Medicaid providers cannot refuse to serve an individual because of that individual's inability to pay the copayment and that the provider may bill the recipient for the amount of copayment due in cases where the recipient is unable to pay the copayment on the date of service. Any uncollected copayment amount is considered a debt to the provider.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Indiana

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

The claims processing system will automatically deduct the copayment amount from the provider's claim for those services for which a copayment is required. The claims processing system will not deduct a copayment for the exemptions identified below. The manner in which the system will identify these exemptions is also described below:

A. Emergency Ambulance Services: The provider will use a specified place of service code denoting emergency ambulance services.

B. Services furnished to pregnant women: The pregnant woman will identify herself to the provider. (Both providers and recipients have been informed that services furnished to pregnant women are exempt from the copay requirement.) Providers will enter a designated code on the claim

- (continued on next page) -

E. Cumulative maximums on charges:

☒ **State policy does not provide for cumulative maximums.**

☐ **Cumulative maximums have been established as described below:**

B. (continued from previous page) form to denote that services were rendered to a pregnant woman. The claims processing system will automatically exempt from the copayment deduction anyone on the recipient eligibility file coded as a "SOBRA" eligible pregnant woman and any claim with a primary or secondary diagnosis code indicating pregnancy.

C. Services furnished to individuals less than 18 years of age: The claims processing system will compare the date of birth on the recipient eligibility file to the from date of service on the claim; if 17 years or younger on date of service, the copayment will not be deducted from the reimbursement.

D. Services furnished to individuals who are inpatients in hospitals, nursing facilities, ICF's/MR or other medical institutions: The provider will use a specified place of service code to denote that these services are exempt from the copayment requirement and the claims processing system will automatically exempt recipients with eligibility file records indicating residence in one of the above-named facility types.

E. Family Planning Services/Supplies for Individuals of Child-Bearing Age - Claims are exempted from the copayment if the primary or secondary diagnosis falls within a designated range of codes.

F. HMO Pharmacy Services - When the "HMO" diagnosis code is indicated on the claim, the claims processing system does not deduct a copayment.

G. Emergency Pharmacy Services - Emergency services are not provided at the retail pharmacy level, therefore no special handling of claims processing is necessary to preclude deduction of copayments. (NOTE: claims for services furnished to inpatients noted in D above are not subject to copayment.)

All affected providers and recipients have been informed of these exemptions and received instructions on proper billing procedures.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Indiana

A. The following charges are imposed on the medically needy for services:

Service	Type of Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay.	
Not applicable.				

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Indiana

B. The method used to collect cost sharing charges for medically needy individuals:

/ Providers are responsible for collecting the cost sharing charges from individuals.

/ The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

Not applicable.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Indiana

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

Not applicable.

E. Cumulative maximums on charges:

/ / State policy does not provide for cumulative maximums.

/ / Cumulative maximums have been established as described below:

Not applicable.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Indiana

Premiums Imposed on Low Income Pregnant Women and Infants

A. The following method is used to determine the monthly premium imposed on optional categorically needy pregnant women and infants covered under section 1902(a)(10)(A)(ii)(IX)(A) and (B) of the Act:

N/A

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

N/A

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Indiana

C. State or local funds under other programs are used to pay for premiums:

☐ Yes ☐ No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Indiana

Optional Sliding Scale Premiums Imposed on
Qualified Disabled and Working Individuals

A. The following method is used to determine the monthly premium imposed on qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act:

N/A

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

N/A

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Indiana

C. State or local funds under other programs are used to pay for premiums:

/_/ Yes /_/ No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

*Description provided on attachment.

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

REIMBURSEMENT FOR INPATIENT HOSPITAL SERVICES
COUNTY TUBERCULOSIS HOSPITALS

A hospital defined and licensed as a County Tuberculosis hospital shall be entitled to Medicaid payment for authorized Medicaid services provided to eligible persons, in accordance with Medicare reasonable cost recognition principles using an all-inclusive **prospective** payment rate for such services. Such hospitals shall be limited to Medicaid reimbursement representing recognition of and payment for the lower of the following: (a) the reasonable cost of services delivered as developed through the applicable **prospective** reasonable cost principles applicable to Title XVIII, or (b) the customary charges to the general public. The upper limits for Medicaid payment of inpatient services to hospitals shall not exceed in the aggregate, the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles.

The Indiana Medicaid program prohibits hospitals from charging the Medicaid program for items or services furnished to Medicaid recipients which are more expensive than those determined to be necessary in the efficient delivery of health services.

The Medicare reasonable cost recognition principles used to establish an all-inclusive prospective payment rate for County Tuberculosis Hospitals involves a comprehensive audit of the hospital's 1991 Medicaid cost report (base year), organizing the facility's costs into logical cost groupings for allocation to major cost centers and eliminating excessive and unallowable costs. This step down method of capturing costs in described in detail in the CFR at 42 CFR 413.24 (d)(1). After arriving at allowable costs including ancillaries, those costs are divided by Medicaid inpatient days to arrive at an all-inclusive daily per diem. This 1991 rate is then inflated to the midpoint of the year for which it is used prospectively by the hospital using the DRI-MCGRAW HILL HOSPITAL MARKETBASKET INDEX.

REIMBURSEMENT FOR INPATIENT HOSPITALS SERVICES

DEFINITIONS

"Allowable costs" means Medicare allowable costs as defined by 42 USC 1395 (f).

"All patient refined DRG grouper" refers to a classification system used to assign inpatient stays to DRGs.

"Base amount," means the rate per Medicaid stay that is multiplied by the relative weight to determine the DRG rate.

"Base period" means the fiscal years used for calculation of the prospective payment rates including base amounts and relative weights.

"Capital costs" are costs associated with the capital costs of the facility. The term includes, but is not limited to, the following:

(1) Depreciation.
(2) Interest.
(3) Property taxes.
(4) Property insurance.

"Children's hospital" means a free-standing general acute care hospital licensed under IC 16-21 that:

(1) is designated by the Medicare program as a "children's hospital"; or
(2) furnishes services to inpatients who are predominately individuals under eighteen (18) years of age, as determined using the same criteria used by the Medicare program to determine whether a hospital's services are furnished to inpatients who are predominantly individuals under eighteen (18) years of age.

"Cost outlier case" means a Medicaid stay that exceeds a predetermined threshold defined as the greater of twice the DRG rate or a fixed dollar amount established by the office. This amount may be changed at the time DRG relative weights are adjusted.

"Diagnosis-related group" or "DRG" means a classification of an inpatient stay according to the principal diagnosis, procedures performed, and other factors that reflect clinically cohesive groupings of inpatient hospital stays using similar resources. Classification is made using the all patient refined (APR) DRG grouper.

"Discharge" means the release of a patient from an acute care facility. Patients may be discharged to their home, another health care facility, or due to death. Transfers from one (1) unit in a hospital to another unit in the same hospital shall not be considered a discharge, unless one (1) of the units is paid according to the level-of-care approach.

"DRG daily rate," means the per diem payment amount for a stay classified into a DRG calculated by dividing the DRG rate by the DRG average length of stay.

"DRG rate," means the product of the relative weight multiplied by the base amount. It is the amount paid to reimburse hospitals for routine and ancillary costs of providing care for an inpatient stay.

"Free-standing" hospital does not mean a wing or specialized unit within a general acute care hospital.

"Inpatient" means a Medicaid patient who was admitted to a medical facility on the recommendation of a physician and who received room, board and professional services in the facility.

"Inpatient hospital facility" means a general acute care hospital, a mental health institution, a state mental health institution or a rehabilitation inpatient facility properly licensed as a hospital in accordance with appropriate Indiana Code.

"Less than one-day stay" means a medical stay of less than twenty-four (24) hours.

"Level-of-care case" means a medical stay that includes psychiatric cases, rehabilitation cases, certain burn cases and long term care hospital admissions.

"Level-of-care rate" means a per diem rate that is paid for treatment of a diagnosis or performing a procedure.

"Long term care hospital" means a free-standing general acute care hospital licensed under IC 16-21 that:

(1) is designated by the Medicare program as a "long term hospital"; or
(2) has an average inpatient length of stay greater than twenty-five (25) days, as determined using the same criteria used by the Medicare program to determine whether a hospital's average length of stay is greater than twenty-five (25) days.

"Marginal cost factor" means a percentage applied to the difference between the cost per stay and the outlier threshold for purposes of the cost outlier computation.

"Medicaid day" means any part of a day, including the date of admission, for which a patient enrolled with the Indiana Medicaid program is admitted as an inpatient and remains overnight. The day of discharge is not considered a Medicaid day. The term does not include any portion of an outpatient service that occurs within three days of an admission as an inpatient for a related condition.

"Medicaid stay" means an episode of care provided in an inpatient setting that includes at least one (1) night in the hospital and is covered by the Indiana Medicaid program.

"Medical education costs" means that costs that are associated with the salaries and benefits of medical interns and residents and paramedical education programs.

"Office" means the Office of Medicaid Policy and Planning of the Indiana Family and Social Services Administration.

"Outlier payment amount" means the amount reimbursed in addition to the DRG rate for certain inpatient stays that exceed cost thresholds established by the office.

"Per diem" means an all-inclusive rate per day that includes routine and ancillary costs and capital costs.

"Principal diagnosis" means the diagnosis, as described by the International Classifications of Diseases, current version, for the condition established after study to be chiefly responsible for occasioning the admission of the patient for care.

"Readmission" means that a patent is admitted into the hospital following a previous hospital admission and discharge for a related condition as defined by the office.

"Rebasing" means the process of adjusting the base amount using more recent claims data, cost report data, and other information relevant to hospital reimbursement.

"Relative weight" means a numeric value that reflects the relative resource consumption for the DRG to which it is assigned. Each relative weight is multiplied by the base amount to determine the DRG rate.

"Routine and ancillary costs" means costs that are incurred in the providing services exclusive of medical education and capital costs.

"Transfer" means a situation in which a patient is admitted to one (1) hospital and is then released to another hospital during the same episode of care. Movement of a patient form one (1) unit within the same hospital will not constitute a transfer unless one (1) of the units is paid under the level-of-care reimbursement system.

"Transferee hospital" means the hospital that accepts a transfer from another hospital.

"Transferring hospital" means the hospital that initially admits then discharges the patient to another hospital.

PROSPECTIVE REIMBURSEMENT METHODOLOGY

The purpose of this section is to establish a prospective reimbursement methodology for services provided by inpatient hospital facilities that are covered by the state of Indiana Medicaid program. The methodology for reimbursement described in this section shall be a prospective.

system wherein a payment rate for each hospital stay will be established according to a DRG reimbursement methodology or a level-of-care reimbursement methodology. Prospective payment shall constitute full reimbursement unless otherwise indicated herein or as indicated in provider manuals and update bulletins. There shall be no year-end cost settlement payments.

Inpatient stays reimbursed according to the DRG methodology shall be assigned to a DRG using the all patient refined DRG grouper. The DRG rate is equal to the relative weight multiplied by the base amount.

Payment of inpatient stays reimbursed according to the DRG methodology shall be equal to the lower of billed charges or the sum of the DRG rate, the capital rate, the medical education rate if applicable, and the outlier payment amount, if applicable.

Payment for inpatient stays reimbursed as level-of-care cases shall be equal to the lower of billed charges or the sum of the per diem rate for each Medicaid day, the capital rate, the medical education rate if applicable, and the outlier payment amount, if applicable.

Relative weights will be reviewed periodically by the office and adjusted no more often than annually using the most recent reliable claims data and cost report data to reflect changes in treatment patterns, technology and other factors that may change the relative use of hospital resources. Interim adjustments to the relative weights will not be made except in response to legislative mandates affecting Medicaid participating hospitals. Each legislative mandate will be evaluated individually to determine wither an adjustment to the relative weights will be made. DRG average length of stay values will be revised when relative weights are adjusted. The office shall include the costs of outpatient hospital and ambulatory surgical center services that lead to an inpatient admission when determining relative weights. Such costs occurring within three (3) calendar days of an inpatient admission will not be eligible for outpatient reimbursement under Attachment 4.19B. For reporting purposes, the day on which the patient is formally admitted as an inpatient is counted as the first inpatient day.

A base amount is the rate per Medicaid stay. DRG base amounts will be reviewed periodically by the office and adjusted no more often than every second year using the most recent reliable claims data and cost report data to reflect changes in treatment patterns, technology, and other factors that may change the cost of efficiently providing hospital services.
The office may establish a separate base amount for children's hospitals to the extent necessary to reflect significant differences in cost. Each children's hospital will be evaluated individually for eligibility for the separate base amount. Children's hospitals with a case mix adjustment cost per discharge greater than one standard deviation above the mean cost per discharge for DRG services will be eligible to receive the separate base amount established under this subsection. The separate base amount is equal to one hundred and twenty percent (120%) of the statewide base amount for DRG services.

Level-of-care rates are per diem rates. Level-of-care rates will be reviewed periodically by the office and adjusted no more often than every second year by using the most recent reliable claims data

and cost report data to reflect changes in treatment patterns, technology, and other factors that may change the cost of efficiently providing hospital services. The office shall not set separate level-of-care rates for different categories of facilities, except as specifically noted in this section.

Effective August 1, 2020, Level-of-Care cases are categorized by DRG number, as defined and grouped using the all patient refined DRG grouper and published on the agency's website, https://www.in.gov/medicaid/providers/669.htm . These DRG numbers represent burn, psychiatric, and rehabilitative care. The office may assign a LOC DRG number for long term care hospital admissions.

In addition to the burn level-of-care rate, the office may establish an enhanced burn level-of-care rate for hospitals with specialized burn facilities, equipment, and resources for treating severe burn cases. In order to be eligible for the enhanced burn rate, facilities must operate a burn intensive care unit.

The office may establish separate level-of-care rates for children's hospitals to the extent necessary to reflect significant differences in cost. Each children's hospital will be evaluated individually for eligibility for the separate level-of-care rate. Children's hospitals with a cost per day greater than one standard deviation above the mean cost per day for level-of-care services will be eligible to receive the separate base amount. Determinations will be made for each level-of-care category. The separate base amount is equal to one hundred twenty percent (120%) of the statewide level-of-care rate.

The office may establish separate level-of-care rates, policies, billing instructions, and frequency for long term care hospitals to the extent necessary to reflect differences in treatment patterns for patients in such facilities. Hospitals must meet the definition of a long-term care hospital to be eligible for the separate level-of-care rate.

Add-On Payments

Capital payment rates cover capital costs. Capital costs are costs associated with the ownership of capital and include the following:

- Depreciation
- Interest
- Property Taxes
- Property insurance

Capital payment rates shall be prospectively determined and shall constitute full reimbursement for capital costs. Capital payment rates will be calculated using a minimum occupancy level for non-nursing beds of 80 percent. Capital per diem rates will be reviewed periodically by the office and adjusted no more often than every second year by using the most recent reliable claims data.

and cost report data to reflect changes in treatment patterns, technology, and other factors that may change the capital costs associated with efficiently providing hospital services. The capital payment amount is calculated as follows:

- for stays reimbursed under the DRG methodology, capital payment is equal to the product of the per diem capital rate and the average length of stay for the assigned DRG. Capital payments shall be pro-rated for a transferring or transferee facility to a maximum of the average length of stay.
- For stays reimbursed under the level-of-care methodology, capital payment is equal to the product of the per diem capital rate for each covered day of care.

The office shall not set separate capital per diem rates for different categories of facilities, except as specifically noted in this plan.

Medical Education rates shall be prospective, hospital-specific per diem amounts. Medical education payment amounts are calculated as follows:

- for stays reimbursed under the DRG methodology medical education payments are equal to the product of the medical education per diem rate and the average length of stay assigned to the DRG. Medical education rates for a transferring or transferee facility shall be pro-rated not to exceed the average length of stay.

- for stays reimbursed under the level-of-care methodology, medical education payments are equal to the medical education per diem rate for each covered day of care.

Medical education rates are facility-specific rates based on medical education costs per day multiplied by the number of residents reported by the facility. No more often than every second year, the office will use the most recent cost report data to determine a cost per day that more accurately reflects the cost of efficiently providing hospital services as it relates to operating a medical education program. The number of residents will be determined according to the most recent available cost report that has been filed and audited by the office or its contractor.

Medical Education payments will be available to hospitals only so long as they continue to operate medical education programs. Hospitals must notify the office within thirty (30) days following discontinuance of their medical education program. For hospitals establishing new medical education programs, the medical education per diem will not be effective prior to notification to the office that the program has been implemented. The medical education per diem shall be based on the most recent reliable claims data cost report data.

A Medicaid stay that exceeds a predetermined threshold, defined as the greater of: (1) twice the DRG rate or (2) the outlier threshold, is a cost outlier case. The calculation for outlier payment amounts is made as follows:

(1) Multiplying the overall facility cost-to-charge ratio by submitted charges. The outlier payment is equal to the marginal cost factor multiplied by the difference between the prospective cost per stay and the greater of the DRG rate or the outlier threshold amount.

(2) Day outliers as required under Section 1902(s) of the Social Security act are provided for through implementation of the DRG/LOC per diem, which is designed to account for unpredictable and lengthy hospital admissions.

Outlier thresholds will be revised as necessary when DRG relative weights are adjusted. Cost outlier payments are not available for cases reimbursed using the level-of-care methodology, except for burn cases that exceed the established threshold.

Other Payment Policies

Readmissions for a related condition as defined by the office within three (3) calendar days after discharge will be treated as the same admission for payment purposes. Readmissions that occur after three (3) calendar days will be treated as separate stays for payment purposes but will be subject to medical review.

Special payment policies shall apply to transfer cases. The transferring hospital and the transferee, or receiving, hospital are paid the sum of the following:

(1) A DRG daily rate for each Medicaid day of the recipient's stay, not to exceed the appropriate full DRG payment, or the level-of-care per diem payment rate for each Medicaid day of care provided.
(2) The capital per diem rate.
(3) The medical education per diem rate.

Transferring hospitals will not receive separate reimbursement for Medicaid patients subsequent to their return from a transferee hospital if the patient is readmitted to the transferring hospital 30 or fewer days from the original admission. Additional costs incurred as a result of the patient's return from a transferee hospital are eligible for cost outlier reimbursement. The office may establish a separate outlier threshold or marginal cost factor for such cases. Transferring hospitals will receive separate reimbursement for Medicaid patients subsequent to their return from a transferee hospital if the patient is readmitted to the transferring hospital more than 30 days after the original admission.

Each facility that submits an Indiana Medicaid cost report will receive a cost-to-charge ratio. The cost-to-charge ratio will be computed from claims data and will be used to determine applicable cost outlier payments. Facilities with less than 30 Medicaid claims annually will be given the statewide median cost-to-charge ratio.

Special payment policies shall apply to less than twenty-four (24) hour stays. For less than twenty-four (24) hour stays, hospitals will be paid under the outpatient reimbursement methodology as described in Attachment 4.19B.

Out-of-state hospitals receive the same DRG and level-of-care payments that are made for the same service to instate facilities computed in accordance with this plan. Each out-of-state hospital that submits an Indiana Medicaid hospital cost report will receive a cost-to-charge ratio. All other out-of-state facilities will use a statewide medial cost-to-charge ratio to determine applicable cost outlier payments, computed in accordance with the outlier provisions of this plan.

Effective July 1, 2023, through July 1, 2025, reimbursement for inpatient hospital services provided by a children's hospital located in a state bordering Indiana will be reimbursed at a rate that is 130% of the Medicaid reimbursement rate. The increase does not apply to the capital per-diem or the medical education per-diem (if applicable). To be eligible, the children's hospital must be located in Illinois, Kentucky, Michigan, or Ohio. Additionally, the children's hospital must be either:

1) A freestanding general acute care hospital that is designated by the Medicare program as a children's hospital or furnishes inpatient and outpatient health care services to patients who are predominantly individuals less than nineteen (19) years of age; or

2) A facility located within a freestanding general acute care hospital that is designated by the Medicare program as a children's hospital or furnishes inpatient and outpatient health care services to patients who are predominantly individuals less than nineteen (19) years of age.

Payments for services to an out-of-state provider will be negotiated on a case-by-case basis to obtain the lowest possible rate, not to exceed 100% of the provider's reasonable and customary charges, and may differ from the aforementioned out-of-state hospital reimbursement policy only when such payments are required because the services are not available in-state or are necessary due to unique medical circumstances requiring care that is available only from a limited number of qualified providers.

To be eligible for a facility-specific per diem medical education rate, out of state providers must be located in a city listed in 405 IAC 5-5-2(a)(3), effective July 25, 1997, through 405 IAC 5-5-2(a)(4), effective July 25, 1997, or have a

minimum of sixty (60) Indiana Medicaid inpatient days annually. Providers must submit annually an Indiana Medicaid hospital cost report to be eligible for this reimbursement. The facility-specific per diem medical education rate for an out-of-state provider shall not exceed the highest in-state medical education per diem rate.

To be considered for a separate base amount for children's hospitals, out-of-state children's hospitals must be located in a city listed in 405 IAC 5-5-2(a)(3), effective July 25, 1997, through 405 IAC 5-5-2(a)(4), effective July 25, 1997, or have a minimum of sixty (60) Indiana Medicaid inpatient days annually. Providers must submit annually an Indiana Medicaid hospital cost report to be eligible for a separate base amount.

MEDICAID INPATIENT PAYMENTS FOR SAFETY-NET HOSPITALS

"Safety-net hospital," for purposes of this section, means an acute care hospital, licensed under IC 16-21, the Indiana hospital licensure statute, and qualified under Section II.E. of this plan as a disproportionate share hospital.

(A) For the state fiscal years ending on or after June 30, 2000*, safety-net hospitals with more than 150 interns and residents, located in a city with a population of over 600,000, and safety-net hospitals which are the sole disproportionate hospital in a city located in a county having a population of more than four hundred thousand (400,000) but less than seven hundred thousand (700,000), which hospitals are also historical disproportionate share hospitals, shall receive reimbursement, subject to the terms of subsection (B) of this section, in an amount calculated by the office from the hospital's cost report filed with the office for the hospital's fiscal period ending during the state fiscal year, equal to the difference between:

(1) the amount of Medicaid payments to the hospital, excluding payments under Section III of this Plan, for Medicaid inpatient services provided by the hospital during the hospital's fiscal year, and

(2) an amount equal to the lesser of the following:

(A) The hospital's customary charges for the services described in subdivision (1).

(B) A reasonable estimate by the office of the amount that would be paid for the services described in subdivision (1) under Medicare payment principles.

The office may also make payments to all other safety-net hospitals in the manner provided in subsection (A) of this section, subject to the provisions of subsection (B) of this section.

(B) If the amount available to pay the inpatient safety-net amount is insufficient to pay each hospital the full amounts calculated above, payments to the hospitals will be reduced by an amount that is proportionate to the amount of the deficiency.

(C) (1) For the Eligibility Period** beginning July 1, 2001, inpatient safety-net hospitals, which meet both the above definition of "safety-net hospital" and the office's Medicaid safety-net criteria as described in A. above (the "office's Medicaid inpatient safety-net criteria"), limited to those hospitals defined as historical disproportionate share providers under Attachment 4.19A, Section II(F) of this plan and those hospitals not defined as historical disproportionate share providers but meeting the office's Medicaid inpatient safety-net criteria for the Eligibility Period ending on June 30, 2001, will receive inpatient safety-net payments equal to 100% of the amount determined in A. and B. above (the "inpatient safety-net amount"). For later Eligibility Periods, hospitals receiving payment adjustments pursuant to this subsection (1) will be subject to (2), (3), (4) and (5) below, as applicable.

(2) For the Eligibility Periods beginning after June 30, 2001, an inpatient safety-net hospital, whether a historical disproportionate share provider or a hospital which is not a historical disproportionate share provider, receiving a Medicaid inpatient safety-net payment adjustment in the amount of 100% of the inpatient safety-net amount, will continue to receive Medicaid inpatient safety-net payment adjustments in the amount of 100% of the inpatient safety-net amount for subsequent Eligibility Periods in which it meets the office's Medicaid inpatient safety-net criteria, unless the hospital has a lapse in meeting the office's Medicaid inpatient safety-net criteria for an Eligibility Period. A hospital that has a lapse in meeting the office's Medicaid inpatient safety-net criteria for an Eligibility Period shall be subject to (3),(4), and (5) below, as applicable, for later Eligibility Periods.

(3) For the Eligibility Periods beginning after June 30, 2001, if an inpatient safety-net hospital, including historical disproportionate share providers and hospitals which are not historical disproportionate share providers, has a lapse in meeting the office's Medicaid inpatient safety-net criteria for any Eligibility Period, the hospital will receive Medicaid inpatient safety-net payment adjustments equal to 0% of its hospital-specific limit for that Eligibility Period. However, upon a later Eligibility Determination† by the office, if the hospital is able to meet the office's Medicaid inpatient safety-net criteria for the Eligibility Period for which the later Eligibility Determination applies, the hospital's Medicaid inpatient safety-net payment adjustment will be calculated as set forth in (2), (4) or (5) of this Section C., as applicable.

(4) Except as set forth in (1) above, for Eligibility Periods beginning after June 30, 2001, inpatient safety-net hospitals, including hospitals defined as historical disproportionate share providers and hospitals which are not defined as historical disproportionate share providers,

(a) licensed under IC 16-21,
(b) meeting the office's Medicaid inpatient safety-net criteria for the current Eligibility Period, and
(c) which did not meet the office's Medicaid inpatient safety-net criteria for the prior Eligibility Period,

will receive Medicaid inpatient safety-net payment adjustments equal to 33 1/3% of their inpatient safety-net amount.

(5) Except as set forth in (2) above, after the Eligibility Period beginning on July 1, 2001, each time the office makes an Eligibility Determination, an inpatient safety-net hospital, including historical disproportionate share providers and hospitals which are not historical disproportionate share providers,

(a) meeting the office's Medicaid inpatient safety-net criteria for two consecutive Eligibility Periods will receive a Medicaid inpatient safety-net payment adjustment equal to 66 2/3% of its hospital-specific limit; or
(b) meeting the office's Medicaid inpatient safety-net criteria for three (or more) consecutive Eligibility Periods will receive a Medicaid inpatient safety-net payment adjustment equal to 100% of its hospital-specific limit.

(6) If the amount available to pay the inpatient safety-net amount is insufficient to pay each hospital the full amounts calculated above, payments to the hospitals will be reduced by an amount that is proportionate to the amount of the deficiency.

*This new payment methodology will apply for Medicaid services on or after April 1, 2000, but will be calculated as set forth in this section. For the state fiscal year ending on June 30, 2000, the state may reimburse, under this section, each safety-net hospital eligible for such reimbursement in an amount not to exceed one-fourth of the amount calculated under the formula described in this section. For state fiscal years ending after June 30, 2000, the state may reimburse, under this section, each safety-net hospital eligible for such reimbursement in an amount up to one hundred percent (100%) of the amount calculated under the formula described in this section.
** The term "Eligibility Period" is defined at Attachment 4.19 A, Section II(P) of this plan.
† The term "Eligibility Determination" is defined at Attachment 4.19A, Section II(O) of this plan.

Hospital-Acquired Conditions

This section applies to payment for inpatient stays reimbursed according to the DRG methodology. This section applies to all inpatient hospital facility reimbursement provisions, including Medicaid supplemental payments; Medicaid enhanced payments and Medicaid disproportionate share hospital payments.

The DRG to be assigned for an inpatient stay shall be a DRG that does not result in higher payment based on the presence of a hospital acquired condition that was not present on the date of admission. If a hospital acquired condition is not present on the date of admission, the discharge will be assigned to a DRG as though the hospital acquired condition was not present.

Secondary diagnoses that are present on the date of admission must be designated as such as part of the claim information submitted by an inpatient hospital facility in order for Medicaid reimbursement to be made. Secondary diagnoses that are not present on the date of admission must be designated as such as part of the claim information submitted by an inpatient hospital facility in order for the diagnoses to be excluded for purposes of assigning the claim to a DRG.

For purposes of this section, a "hospital acquired condition" means a condition associated with a diagnosis code selected by the Secretary of the U.S. Department of Health and Human Services pursuant to 42 U.S.C. 1395ww(d)(4)(D) and in effect on the date of admission.

Effective for services provided on or after July 1, 2012, this section applies to all inpatient stays reimbursed according to the DRG and level-of-care methodologies. A hospital-acquired condition (or "health care-acquired condition") means a condition associated with a diagnosis code selected by the Secretary of the U.S. Department of Health and Human Services pursuant to 42 U.S.C. 1395ww(d)(4)(D) and 42 CFR 447.26(b) and in effect on the date of admission.

Other Provider-Preventable Conditions

Effective for services provided on or after July 1, 2012, the State identifies the following other provider-preventable conditions, as defined at 42 CFR 447.26(b), for non-payment under Section 4.19A: wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

The rates paid to providers in accordance with methods described in the preceding pages of Attachment 4.19-A for inpatient hospital services, excluding supplemental Medicaid inpatient payments for Safety-Net hospitals, are subject to a 5% reduction for services on and after January 1, 2010. The 5% rate reduction will remain in effect through December 31, 2013. Medicaid payments for inpatient hospital services, excluding supplemental Medicaid inpatient payments for Safety-Net hospitals, are subject to a 3% reduction for services on and after January 1, 2014 through June 30, 2021.

Notwithstanding the preceding paragraph, for the period beginning July 1, 2011, Indiana hospital rates are subject to a hospital adjustment factor. The hospital adjustment factors will result in aggregate payments that reasonably approximate the upper payment limits but do not result in payments in excess of the upper payment limits.

A test will be made following the close of each state fiscal year to assure that annual inpatient payments do not exceed total inpatient billed charges for the fiscal year. Payments in excess of billed charges will be recovered. As permitted by 42 CFR 447.271(b), nominal charge hospitals identified in IC 12-15-15-11 are not subject to the inpatient charge limitation above.

The following sections of the State Plan do not apply for the period beginning July 1, 2011:

- Limitations on payments for an individual claim to the lesser of the amount computed or billed charges.
- Medicaid Inpatient Payments for Safety net Hospitals
- Medicaid Hospital Reimbursement Add-On Payment Methodology to Compensate Hospitals that Deliver Hospital Care for the Indigent Program Service.
- Municipal Hospital Payment Adjustments
- Supplemental Payments to Privately-Owned Hospitals.
- High Volume Outlier Payment Adjustment

The agency's rates are published in provider bulletins which are accessible through the agency's website, www.indianamedicaid.com.

MEDICAID HOSPITAL REIMBURSEMENT ADD-ON PAYMENT METHODOLOGY TO COMPENSATE HOSPITALS THAT DELIVER HOSPITAL CARE FOR THE INDIGENT PROGRAM SERVICE

In order to be eligible for and to receive a payment under the Indiana Hospital Care for the Indigent Care (HCI) program, a hospital must (1) be enrolled in and be providing inpatient services to patients enrolled in the Indiana Medicaid program during the state fiscal year for which payment is being made; and (2) have an audited cost report from the most recent common state fiscal year for which audited cost reports are on file with the office for all potentially eligible hospitals on June 30 of a preceding state fiscal year, unless extenuating circumstances exist. Hospitals that are no longer accepting Medicaid and HCI patients shall not receive payment under this section. Reimbursement under this program will be in the form of Medicaid add-on payments. The Medicaid add-on payments will provide additional reimbursement to eligible hospitals for the Medicaid-covered hospital services the hospitals provide to Medicaid enrollees. The amount and availability of the add-on payments will be limited by the charge limit and the upper payment limit pursuant to 42 C.F.R. §§ 447.271 and 447.272, the amount of services rendered to Medicaid and HCI patients, and the rates for inpatient hospital services as stated in Attachment 4.19-A, Pages 1A through Page 1G of this state plan. The add-on payments will be calculated and paid using the formula set forth below.

An eligible hospital for HCI purposes is defined as an acute care hospital licensed under Indiana Code 16-21, as defined and interpreted in the disproportionate share payment section of the Indiana Medicaid state plan amendment, and as defined and interpreted under the prior Medicaid HCI add-on payment methodology. I.C. 12-15-15-8 contained the payment methodology that was used to determine and make payments under the HCI program prior to state fiscal year 1998 and therefore, will not be used to calculate the payments for each state fiscal year beginning July 1, 1997 and thereafter.

PAYMENT FORMULA

In accordance with I.C. 12-15-15-9.6, for each state fiscal year beginning July 1, 2003 and thereafter, the total Medicaid HCI add-on payments to hospitals for a state fiscal year shall not exceed an amount equal to all amounts transferred from the hospital care for the indigent fund to the Medicaid indigent care trust fund, including amounts attributable to each county's *ad valorem* HCI property tax levy, for a state fiscal year. A Medicaid add-on payment due to an eligible hospital must be based on a formula that provides additional Medicaid reimbursement for inpatient hospital services the hospital provides to Medicaid enrollees. The amount and availability of a Medicaid add-on payment for a hospital will be limited by the upper payment limits imposed under 42 CFR § § 447.271 and 447.272. Variations in the amount of Medicaid add-on payments paid to eligible hospitals will be based upon the amount of inpatient hospital services an eligible hospital provides to Medicaid enrollees, the hospital's HCI patient case-load, and the amount of funds, including a county's *ad valorem* HCI property tax levy, transferred to the state hospital care for the indigent fund by each county to which one or more of the eligible hospital's HCI claims are attributed.

STEP 1: For each eligible hospital, the Office of Medicaid Policy and Planning ("office") shall identify the inpatient hospital services the hospital provided to Medicaid enrollees during the state fiscal year.

STEP 2: For each eligible hospital, the office shall calculate the amount of Medicaid reimbursement paid to the hospital for covered hospital services the hospital provided to Medicaid enrollees identified in STEP 1.

STEP 3: For each eligible hospital, the office shall calculate an amount equal to the amount calculated under STEP 3F of the following formula:

STEP 3A: Identify:

(1) Each eligible hospital that provided necessary emergency medical care during the state fiscal year to an individual who qualifies under IC 12-16-3.5 et seq. and the rules promulgated thereunder, and;

(2) the county of residence of the individual or, if the individual was not a resident of Indiana or the individual's Indiana county of residence cannot be ascertained, the county where the onset of the medical condition that necessitated the individual's emergency medical care occurred.

STEP 3B: For each county identified in (2) of STEP 3A, identify:

(1) each eligible hospital that provided care described in (1) of STEP 3A attributed to the county during the state fiscal year; and

(2) the total amount (using the office's fee for service reimbursement rates) of all eligible hospital episodes of care described in (1) of STEP 3A attributed to the county during the state fiscal year.

STEP 3C: For each county identified in (2) of STEP 3A, identify the amount of the county's HCI funds, including its HCI ad valorem property taxes, transferred from the hospital care for the indigent fund to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b).

STEP 3D: For each eligible hospital identified in (1) of STEP 3A, with respect to each county identified in (2) of STEP 3A, calculate the hospital's percentage share of the county's HCI funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b). Each hospital's percentage share is based on the total amount (using the office's fee for service reimbursement rates) of the hospital's care described in (1) of STEP 3A attributed to the county during the state fiscal year, calculated as a percentage of the total amount (using the office's fee for service reimbursement rates) of all hospital care described in (1) of STEP 3A attributed to the county during the state fiscal year.

STEP 3E: For each hospital identified in (1) of STEP 3A, with respect to each county identified in (2) of STEP 3A, multiply the hospital's percentage share calculated under STEP 3D by the amount of the county's HCI funds transferred from the hospital care for the indigent fund to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b).
STEP 3F: Determine the sum of all amounts calculated under STEP 3 E for each eligible hospital identified in (1) of STEP 3A with respect to each county identified in (2) of STEP 3A.

STEP 4: Subject to STEP 5 and STEP 6, the office shall pay to each eligible hospital a Medicaid add-on payment equal to the amount calculated for the hospital under STEP 3F and, in doing so, shall allocate the amount of the payment to each of the Medicaid covered inpatient hospital services identified for the hospital under STEP 1.

STEP 5: The office's allocation of a payment described in STEP 4 for a hospital's Medicaid covered inpatient service shall be limited to an amount not to exceed either (1) the amount that, when combined with the amount of reimbursement previously paid for the service as calculated under STEP 2, does not exceed the upper payment limit for inpatient hospital services under 42 C.F.R. § 447.271 and 42 C.F.R. § 447.272; or (2) the amount attributable to the hospital's inpatient hospital services that are rendered to each individual described in STEP 3A(1).

STEP 6: For any eligible hospital: (1) which receives a payment under STEP 4 that is less than the total amount (using the office's fee for service reimbursement rates) of the hospital's care in (1) of STEP 3A above during the state fiscal year; and (2) which could receive additional reimbursement for the services identified for the hospital under STEP 1 above without exceeding any applicable upper payment limits under 42 CFR § § 447.271 or 447. 272, the office shall calculate an amount equal to the amount calculated for the hospital under STEP 6H below:

STEP 6A: Identify each county whose transfer of HCI funds to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) for the state fiscal year was less than the total amount (using the office's fee for service reimbursement rates) of all hospital care identified in (1) in STEP 3A above attributed to the county during the state fiscal year.

STEP 6B: For each county identified in STEP 6A, calculate the difference between the amount of HCI funds of the county transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) and the total amount (using the office's fee for service reimbursement rates) of all hospital care identified in (1) of STEP 3A above attributed to the county during the state fiscal year.

STEP 6C: Calculate the sum of the amounts calculated for those counties under STEP 6(B).

STEP 6D: Identify each hospital: (1) which receives a payment under STEP 4 above that is less than the total amount (using the office's fee for service reimbursement rates) of the hospital's care in (1) of STEP 3A above during the state fiscal year; and (2) which could receive additional reimbursement for the services identified for the hospital under STEP 1 above without exceeding any applicable upper payment limit under 42 CFR § § 447.271 or 447.272.

STEP 6E: Calculate for each hospital identified in STEP 6D the difference between the hospital's payment under STEP 4 above and the total amount (using the office's fee for service reimbursement rates) of the hospital's care in (1) of STEP 3A above during the state fiscal year.

STEP 6F: Calculate the sum of the amounts calculated for each of the hospitals under STEP 6E.

STEP 6G: For each hospital identified in STEP 6D, calculate the hospital's percentage share of the amount calculated under STEP 6F. Each hospital's percentage share is based on the amount calculated for the hospital under STEP 6E calculated as a percentage of the sum calculated under STEP 6F.

STEP 6H: For each hospital identified in STEP 6D, multiply the hospital's percentage share calculated under STEP 6G by the sum calculated under STEP 6C.

STEP 7: Subject to STEP 8, the office shall pay to each eligible hospital identified in STEP 6 a Medicaid add-on payment equal to the amount calculated for the hospital under STEP 6H and, in doing so, shall allocate the amount of the payment to each of the hospital services identified for the hospital under STEP 1.

STEP 8: The office's allocation of a payment described in STEP 7 for a hospital's Medicaid covered inpatient service shall be limited to an amount that, when combined with the amount that is the sum of reimbursements previously paid for the service as calculated under STEP 2 and STEP 4, does not exceed either (1) the amount of the upper payment limit for inpatient hospital services under 42 C.F.R. § 447.271 and 42 C.F.R. § 447.272; or (2) the amount attributable to the hospital's inpatient hospital services that are rendered to each individual described in STEP 3A(1).

Total non-federal share of payments to hospitals under this program for each state fiscal year may not exceed the amount equal to the product calculated when the amount transferred to the Medicaid indigent care trust fund by counties is multiplied by the state Medicaid medical assistance percentage for the state fiscal year for which the payments are made.

In the event there are insufficient state matching funds to pay each hospital the amounts calculated, the amount paid to each hospital will be reduced proportionate to the amount of the deficiency of funds. Payments shall be made prior to December 15 that next succeeds the end of the state fiscal year.

EFFECTIVE DATE Subject to approval by CMS, these payments are to be effective on July 1, 2003.

State-Owned Psychiatric Hospitals

Section 1 Policy; scope

Sec. 1. (a) This section of the State Plan sets forth procedures for payment for services rendered to Medicaid recipients by duly certified and state-owned psychiatric hospitals. All payments referred to within this section of the State Plan for the provider groups and levels of care are contingent upon the following:

(1) Proper and current certification.
(2) Compliance with applicable state and federal statutes and regulations.

(b) The procedures described in this section of the State Plan set forth methods of reimbursement that promote quality of care, efficiency, economy, and consistency. These procedures recognize level and quality of care, establish effective accountability over Medicaid expenditures, provide for a regular review mechanism for rate changes, compensate providers for reasonable, allowable costs incurred by a prudent businessperson, and allow incentives to encourage efficient and economic operations. The system of payment outlined in this section of the State Plan is a retrospective system using interim rates predicated on a reasonable, cost-related basis, in conjunction with a final settlement process. Cost limitations are contained in this section of the State Plan which establish parameters regarding the allowability of costs and define reasonable allowable costs.

(c) Retroactive repayment will be required by providers when an audit verifies overpayment due to discounting, intentional misrepresentation, billing or payment errors, or misstatement of historical financial or historical statistical data which caused a rate higher than would have been allowed had the data been true and accurate. Upon discovery that a provider has received overpayment of a Medicaid claim from the office, the provider must complete the appropriate Medicaid billing adjustment form and reimburse the office for the amount of the overpayment.

(d) The office may implement Medicaid rates prospectively without awaiting the outcome of the administrative appeal process. However, any action by the office to recover an overpayment from previous rate reimbursements, either through deductions of future payments or otherwise, shall await the completion of the provider's administrative appeal within the office, providing the provider avails itself of the opportunity to make such an appeal. Interest shall be assessed in accordance with IC 12-15-13-3.

Section 2 Definitions

Sec. 2. (a) As used in this section of the State Plan, "all-inclusive rate" means a per diem rate which, at a minimum, reimburses for all nursing care, room and board, supplies, and ancillary therapy services within a single, comprehensive amount.

(b) As used in this section of the State Plan, "annual, historical, or budget financial report" refers to a presentation of financial data, including accompanying notes, derived from accounting records and intended to communicate the provider's economic resources or obligations at a point in time, or the changes therein for a period of time in compliance with the reporting requirements of this section of the State Plan which shall constitute a comprehensive basis of accounting.

(c) As used in this section of the State Plan, "budgeted/forecasted data" means financial and statistical information that presents, to the best of the provider's knowledge and belief, the expected results of operation during the rate period.

(d) As used in this section of the State Plan, "cost center" means a cost category delineated by cost reporting forms prescribed by the office.

(e) As used in this section of the State Plan, "office" means the office of Medicaid policy and planning.

(f) As used in this section of the State Plan, "desk review" means a review and application of these regulations to a provider submitted annual financial report including accompanying notes and supplemental information.

(g) As used in this section of the State Plan, "field audit" means a formal official verification and methodical examination and review, including the final written report of the examination of original books of accounts by auditors.

(h) As used in this section of the State Plan, "forms prescribed by the office" means forms provided by the office or substitute forms which have received prior written approval by the office.

(i) As used in this section of the State Plan, "general line personnel" means management personnel above the department head level who perform a policy making or supervisory function impacting directly on the operation of the facility.

(j) As used in this section of the State Plan, "generally accepted accounting principles" means those accounting principles as established by the American Institute of Certified Public Accountants.

(k) As used in this section of the State Plan, "like levels of care" means psychiatric hospital level of care provided in a state-owned psychiatric hospital.

(l) As used in this section of the State Plan, "ordinary patient related costs" means costs of services and supplies that are necessary in the delivery of patient care by similar providers within the state.

(m) As used in this section of the State Plan, "patient/recipient care" means those Medicaid program services delivered to a Medicaid enrolled recipient by a certified Medicaid provider.

(n) As used in this section of the State Plan, "reasonable allowable costs" means the price a prudent, cost conscious buyer would pay a willing seller for goods or services in an arm's-length transaction, not to exceed the limitations set out in this section of the State Plan.

(o) As used in this section of the State Plan, "unit of service" means all patient care included in the established per diem rate required for the care of an inpatient for one (1) day (twenty-four (24) hours).

Section 3 Accounting records; retention schedule; audit trail; cash basis; segregation of accounts by nature of business and by location

Sec. 3. (a) The basis of accounting used under this section of the State Plan is a comprehensive basis of accounting other than generally accepted accounting principles. However, generally accepted accounting principles as prescribed by the Governmental Accounting Standards Board pronouncements shall be followed in the preparation and presentation of all financial reports and all reports detailing proposed change of provider transactions unless otherwise prescribed by this section of the State Plan.

(b) Each provider must maintain financial records for a period of three (3) years after the date of submission of financial reports to the office. State accounting records are maintained on a cash basis, which shall be used in all data submitted to the office. The provider's accounting records must establish an audit trail from those records to the financial reports submitted to the office.

(c) In the event that a field audit visit indicates that the provider's records are inadequate to support data submitted to the office, and the auditor is unable to complete the audit and issue an opinion, the provider shall be given, in writing, a list of the deficiencies and allowed sixty (60) days from the date of receipt of this notice to correct the deficiencies. In the event the deficiencies are not corrected within the sixty (60) day period, the office shall not grant any rate increase to the provider until the cited deficiencies are corrected and certified to the office by the provider. However, the office may:

(1) make appropriate adjustments to the applicable cost reports of the provider resulting from inadequate records;
(2) document such adjustments in a finalized exception report; and
(3) incorporate such adjustments in prospective rate calculations under section 1(d) of this section of the State Plan.

(d) If a provider has business enterprises other than those reimbursed by Medicaid under this section of the State Plan, the revenues, expenses, and statistical and financial records for such enterprises shall be clearly identifiable from the records of the operations reimbursed by Medicaid. If a field audit establishes that records are not maintained so as to clearly identify Medicaid information, none of the commingled costs shall be recognized as Medicaid allowable costs and the provider's rate shall be adjusted to reflect the disallowance effective as of the date of the most recent rate change.

Section 4 Financial report to office; annual schedule; prescribed form; extensions

Sec. 4. (a) Each provider shall submit an annual financial report to the office not later than ninety (90) days after the close of the provider's reporting year. The annual financial report shall coincide with the fiscal year used by the provider to report federal income taxes for the operation unless the provider requests in writing that a different reporting period be used. Such a request shall be submitted within sixty (60) days after the initial certification of a provider. This option may be exercised only one (1) time by a provider. If a reporting period other than the tax year is established, audit trails between the periods are required, including reconciliation statements between the provider's records and the annual financial report.

(b) The provider's annual financial report shall be submitted using forms prescribed by the office. All data elements and required attachments shall be completed so as to provide full financial disclosure and shall include the following as a minimum:

(1) Patient census data.
(2) Statistical data.
(3) Ownership and related party information.
(4) Statement of all expenses and all income.
(5) Detail of fixed assets and patient related interest bearing debt.
(6) Schedule of Medicaid and private pay charges; private pay charges shall be lowest usual and ordinary charge on the last day of the reporting period.
(7) Certification by the provider that the data are true, accurate, related to patient care, and that expenses not related to patient care have been clearly identified.
(8) Certification by the preparer, if different from the provider, that the data were compiled from all information provided to the preparer by the provider and as such are true and accurate to the best of the preparer's knowledge.

(c) Extension of the ninety (90) day filing period shall not be granted unless the provider substantiates to the office circumstances that preclude a timely filing. Requests for extensions shall be submitted to the office, prior to the date due, with full and complete explanation of the reasons an extension is necessary. The office shall review the request for extension and notify the provider of approval or disapproval within ten (10) days of receipt. If the request for extension is disapproved, the report shall be due twenty (20) days from the date of receipt of the disapproval from the office.

Section 5 New provider; initial financial report to office; criteria for establishing initial rates; supplemental report

Sec. 5. (a) Rate requests to establish initial rates for a new operation or a new type of certified service shall be filed by completing the budget financial report form and submitting it to the office on or before thirty (30) days after notification of the certification date or establishment of a new service or new operation. The budget financial report shall reflect the forecasted data of operating for the first twelve (12) months and shall be subject to appropriate reasonableness tests. Initial rates shall be effective upon certification, or the date that a service is established, whichever is later.

(b) The methodology, set out in this section of the State Plan, used to compute rates for active providers shall be followed to compute initial rates for new providers, except that historical data are not available.

Section 6 Active providers; rate review; annual request; additional requests; requests due to change in law

Sec. 6. (a) As a normal practice, rates shall be reviewed once each year using the annual financial report as the basis of the review. The rate effective date shall be the first day of the month following the provider's reporting year end, provided the annual financial report is submitted within ninety (90) days of the end of the provider's reporting period. If the provider requests that the interim rate be reviewed, a budget financial report covering the twelve (12) month period immediately following the expected rate effective date shall be prepared by the provider and submitted with the annual financial report.

(b) A provider shall not be granted an additional interim rate review until the review indicated in subsection (a) has been completed. A provider may request no more than one (1) additional interim rate review during its budget reporting year when the provider can reasonably demonstrate the need for a change in rate based on more recent historical and forecasted data. This additional interim rate review shall be completed in the same manner as the annual interim rate review, using all other limitations in effect at the time the annual interim review took place.

(c) To request the additional interim review, the provider shall submit, on forms prescribed by the office, a minimum of six (6) months of historical data of which at least four (4) months must be subsequent to the fiscal year end of the annual financial report. In addition, a budget financial report covering the twelve (12) month period immediately following the expected rate effective date shall be submitted. Any new rate resulting from this additional interim review shall be effective on the first day of the month following the submission of data to the office.

Section 7 Request for rate review; budget component; occupancy level assumptions; effect of inflation assumptions

Sec. 7. Under this rate setting system, emphasis is placed on proper planning, budgeting, and cost control by the provider. To establish consistency in the submission and review of forecasted costs, the following apply:

(1) Each interim rate review request shall include a budget financial report. If a budget financial report is not submitted, the interim rate review will not result in an increase in Medicaid rates but may result in a rate decrease based on historical or annual financial reports submitted.
(2) All budget financial reports shall be submitted using forms prescribed by the office. All forecasted data and required attachments shall be completed to provide full financial disclosure and will include as a minimum the following:
(A) Patient census data.
(B) Statistical data.
(C) Ownership and related party information.
(D) Statement of all expenses and all income.
(E) Detail of fixed assets and patient related interest bearing debt.
(F) Schedule of Medicaid and private pay charges; charges shall be the lowest usual and ordinary charge on the rate effective date of the rate review.
(G) Certification by the provider that forecasted data has been prepared in good faith, with appropriate care by qualified personnel, using appropriate accounting principles and assumptions, and that the process to develop the forecasted data uses the best information that is reasonably available and is consistent with the plans of the provider. The certification shall state that all expenses not related to patient care have been clearly identified or removed.
(H) Certification by the preparer, if the preparer is different from the provider, that the forecasted data were compiled from all information provided to the preparer and that the preparer has read the forecasted data with its summaries of significant assumptions and accounting policies and has considered them to be not obviously inappropriate.
(3) The provider shall adjust patient census data based on the highest of the following:
(A) Historical patient days for the most recent historical period unless the provider can justify the use of a lower figure for the patient days.
(B) Forecasted patient days for the twelve (12) month budget period.

Section 8 Limitations or qualifications to Medicaid reimbursement; advertising

Sec. 8. Advertising is not an allowable cost under this section of the State Plan except for those advertising costs incurred in the recruitment of facility personnel necessary for compliance with facility certification requirements. Advertising costs are not allowable in connection with public relations, fundraising, or to encourage patient utilization.

Section 9 Criteria limiting rate adjustment granted by office

Sec. 9. The Medicaid reimbursement system is based on recognition of the provider's allowable costs. Providers reimbursed under this section of the State Plan will be reimbursed with a retrospective payment system. The annual financial reports filed by the providers will be used to determine the actual cost per day for services. A retroactive settlement will be determined for the time period covered by the annual financial report. The total allowable costs will be divided by the actual client days to determine the actual per diem rate. The variance between the actual per diem rate and the interim per diem rates based on the projected budget and paid during the report period will be multiplied by the paid client days to arrive at the annual settlement.

Section 10 Computation of annual and interim rate; allowable costs; review of cost reasonableness

Sec. 10. (a) The annual rate, per Section 6, for a room with two (2) beds, which is the basic per diem room rate, shall be established as a ratio between total allowable costs and patient days as determined from the annual financial report, subject to all other limitations described in this section of the State Plan.

(b) Costs and revenues shall be reported as required on the annual financial report form. Patient care costs shall be clearly identified.

(c) The provider shall report as patient care costs only costs that have been incurred in the providing of patient care services. The provider shall certify on the annual financial report that costs not related to patient care have been separately identified on the financial report.

(d) In determining reasonableness of costs, the office may compare line items, cost centers, or total costs of providers with like levels of care. The office may request satisfactory documentation from providers whose costs do not appear to be reasonable.

(e) The interim rate, per Section 6, for a room with two (2) beds, which is the basic per diem room rate, shall be established as a ratio between total budgeted costs and budgeted patient days as determined from the budgeted financial report, subject to all other limitations described in this section of the State Plan.

(f) Budgeted Costs and revenues shall be reported as required on the budgeted financial report form. Budgeted patient care costs shall be clearly identified.

(g) The provider shall report as patient care costs only costs that are anticipated to be incurred in the providing of patient care services. The provider shall certify on the budget financial report that costs not related to patient care have been separately identified on the financial report.

(h) In determining reasonableness of budgeted costs, the office may compare line items, cost centers, or total costs of providers with like levels of care. The office may request satisfactory documentation from providers whose budgeted costs do not appear to be reasonable.

(i) In determining reasonableness of budgeted cost, the office shall compare forecasted data to the inflationary or deflationary effect on historical data for the period between the midpoint of the historical or annual financial report time period and the midpoint of the budget financial report. The office may request satisfactory documentation from providers whose budgeted costs do not appear to be reasonable. Unsupported forecasted data may be adjusted based upon reasonably anticipated rates of inflation.

Section 11 Allowable costs; capital reimbursement; depreciable life

Sec. 11. (a) Providers shall be reimbursed for the use of facilities and equipment, regardless of whether they are owned or leased. Such reimbursement shall include all depreciation, interest, lease, rent, or other consideration paid for the use of property. This includes all central office facilities and equipment whose patient care-related depreciation, interest, or lease expense is allocated to the facility.

(b) The straight line method will be used to calculate the allowance for depreciation. For depreciation purposes, the following will be used:

Property	Depreciable Life
Land improvements	20 years
Buildings and building components	40 years
Building improvements	20 years
Movable equipment	10 years
Vehicles	4 years
Software	3 years

Section 12 Capital reimbursement; basis; historical cost; mandatory record keeping; valuation

Sec. 12. (a) The basis used in computing the capital reimbursement shall be the historical cost of all assets used to deliver patient related services, provided the following:

(1) They are in use.
(2) They are identifiable to patient care.
(3) They are available for physical inspection.
(4) They are recorded in provider records.

If an asset does not meet all of the requirements prescribed in this section, the cost shall not be included in computing the reimbursement.

(b) The provider shall maintain detailed property schedules to provide a permanent record of all historical costs and balances of facilities and equipment. Summaries of such schedules shall be submitted with each annual financial report, and the complete schedule shall be submitted to the office upon request.

(c) Assets used in computing capital reimbursement shall include only items currently used in providing services customarily provided to patients.

(d) When an asset is acquired by trading one (1) asset for another, or a betterment or improvement is acquired, the cost of the newly acquired asset, betterment, or improvement shall be added to the appropriate property category. All of the historical cost of the traded asset or replaced betterment or improvement shall be removed from the property

category in which it was included.

(e) If a single asset or collection of like assets acquired in quantity, including permanent betterment or improvements, has at the time of acquisition an estimated useful life of at least three (3) years and a historical cost of at least five hundred dollars ($500), the cost shall be included in the property basis for the approved useful life of the asset. Items that do not qualify under this subsection shall be expensed in the year acquired.

(f) The property basis of donated assets, except for donations between providers or related parties, shall be the fair market value defined as the price a prudent buyer would pay a seller in an arm's-length sale., or if over two thousand dollars ($2,000), the appraised value, whichever is lower. An asset is considered donated when the provider acquires the asset without making any payment for it in the form of cash, property, or services. If the provider and the donated asset are related parties, the net book value of the donor shall be the basis, not to exceed fair market value. Cash donations shall be treated as revenue items and not as offsets to expense accounts.

Section 13 Unallowable costs; cost adjustments; charity and courtesy allowances; discounts; rebates; refunds of expenses

Sec. 13. (a) Charity, courtesy allowances, discounts, refunds, rebates, and other similar items granted by a provider shall not be included in allowable costs. Bad debts incurred by a provider shall not be an allowable cost.

(b) Payments that must be reported on the annual financial report form that are received by a provider, an owner, or other official of a provider in any form from a vendor shall be considered a reduction of the provider's costs for the goods or services from that vendor.

(c) The cost of goods or services sold to nonpatients shall be offset against the total cost of such service to determine the allowable patient related expenses. If the provider has not determined the cost of such items, the revenue generated from such sales shall be used to offset the total cost of such services.

Section 14 Allowable costs; wages; costs of employment; record keeping; owner or related party compensation

Sec. 14. (a) Reasonable compensation of individuals employed or to be employed by a provider is an allowable cost, provided such employees are engaged in, or will be engaged in, patient care-related functions and that forecasted compensation amounts are reasonable in light of historical data under this section and section 15 of this section of the State Plan.

(b) The provider shall report on the financial report form in the manner prescribed, using the forms prescribed by the office, all patient related staff costs and hours incurred, and forecasted to be incurred, to perform the function for which the provider was certified. Both total compensation and total hours worked, and forecasted to be worked, shall be reported. If a service is performed through a contractual agreement, imputed hours for contracted services shall be reported.

(c) Payroll records shall be maintained by the provider to substantiate the staffing costs reported to the office. Said records shall indicate each employee's classification, hours worked, rate of pay, and the department or functional area to which the employee was assigned and actually worked. If an employee performs duties in more than one (1) department or functional area, the payroll records shall indicate the time allocations to the various assignments.

Section 15 Allowable costs; calculation of allowable owner or related party compensation; wages; salaries; fees; fringe benefits

Sec. 15. (a) Compensation for management, consultant, or any individual or entity rendering services above the department head level shall be subject to the annual limitations described in this section. All compensation received by the parties as described in this subsection shall be reported and separately identified on the financial report form even though such payment may exceed the limitations. This compensation is allowed to cover costs for all administrative, policy making, decision making, and other management and consultant functions above the department head level. This includes wages, salaries, and fees for owner, administrator, assistant administrator, management, contractor, and consultant as well as any other individual or entity performing such tasks.

(b) The maximum amount of management compensation for the parties identified in subsection (a) shall be the lesser of the amount under subsection (c), as updated by the office on July 1 of each year by determining the average rate of change of the most recent twelve (12) quarters of the Gross National Product Implicit Price Deflator, or the amount of patient related wages, salaries, or fees actually paid or withdrawn which were properly reported to the federal Internal Revenue Service as wages, salaries, fringe benefits, expenses, or fees. If liabilities are established, they shall be paid within seventy-five (75) days after the end of the accounting period or such costs shall be disallowed.

(c) The management compensation limitation per operation effective July 1, 1995, shall be as follows:

Owner and Management Compensation	
Beds	Allowance
10	$21,542
20	$28,741
30	$35,915
40	$43,081
50	$50,281
60	$54,590
70	$58,904
80	$63,211
90	$67,507
100	$71,818
110	$77,594
120	$83,330
130	$89,103
140	$94,822
150	$100,578
160	$106,311
170	$112,068
180	$117,807
190	$123,562
200	$129,298
200 & over	$129,298+ $262/bed over 200

This subsection applies to each provider of a certified Medicaid operation. The unused portions of the allowance for one (1) operation shall not be carried over to other operations.

Section 16 Allocation of costs

Sec. 16. (a) The detailed basis for allocation of expense between different levels of care in a facility shall remain a prerogative of the provider as long as the basis is reasonable and consistent between accounting periods.

(b) However, the following relationships shall be followed:

(1) Reported expenses and patient census information must be for the same reporting period.
(2) Nursing salary allocations must be on the basis of nursing hours worked and must be for the reporting period except when specific identification is used based on the actual salaries paid for the reporting period.
(3) Any change in the allocations must be approved by the office prior to the changes being implemented. Proposed changes in allocation methods must be submitted to the office for approval at least ninety (90) days prior to the provider's reporting year end.

Section 17 State-owned facilities per diem rate

Sec. 17. The per diem rate for providers reimbursed under this section of the State Plan is an all-inclusive rate. The per diem rate includes all services provided to recipients by the facility.

Section 18 Administrative reconsideration; appeal

Sec. 18. (a) The Medicaid rate setting contractor shall notify each provider of the provider's rate after such rate has been computed. If the provider disagrees with the rate determination, the provider must request an administrative reconsideration by the Medicaid rate setting contractor. Such reconsideration request shall be in writing and shall contain specific issues to be reconsidered and the rationale for the provider's position. The request shall be signed by the provider or the authorized representative of the provider and must be received by the contractor within forty-five (45) days after release of the rate computed by the Medicaid rate setting contractor. Upon receipt of the request for reconsideration, the Medicaid rate setting contractor shall evaluate the data. After review, the Medicaid rate setting contractor may amend the rate, amend the challenged procedure or determination, or affirm the original decision. The Medicaid rate setting contractor shall thereafter notify the provider of its final decision in writing, within forty-five (45) days of the Medicaid rate setting contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the rate setting contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies as set out in subsection (c).

(b) If the provider disagrees with a rate redetermination resulting from an audit adjustment, the provider must request an administrative reconsideration from the Medicaid audit contractor. Such reconsideration request shall be in writing and shall contain specific issues to be considered and the rationale for the provider's position. The request shall be signed by the provider and must be received by the Medicaid audit contractor within forty-five (45) days after release of the rate computed by the Medicaid rate setting contractor. Upon receipt of the request for reconsideration, the Medicaid audit contractor shall evaluate the data. After review, the Medicaid audit contractor may amend the audit adjustment or affirm the original adjustment. The Medicaid audit contractor shall thereafter notify the provider of its final decision in writing within forty-five (45) days of the Medicaid audit contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the audit contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies under subsection (c).

(c) After completion of the reconsideration procedure under subsection (a) or (b), the provider may initiate an appeal under 405 IAC 1-1.5.

(d) The office may take action to prospectively implement Medicaid rates without awaiting the outcome of the administrative process.

DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

I. AUTHORITY

In compliance with Section 1902 (a)(13)(A) of the Act, Section 1923 of the Act, and specifically the mandates of section 4112 (OBRA 1987), P.L. 100-203, the Indiana Medicaid program adopts the following definitions and methodologies to identify and make payments to hospitals to take into account the situation of such providers that serve a disproportionate number of low-income patients with special needs.

II. DEFINITIONS

(A) "Acute Care Hospital" has the following meaning: "Any institution, place, building, or agency represented and held out to the general public as ready, willing, and able to furnish care, accommodations, facilities, and equipment, for the use, in connection with the services of a physician, of persons who may be suffering from deformity, injury, or disease, or from any other condition, from which medical or surgical services would be appropriate for care, diagnosis, or treatment." The term does not include a state mental health institution or a private psychiatric institution, nor does it include convalescent homes, boarding homes, homes for the aged or freestanding health facilities licensed for long term care such as nursing facilities.

(B) "State Mental Health Institution" has the following meaning: "A state-owned or state-operated institution for the observation, care, treatment, or detention of an individual; and under the administrative control of the division of mental health." This group of providers is commonly referred to as state hospitals.

(C) "Private Psychiatric Institution" has the following meaning: "An acute care inpatient facility, properly licensed for the treatment of persons with mental illness." This group of providers is commonly referred to as private psychiatric hospitals.

(D) "Community Mental Health Center" has the following meaning: "a program of services approved by the division of mental health and organized for the purpose of providing multiple services for the mentally handicapped and operated by one of the following or combinations thereof:

(1) Any city, town, county or other political subdivision of this state; any agency of the state of Indiana or of the United States; and any political subdivision of another state; including but not limited to and without limiting the generality of the foregoing, hospitals owned or operated by units of government and building authorities organized for the purpose of constructing facilities to be leased to units of government;

(2) A corporation incorporated under the provisions of IC 1971, 23-7-1.1, the "Indiana General Not for Profit Corporation Act";

(3) A nonprofit corporation incorporated in another state; and

(4) A university of college.

(E) "Disproportionate Share Hospital" has the following meaning: An Acute Care Hospital licensed under IC 16-21, the Indiana hospital licensure statute; a State Mental Health Institution under the administrative control and responsibility of the Director of the State Division of Mental Health; or a Private Psychiatric Institution licensed under IC 12-25, that qualifies as an inpatient hospital eligible for DSH payments as set out in the requirements in section 1923 of the Act,

(1) whose Medicaid Inpatient Utilization Rate is at least one standard deviation above the Statewide Mean Medicaid Inpatient Utilization Rate for such provider hospitals receiving Medicaid payments in Indiana, or,

(2) whose low income utilization rate exceeds twenty-five percent (25%).

No hospital may be a disproportionate share hospital unless the hospital:

(i) has a Medicaid utilization rate of at least one percent (1%); and
(ii) has at least two (2) obstetricians with staff privileges, who have agreed to provide obstetric services to individuals entitled to such services under the Indiana Medicaid state plan. For a hospital located in a rural area (as defined in Section 1886 of the Social Security Act), the term obstetrician includes a physician with staff privileges at the hospital to perform non-emergency obstetric procedures. This provision, (ii), does not apply to a hospital the inpatients of which are predominately individuals under 18 years of age; or which did not offer non-emergency obstetric services as of December 21, 1987.

For state fiscal years ending after June 30, 1997, eafch hospital's eligibility for disproportionate share payments under this section shall be based on utilization and revenue data from the most recent year for which an audited cost report for the individual hospital is on file with the office.

(F) "Historical disproportionate share provider" has the following meaning:

An acute care hospital licensed under IC 16-21 which was eligible for a disproportionate share hospital payment for the state fiscal year ending on June 30, 1998, and which is eligible for a disproportionate share hospital payment in the year for which payments are being calculated.

(G) "Municipal Disproportionate Share Provider" has the following meaning: An acute care hospital licensed by the State of Indiana and established and operated under Indiana Code 16-22-2 or 16-23, that based on utilization and revenue date from the most recent year for which an audited cost report is on file with the office, has a Medicaid Inpatient Utilization Rate greater than one percent (1%). IC 16-22-2 and 16-23 are enabling statutes for county and city-county hospitals under Indiana law.

(H) "Community Mental Health Center Disproportionate Share Provider" has the following meaning: A community health center designated as such by the state division of mental health, that receives funding under Indiana Code 12-29-1-7(b) or from other county sources, that provides inpatient services to Medicaid patients, and whose Medicaid Inpatient Utilization Rate, based on utilization and revenue data from the most recent year for which an audited cost report is on file with the office, is greater than one percent (1%). Indiana Code 12-29-1-7(b) provides for property tax funding by individual counties of community mental health centers situated in those counties.

(I) "Medicaid Inpatient Utilization Rate" for a provider, has the following meaning: A fraction (expressed as a percentage) for which:

(1) the numerator is the provider's total Medicaid inpatient days in the most recent year for which an audited cost report is on file with the office; and

(2) the denominator is the total number of the provider's inpatient days in that same cost reporting period, where inpatient days includes each day in which an individual (including newborns, Medicaid managed care beneficiaries, and Medicaid beneficiaries from other states) is an inpatient in the hospital, whether or not the individual is in a specialized ward (including acute care excluded unit distinct part subproviders of the provider) and whether or not the individual remains in the hospital for lack of suitable placement elsewhere. The term "inpatient days" includes days attributable to Medicaid managed care recipients and Medicaid eligible patients. The term does not include days attributable to Medicaid patients between the ages of 21 and 65 in Institutions for Mental Disease.

(J) "Statewide Mean Medicaid Inpatient Utilization Rate" has the following meaning: A fraction (expressed as a percentage) for which:

(1) the numerator is the total of all Medicaid enrolled hospital providers' Medicaid Inpatient Utilization Rates in the most recent year for which audited cost reports are on file with the office; and

(2) the denominator is the total number of all such Medicaid enrolled provider hospitals.

In calculating the Statewide Mean Medicaid Inpatient Utilization Rate, the Medicaid agency shall not include in the statistical database for the statewide mean calculation, the Medicaid Inpatient Utilization Rates of providers whose low income utilization rates exceed twenty-five percent (25%).

(K) A provider's "Low Income Utilization Rate" is the sum of:

(1) a fraction (expressed as a percentage) for which:

(A) the numerator is the sum of the following:

(i) the total Medicaid patient revenues paid to the provider during the most recent year for which an audited cost report is on file with the office; plus

(ii) the amount of the cash subsidies received directly from state and local governments, during the most recent year for which an audited cost report is on file with the office, including payments made under the hospital care for the indigent program; and

(B) the denominator is the total amount of the provider's revenues for patient services (including cash subsidies) during the most recent year for which an audited cost report is on file with the office; and

(2) a fraction (expressed as a percentage) for which:

(A) the numerator is the total amount of the provider's charges for inpatient services during the most recent year for which an audited cost report is on file with the office that are attributable to care provided to individuals who have no source of payment or third party or personal resources, less the amount of any cash subsidies described in clause (K)(1)(A)(ii) above; and

(B) the denominator is the total amount of charges for inpatient services in the same cost reporting period.

The numerator in clause (2)(A) shall not include contractual allowances and discounts other than for indigent patients not eligible for medical assistance under an approved Medicaid state plan.

(L) For purposes of eligibility, utilization rate and payment adjustment determinations for State fiscal years ending after June 30, 1997, "utilization and revenue data from the most recent year for which an audited cost report is one file" means utilization and revenue data from the most recent cost report which is on file for each individual provider as of June 30 of the state fiscal year immediately preceding the fiscal year for which the determination of eligibility of the calculation or rates or the calculation of payment adjustments is being made, and which has been audited prior to the date on which the determination or calculation is made.

(M) For purposes of calculating DSH eligibility, audited is defined as a targeted limited scope desk review where the data used for DSH calculations is thoroughly reviewed and adjusted where necessary.

(N) "Non-State Government-Owned or Operated Hospital" means a health care facility providing inpatient and outpatient hospital services that is (1) licensed as an acute care hospital under Indiana Code 16-21; and (2) is established and operated as a non-state governmental hospital under Indiana Code 16-22-2, Indiana Code 16-22-8 or Indiana Code 16-23.

(O) "Eligibility Determination" means the office's targeted limited scope desk review of survey data, cost and claims reports, and documentation in order to determine (1) the criteria for qualification as a disproportionate share hospital under Section II(E); and (2) hospitals which satisfy that criteria.

(P)"Eligibility Period" means the state fiscal year(s) for which an Eligibility Determination applies and which ends immediately prior to the commencement of the state fiscal year for which the office next makes an Eligibility Determination. The duration of an Eligibility Period shall be at least two SFYs, but no more than four SFYs, in length.

III. PAYMENT ADJUSTMENTS

A. Inpatient Disproportionate Share Payment Adjustment

Subject to Subsection H, Disproportionate Share Hospitals shall receive, in addition to their allowable regular claims payments and any other payment adjustments to which they are entitled, a disproportionate share payment adjustment calculated in the following manner for SFY 2012 and thereafter:

In no instance will any Disproportionate Share Hospital payments exceed the hospital specific limit as defined in subsection B 1. The provisions in subsection B 1 are applicable for SFY 2012 and thereafter and also apply to DSH eligible freestanding psychiatric institutions licensed under IC 12-25. DSH payments that are retrospectively determined to exceed the hospital specific limit shall be recovered by the office. For DSH payments made on or after 7/1/2011, any DSH allotment recovered by the office may be redistributed to other DSH eligible hospitals in accordance with the payment order below, not to exceed any hospital's hospital specific limit. The amount of DSH redistribution payments is limited to the amount recouped by the office.

Any Disproportionate Share Hospital may decline all or part of the annual DSH payments by submitting documentation to the State indicating that it declines the DSH payments and the amount of DSH payments being declined.

1. Step One: Each Disproportionate Share Hospital receives a payment of $1,000, not to exceed the hospital's hospital specific limit.

2. Step Two: Municipal Disproportionate Share Providers established and operated under Indiana Code 16-22-2 or 16-23 receive payment amounts equal to the lower of the hospital's hospital specific limit for the payment year less any Step One amount received by that hospital; or the hospital's net 2009 supplemental payment amount.

3. Step Three: DSH eligible acute care hospitals licensed under IC 16-21 located in Lake County, Indiana receive payment amounts equal to the hospital's hospital specific limit for the payment year, less any Step One amount received by that hospital.

4. Step Four: DSH eligible private acute care hospitals licensed under IC 16-21 and DSH eligible hospitals established and operated under Indiana Code 16-22-8 receive payment amounts equal to the hospital's hospital specific limit for the payment year, less any payment received by that hospital under step one. If not enough DSH funds are available to pay all eligible hospitals in this group up to their respective hospital specific limits, the amount paid to each hospital will be reduced by the same percentage for all hospitals in the group.

5. Step Five: If there is DSH remaining after the above steps, DSH eligible freestanding psychiatric institutions licensed under IC 12-25 receive payment amounts equal to the institution's hospital specific limit for the payment year, less any payment received by the institution under step one. If not enough DSH funds are available to pay all eligible institutions in this group up to their respective hospital specific limits, the amount paid to each institution will be reduced by the same percentage for all institutions in the group. Institutions owned by the State of Indian are not eligible for payments from this pool.

Steps six and seven below apply to DSH payments for SFYs 2013 and thereafter.

6. Step Six: If there is DSH remaining after the above steps:
    a. a Municipal Disproportionate Share Provider established and operated under Indiana Code 16-22-2 or 16-23 receives a payment amount equal to the hospital's hospital specific limit for the payment year, less any payment received by that hospital for the payment year under step one and step two; and

    b. a private acute care hospital established and operated under Indiana Code 16-21-2 that:
        i. has a Medicaid inpatient utilization rate for the DSH eligibility period for the payment year that is at least equal to the mean Medicaid inpatient utilization rate as calculated for purposes of determining Medicaid disproportionate share eligibility, but does not equal or exceed one (1) standard deviation above the mean Medicaid inpatient utilization rate; and
        ii. satisfies the obstetric service provisions of 42 U.S.C. 1396r-4(d);

    receives a payment amount equal to the hospital's hospital specific limit for the payment year.

    If not enough DSH funds are available to pay all hospitals eligible under this step up to their respective hospital specific limits, the amount paid to each hospital under this step will be reduced by the same percentage for all hospitals eligible under this step.

7. Step Seven: If there is DSH remaining after the above steps, a private acute care hospital established and operated under Indiana Code 16-21-2 that:

    a. has a Medicaid inpatient utilization rate for the DSH eligibility period for the payment year that is less than the mean Medicaid inpatient utilization rate as calculated for purposes of determining Medicaid disproportionate share eligibility, but is at least greater than one percent (1%); and

    b. satisfies the obstetric service provisions of 42 U.S.C. 1396r-4(d);

    receives a payment amount equal to the hospital's hospital specific limit for the payment year.

    If not enough DSH funds are available to pay all hospitals eligible under this step up to their respective hospital specific limits, the amount paid to each hospital under this step will be reduced by the same percentage for all hospitals eligible under this step.

Disproportionate share hospital payments described in this section may be made on an interim basis throughout the year as determined by the office.

Interim DSH payments will be calculated using the payment methodology described above, based on the best available data at the time of the calculation. To determine the interim payment amount, the hospitals' calculated DSH payments will be multiplied by two percentages: 1) the ratio of the total DSH allotment for the payment year divided by the sum of all DSH eligible and appealing hospitals' hospital specific limits for that same year, not to exceed 1, and 2) the percentage of the state fiscal year that has been completed at the time of the payment. Partial payments to psychiatric hospitals will be limited to the amount paid in step 1.

The disproportionate share payment adjustment calculations described below and in subsections B 2 and C through G do not apply for SFY 2012 and thereafter.

(1) For each of the state fiscal years ending after June 30, 1995, a pool not exceeding two million dollars ($2,000,000) shall be distributed to all qualified private psychiatric DSH's licensed by the director of the state department of health to provide private institutional psychiatric care, whose Medicaid impatient utilization rates are at least one (1) standard deviation above the statewide mean Medicaid inpatient utilization rate for providers receiving Medicaid payments in Indiana and/or whose low income utilization rate exceeds twenty-five percent (25%). The funds in this pool must be distributed to the qualifying hospitals in the proportion that each qualifying hospital's Medicaid inpatient utilization rate bears to the total of the Medicaid inpatient utilization rates of all hospitals in the pool as determined based on data form the most recent year for which an audited cost report is on file with the office for each potentially eligible hospital. In no instance will any hospital in this pool be entitled to disproportionate share amounts that when added to the hospital's payments associated with Medicaid and uninsured care yield a combined total reimbursement that exceeds 100% of the hospital's allowable cost of delivering Medicaid and uninsured care. DSH payments that are retrospectively determined to exceed this cap of 100% of allowable cost shall be recovered by the office.

(2) For each state fiscal year ending on or after June 30, 1995, a pool not exceeding one hundred ninety-one million dollars ($191,000,000) shall be distributed to all state mental health DSH's whose inpatient utilization rates are al least one (1) standard deviation above the statewide mean Medicaid inpatient utilization rate for providers receiving Medicaid payments in Indiana or whose low income utilization rate exceeds twenty-five percent (25%). The fund in this pool must be distributed to the qualifying hospitals in the proportion that each hospital's low income utilization rate, multiplied by total Medicaid days, bears to the product of the same factors of all hospital in the pool using data from the most recent year for which an audited cost report is on file with the office for each potentially eligible hospital.

Disproportionate share payments described in this section shall be made on an interim basis throughout the year as determined by OMPP.

B. DSH Payments to Acute Care Hospitals Licensed Under IC 16-21

1. For the state fiscal years ending after June 30, 2000, the following payment methodology will be utilized for the distribution of payments to acute care hospitals licensed under IC 16-21:

   (1) The office will distribute disproportionate share payments to all qualifying acute care hospitals, in an aggregate sum which does not exceed the limits imposed by federal law and regulation, including the statewide allocation limits for disproportionate share payments imposed by 42 USC 1396r-4(f).

   (2) Each qualifying hospital's "hospital specific limit" is the sum of all costs for services provided to uninsured patients, less any cash payments made by them, and all costs for services provided to Medicaid patients, less the amount paid to the hospital under the non-DSH payment provisions of the State Plan.

   (3) The hospital-specific limit for each hospital shall be determined by the office taking into account data provided by each hospital that is considered reliable by the office based on a system of periodic audits, and the use of trending factors applied to such data. The office may require independent certification of data provided by a hospital to determine the hospital's hospital-specific limit.

2. (a) For the Eligibility Period beginning July 1, 2001, hospitals meeting the office's Medicaid disproportionate share provider criteria as described in Attachment 4.19A, Section II(E) of this Plan (the "office's Medicaid DSH criteria"), limited to those hospitals defined as historical disproportionate share providers under Attachment 4.19A, Section II(F) of this plan and those hospitals not defined as historical disproportionate share providers but meeting the office's Medicaid DSH criteria for the Eligibility Period ending on June 30, 2001, will receive disproportionate share payments equal to 100% of their individual hospital-specific limit. For later Eligibility Periods, hospitals receiving payment pursuant to this subsection (a) will be subject to (b), (c), (d) and (e) below, as applicable.

(b) For the Eligibility Periods beginning after June 30, 2001, a hospital, whether a historic disproportionate share provider or a hospital which is not a historical disproportionate share provider, receiving a Medicaid disproportionate share payment in the amount of 100% of its hospital-specific limit will continue to receive Medicaid disproportionate share payments in the amount of 100% of its hospital-specific limit for subsequent Eligibility Periods in which it meets the office's Medicaid DSH criteria unless the hospital has a lapse in meeting the office's Medicaid DSH criteria for an Eligibility Period. A hospital that has a lapse in meeting the office's Medicaid DSH criteria for an Eligibility Period shall be subject to (c), (d), and (e) below, as applicable, for later Eligibility Periods.

(c) For the Eligibility Periods beginning after June 30, 2001, if a hospital, including historical disproportionate share providers and hospitals which are not historical disproportionate share providers, has a lapse in meeting the office's Medicaid DSH criteria for any Eligibility Period, the hospital will receive Medicaid disproportionate share payment adjustments equal to 0% of its hospital-specific limit for that Eligibility Period. However, upon a later Eligibility Determination by the office, if the hospital is able to meet the office's Medicaid DSH criteria for the Eligibility Period for which the later Eligibility Determination applies, the hospital's Medicaid disproportionate share payment will be calculated as set forth in (b), (d) or (e) of this section 2., as applicable.

(d) Except as set forth in (a) above, for Eligibility Periods beginning after June 30, 2001, hospitals, including hospitals defined as historical disproportionate share providers and hospitals which are not defined as historical disproportionate share providers,

(i) licensed under IC 16-21,

(ii) meeting the office's Medicaid DSH criteria for the current Eligibility Period, and

(iii) which did not meet the office's Medicaid DSH criteria for the prior Eligibility Period,

will receive disproportionate share payments equal to 33 1/3% of their individual hospital-specific limit.

(e) Except as set forth in (b) above, after the Eligibility Period beginning on July 1, 2001, each time the office makes an Eligibility Determination, a hospital, including historical disproportionate share providers and hospitals which are not historical disproportionate share providers,

(i) meeting the office's Medicaid DSH criteria for two consecutive Eligibility Periods will receive a disproportionate share payment equal to 66 2/3% of its hospital-specific limit; or

(ii) meeting the office's Medicaid DSH criteria for three (or more) consecutive Eligibility Periods will receive a disproportionate share payment equal to 100% of its hospital-specific limit.

(f) Except for payments to Non-State Government-Owned or Operated Hospitals, as defined on Attachment 4.19A, Page 17 of this plan, if the amount available to pay the disproportionate share amount is insufficient to pay each hospital the full amounts calculated above, payments to the hospitals will be reduced by an amount that is proportionate to the amount of the deficiency.

The OMPP may, however, adjust the disproportionate share payment specified above as provided for in 42 CFR 447.297(d)(3), allowing the state to make additional disproportionate share expenditures after the end of each federal fiscal year that relate back to a prior federal fiscal year. Each eligible hospital may receive an additional disproportionate share payment adjustment, if:

(1) additional funds are made available which are eligible for federal financial participation pursuant to 42 U.S.C. 1396b (w)(6)(A) and 42 CFR §433.51; and

(2) the total disproportionate share payments to each individual hospital, and all qualifying hospitals in the aggregate, do not exceed the limits provided by federal law and regulation.

The office may also, before the end of a state fiscal year, make a partial payment to one or more qualifying hospitals, if:

(1) sufficient funds are made available which are eligible for federal financial participation pursuant to 42 U.S.C. 1396b (w)(6)(A) and 42 CFR §433.51;

(2) the partial disproportionate share payment to each hospital does not exceed the limits provided by federal law and regulations; and

(3) no hospital qualifying for a disproportionate share payment for the same state fiscal year for which a partial payment is made will receive a net disproportionate share payment for that state fiscal year in an amount less than the amount the hospital would have received if no partial payment had been made before the end of the fiscal year.

C. Contributions by State of Indiana to the Medicaid Indigent Care Trust Fund

The office shall, in each state fiscal year, provide, for acute care hospitals licensed under IC 16-21 that qualify for disproportionate share payments under Section II.E. of this plan, sufficient funds, other than funds transferred by other governmental units to the Medicaid indigent care trust fund, that equal an amount equal to twenty-six million dollars ($26,000,000) minus the product of twenty-six million dollars ($26,000,000) multiplied by the federal medical assistance percentage.

D. Municipal Disproportionate Share Payment Adjustments

For each state fiscal year ending on or after June 30, 1998, OMPP will make municipal disproportionate share payments to qualifying municipal disproportionate share hospitals as follows:

A pool not exceeding the sum of the hospital specific limits for all qualifying hospitals shall be distributed to each qualifying hospital in an amount which equals to the extent possible, but in no case exceeds, the hospital's hospital-specific limit provided under 42 U.S.C. 1396r-4(g). Each hospital's "hospital specific limit" is the sum of all costs for services provided to uninsured patients, less any cash payments made by them, and all costs for services provided to Medicaid patients, less the amount paid by the State under the non-DSH payment provisions of the State Plan. The hospital-specific limit for each hospital, in each state fiscal year, shall be determined by the office taking into account data provided by the hospital that is considered reliable by the office, based on a system of periodic audits, and the use of trending factors applied to such data. The office may require independent certification of data provided by a municipal disproportionate share hospital to determine the hospital's hospital-specific limit.

The OMPP may, however, adjust the municipal disproportionate share payment specified above as provided for in 42 CFR 447.297(d)(3), allowing the state to make additional municipal disproportionate share expenditures after the end of each federal fiscal year that relate back to the prior federal fiscal year. Each eligible hospital may receive an additional municipal disproportionate share payment adjustment, if:

(1) additional funds are made available which are eligible for federal financial participation pursuant to 42 U.S.C. 1396b(w)(6)(A) and 42 CFR §433.51; and

(2) the total disproportionate share payments to each individual hospital, and all qualifying hospitals in the aggregate, do not exceed the limits provided by federal law and regulation.

For the state fiscal year ending June 30, 2000, the total municipal disproportionate share payments available to qualifying municipal disproportionate share hospitals shall be twenty-two million dollars ($22,000,000), except, as provided in Section III.G. of this plan.

E. Community Mental Health Center Disproportionate Share Payment Adjustments.

For each state fiscal year ending after June 30, 1997, OMPP will make community mental health center disproportionate share payments to qualifying community mental health centers as follows:

Each qualifying community mental health center shall receive an amount determined by subtracting the amount paid to the community mental health center during the state fiscal year by the county treasurer of the county in which the community mental health center is located, as authorized by the county executive and appropriated by the county fiscal body, or funds received by the community mental health center from other county sources, from an amount consisting of the foregoing amount divided by the state medical assistance percentage applicable to the state fiscal year.

The OMPP may, however, adjust the community mental health center disproportionate share payment specified above as provided for in 42 CFR 447.297(d)(3), allowing the state to make additional community mental health center disproportionate share expenditures after the end of each federal fiscal year that relate back to the prior federal fiscal year. Each eligible community mental health center may receive an additional community mental health center disproportionate share payment adjustment, if:

(1) funds are made available by one or more counties which have been certified as expenditures eligible for financial participation under 42 U.S.C. 1396(w)(6)(A) and 42 CFR 433.51;

(2) the total disproportionate share payments to each individual community mental health center do not exceed the institution specific limit provided under 42 U.S.C. 1396r-4(g); and

(3) the total disproportionate share payments to community mental health centers do not result in total disproportionate share payments in excess of the state limit on such expenditures for institutions for mental diseases under 42 U.S.C. 1396r-4(h).

The office shall assist a county treasurer in making the certification described in III.E.(1) above.

The institution specific limit for a state fiscal year shall be determined by the office taking into account data provided by the community mental health center that is considered reliable by the office based on a system of periodic audits, and the use of trending factors applied to such data. The office may require independent certification of data provided by a community mental health center to determine the institution specific limit.

The office may reduce, on a pro rata basis, payments due to community mental health centers under this section for a fiscal year if necessary to avoid exceeding the state limit on disproportionate share expenditures for institutions for mental diseases. Further, a payment under this provision may be recorded by the office from the community mental health center if federal financial participation is disallowed for the funds certified under IC 12-29-1-7(b) upon which such payment was based.

For the state fiscal year beginning July 1, 1999, and ending June 30, 2000, the total community mental health center disproportionate share payments available under this section to qualifying community mental health center disproportionate share providers, is six million dollars ($6,000,000), except as provided in Section III.G. of this plan.

F. Hospital Specific Limit on Disproportionate Share Payments

1. Total disproportionate share payments to a provider shall not exceed the hospital specific limit provided under 42 U.S.C. 1396r-4(g). The hospital specific limit for a state fiscal year shall be determined by the office taking into account data provided by each hospital that is considered reliable by the office based on a system of periodic audits, and the use of trending factors applied to such data. The office may require independent certification of data provided by a hospital or other qualifying provider to determine the provider's hospital specific limit. Each hospital's "hospital specific limit" is the sum of all costs for services provided to uninsured patients, less any cash payments made by them, and all costs for services provided to Medicaid patients, less the amount paid by the State under the non-DSH payment provisions of the State Plan.

2. Notwithstanding the foregoing, for SFYs beginning after June 30, 2003 and to the extent permitted under Section 701(c) of the Benefits Improvement Act (BIPA) of 2000, Section 1(a)(6) of Public Law 106-554, a Non-State Government-Owned or Operated Hospital will receive a DSH payment which shall not exceed 175% of its hospital-specific limit. The amount paid to each hospital is contingent upon available room under Indiana's statewide disproportionate share allocation as limited by 42 USC 13964-4(f). If the amount of state matching funds available is not sufficient to pay each hospital its full amount as determined by the office, the amount paid to each hospital will be reduced proportionately.

G. State Limit on Disproportionate Share Payments

1. For the state fiscal year ending June 30, 2000, if the state exceeds the state disproportionate share allocation (as defined in 42 USC 1396r-4(f)(2)) or the state limit on disproportionate share expenditures for institutions for mental disease (as defined in 42 U.S.C. 13964-4(b)), the state shall pay providers as follows:

   (1) The state shall make disproportionate share provider payments to municipal disproportionate share providers qualifying under Section II.(G) of this plan, until the state exceeds the state disproportionate share allocation. The total amount paid to the municipal disproportionate share providers under this plan for the state fiscal year ending June 30, 2000, may not exceed twenty-two million dollars ($22,000,000), except as provided elsewhere in this section.

   (2) After the state makes all payments under subdivision (1), if the state fails to exceed the state disproportionate share allocation, the state shall make community mental health center disproportionate share provider payments to providers qualifying under section II.(H) of this plan. The total paid to the qualified community mental health center disproportionate share providers under section 9(a) of this chapter, may not exceed six million dollars ($6,000,000) for the state fiscal year ending June 30, 2000, except as provided elsewhere in this section.

   (3) After the state makes all payments under subdivision (2), if the state fails to exceed the state disproportionate share allocation, the state shall make disproportionate share provider payments to acute care hospitals licensed under IC 16-21 and qualifying under section II.(E) of this plan.

2. For each state fiscal year beginning after June 30, 2000, if the state exceeds the state disproportionate share allocation (as defined in 42 U.S.C. 1396r-4(f)(2)) or the state limit on disproportionate share expenditures for institutions for mental diseases (as defined in 42 U.S.C. 1396r-4(h)), the state shall pay providers as follows:

   (1) The state shall make municipal disproportionate share provider payments to providers qualifying under Section II.(G) of this plan, until the state exceeds the state disproportionate share allocation.

   (2) After the state makes all payments under subdivision (1), if the state fails to exceed the state disproportionate share allocation, the state shall make disproportionate share provider payments to providers qualifying under Section II.(E) of this plan.

   (3) After the state makes all payments under subdivision (2), if the state fails to exceed the state disproportionate share allocation, the state shall make community mental health center disproportionate share provider payments to providers qualifying under Section II.(H) of this plan.

The dollar limitations imposed by this section on disproportionate share payments to municipal disproportionate share hospitals and community mental health center disproportionate share providers shall not be applicable in the event that additional disproportionate share expenditures are made under the provisions of this plan after the end of a federal fiscal year, relating back to a prior federal fiscal year. An eligible provider may receive an additional disproportionate share payment adjustment as authorized by this Plan, if:

(1) additional funds are made available which are eligible for federal financial participation pursuant to 42 U.S.C. 1396b(w)(6)(A) and 42 CFR §433.51; and

(2) the total disproportionate share payments to the individual provider, and all qualifying providers in the aggregate, to not exceed the limit provided by federal law and regulation.

H. Inpatient Disproportionate Share Payment Adjustments in the Event of a Reduced Federal DSH Allotment

a. For purposes of Subsection H:

i. The term "base disproportionate share payment program" shall mean the provisions for distributing disproportionate share payments set forth in Subsection A of Section III of Attachment 4.19-A of the Indiana Medicaid State Plan effective January 1, 2019.

ii. The term "CMS" shall mean the Centers for Medicare and Medicaid Services.

iii. The term "disproportionate share payment plan" shall mean the plan for distributing disproportionate share payments for the State Fiscal Year beginning July 1, 2020.

iv. The term "federal DSH allotment" shall mean the allotment of federal disproportionate share funds calculated for the State under 42 U.S.C. 1396r-4.

v. The term "reduced federal DSH allotment" shall mean a federal DSH allotment for the State for the Federal Fiscal Year beginning October 1, 2020, that, by operation of 42 U.S.C. 1396r-4(f)(7), is less than the federal DSH allotment for the State for the Federal Fiscal Year beginning October 1, 2018.

vi. The term "terminating event" shall mean federal legislation, including an amendment to 42 U.S.C. 1396r-4, a regulation issued by CMS or any other federal agency, any sub-regulatory policy or directive issued by CMS or other federal agency, or a judicial ruling, that is enacted or issued on or before March 30, 2021, that: (1) cancels, or postpones to a subsequent federal fiscal year, a reduced federal DSH allotment; and (2) does not cause the state to incur a reduced federal DSH allotment.

b. Subject to paragraph c, the disproportionate share payment plan for the State Fiscal Year beginning July 1, 2020 shall be as follows:

i. The disproportionate share payment paid to an acute care hospital that qualifies as:

(A) a municipal disproportionate share provider under Step Two of the base disproportionate share payment program;

(B) a disproportionate share provider under Step Three of the base disproportionate share payment program; or

(C) a disproportionate share provider under Step Four of the base disproportionate share payment program;

shall be reduced by the percentage described in subparagraph ii.

ii. The percentage reduction in disproportionate share payments described in subparagraph i shall be applied uniformly to all hospitals to which subparagraph i applies. The percentage of the reduction in disproportionate share payments described in subparagraph i shall be the percentage determined by the office to cause the total disproportionate share payments made under subparagraph i to maximize the expenditure of, without exceeding, the reduced federal DSH allotment.

c. If a terminating event occurs, paragraph b of Subsection H shall not apply to the disproportionate share payment plan for the State Fiscal Year beginning July 1, 2020. If a terminating event occurs, disproportionate share payments for the State Fiscal Year beginning July 1, 2020 shall be governed by the base disproportionate share payment program.

d. Subsection H shall only apply to disproportionate share payments for the State Fiscal Year beginning July 1, 2020.

State: Indiana

Attachment 4.19A

IV. DISPROPORTIONATE SHARE PAYMENT EXAMPLES

To illustrate the payment methodology proposed by TN _____ for disproportionate share payments, the following examples are displayed within this plan.

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Example 1 - **Provider is an acute care hospital licensed under I.C. 16-21 that qualifies as a disproportionate share provider**

Facts— Hospital's Medicaid inpatient utilization rate = 28% and exceeds one standard deviation from the statewide mean Medicaid IUR which is 15%.

Hospital is determined to be a disproportionate share acute care hospital under Section II.(B) of this plan, that qualifies for a disproportionate share payment under section II.(E) of this plan. Hospital qualified as a disproportionate share provider in state fiscal year 1998 and continues to qualify as a disproportionate share provider in the state fiscal year for which a distribution is being made.

Hospital's hospital specific limit is $11,000,000.

The hospital's disproportionate share payment is equal to 100% of its hospital-specific limit, or .....**$11,000,000**.

****

Example 2 - Provider is a state mental health institution (state psychiatric hospital) that qualifies for DSH payments (for SFYE 6-97)

Facts— Hospital's low-income utilization rate = 40%. The provider meets the definition found at II(B) of the plan, and qualifies to participate in DSH basic pool (4) as described at Section III(A)(2) of this plan.

This pool had $191,000,000 available for distribution in the SFYE 6-95 and was adjusted for SFYE 6-96 by a ratio as provided for on page 7 of this plan resulting in a reduction of 5% of the 1995 pool amount to a new pool amount of $181,450,000 for FYE 6-96. This pool was again adjusted for SFYE 6-97 as provided for on page 7 of the plan by an increase of 12% from the SFY 6-96 base to $203,224,000 (181,450,000 x 112%).

The hospital's total inpatient days equal 1,000. The distribution factor is the low income utilization rate times the total inpatient days. (40 x 1000) = 40,000.

All qualifying hospital in the pool have a sum total distribution factor of 400,000. This hospital's percentage of the total distribution is 40,000/400,000 or 10%.

This hospital's distribution for DSH for SFYE 6-97 is set at $20,322,400. (203,224,000 x 10%).

The hospital has been determined to have a Medicaid shortfall and uncompensated charity care total, for the hospital's fiscal year ending in SFY 1997, of $13,400,000. The OBRA '93 hospital specific DSH limit for '97 is set at $13,400,000 (100% of the determined total).

The hospital receives **$13,400,000** rather than $20,322,400 based on the OBRA '93 DSH limit.

****

All disproportionate share payments made in accordance with these examples and under the provisions of this disproportionate share payment methodology will be made subject to all applicable federal DSH spending caps and any Indiana specific DSH caps, and specific provider payments will not exceed the individual provider's OBRA '93 calculated DSH payment limit. The "hospital's OBRA '93 calculated DSH payment limit" is the sum of all costs for services provided to uninsured patients, less any cash payments made by them, and all costs for services provided to Medicaid patients, less the amount paid by the State under the non-DSH payment provisions of the State Plan. The formula appears as follows:

DSH LIMIT = M + U

M = Cost of services to Medicaid patients, less the amount paid by the State under the non-DSH payment provisions of the State Plan

U = Cost of services to uninsured patients, less any cash payments made by them

High Volume Outlier Payment Adjustment

I. General

In addition to regular claims payments and any other payment adjustments to which they are entitled, each in-state hospital may receive an additional inpatient Medicaid outlier payment adjustment, which shall not exceed the inpatient charge limitations pursuant to 42 CFR 447.271. Total payments to all hospitals will not exceed the applicable inpatient upper payment limit in accordance with 42 CFR 447.272. The outlier payment adjustment is available to in-state hospitals that have a high volume of inpatient hospital stays that qualify for outlier payments. Each hospital's percentage of the state's Medicaid fee-for-service inpatient outlier stays will be calculated annually, based on fee-for-service claims adjudicated through the MMIS to a paid status during the most recently completed state fiscal year. The outlier payment adjustment will be made annually after the office has computed the payment under this methodology. The outlier payment adjustment will be made prior to any hospital supplemental payment adjustments. The outlier payment adjustment is effective May 1, 2011 for each state fiscal year ending on or after June 30, 2011.

II. Eligibility Determination

Step One: Identify the total number of Medicaid fee-for-service claims that qualify for outlier payment that were adjudicated to a paid status during the most recently completed state fiscal year.

Step Two: For each in-state hospital, identify the number of Medicaid fee-for-service claims that qualify for outlier payment that were adjudicated to a paid status during the most recently completed state fiscal year. The current threshold amount is the greater of two times the DRG payment rate or the outlier threshold of $34,425.

Step Three: For each in-state hospital, calculate the number of claims identified in Step Two as a percentage of the total number of claims identified in Step One. This percentage is the hospital's percentage of the total number of outlier claims. To be eligible for the outlier payment adjustment, a hospital must provide more than fifteen percent (15%) of the state's Medicaid fee-for-service inpatient stays that qualify for outlier payment.

III. Payment Methodology

The outlier payment adjustment will be the difference between the hospital's total claim reimbursement for paid Medicaid fee-for-service inpatient claims qualifying for outlier payment and the costs of providing such services. For eligible hospitals, the outlier payment adjustment will be calculated using the following methodology:

Step One: For each eligible hospital, identify the Medicaid fee-for-service claims that qualify for outlier payment that were paid during the most recently completed state fiscal year.

Step Two: Calculate the total aggregate cost of the claims identified in Step One. Total cost is determined by multiplying routine units from the claim by routine per diems and by multiplying ancillary charges from the claim by ancillary cost-to-charge ratios. Routine per diems and ancillary cost-to-charge ratios will be obtained from the hospital's latest cost report on file with the office.

Step Three: Determine the total aggregate claim payments previously received for the claims identified in Step One, including Medicaid claim payments, non-Medicaid claim payments, such as third party liability (TPL) payments and Medicare payments, and spend-down.

Step Four: Subtract total aggregate claim payments in Step Three from total aggregate costs in Step Two. This difference is the outlier payment adjustment. If the payments in Step Three exceed the costs calculated in Step Two, no outlier payment adjustment will be made.

MUNICIPAL HOSPITAL PAYMENT ADJUSTMENTS

I. AUTHORITY

In compliance with Section 1902 (a)(13)(A), Section 1903 (w)(3), and Section 1903 (w)(6) of the Act, the Indiana Medicaid program (the "Office") adopts the following definitions and methodologies to identify and make payment adjustments to Municipal Hospitals.

II. DEFINITIONS

"Non-State Government-Owned Or Operated Hospital" has the following meaning: a health care facility providing inpatient and outpatient hospital services that is: (1) licensed as an acute care hospital under Indiana Code 16-21; and (2) is established and operated as a non-state governmental hospital under Indiana Code 16-22-2, Indiana Code 16-22-8 or Indiana Code 16-23.

"Municipal Hospital" has the following meaning: a non-state government-owned or operated health care facility providing inpatient and outpatient hospital services that is: (1) licensed as an acute care hospital under Indiana Code 16-21; and (2) is established and operated as a non-state governmental ~~county~~ hospital under Indiana Code 16-22-2, or ~~as a municipal hospital under~~ Indiana Code 16-23.

"Medicaid Payments" are all payments made to Municipal Hospitals by on or behalf of the Office pursuant to the Medicaid reimbursement provisions under Article 15 of the Indiana Code. This includes, but is not limited to, claim specific payments for inpatient Medicaid services, ~~and~~ non-claim specific additional Medicaid payments such as the Medicaid Hospital Care for the Indigent (HCI) add-on payments, and the payment adjustments provided for in this state plan amendment. This does not include the Disproportionate Share Hospital (DSH) payments made pursuant to Indiana Code 12-15-16 and 12-15-19, which contain the methodologies used to determine and distribute ~~the Basic Acute Care and Enhanced~~ DSH payments, ~~respectively.~~

"Medicaid Services" are those inpatient services provided by a Municipal Hospital that are reimbursable under the Medicaid program.

III. PAYMENT ADJUSTMENTS

A Municipal Hospital ("hospital") shall receive, in addition to its allowable regular Medicaid claims payments to which it is entitled, a payment adjustment calculated in the following manner:

(1) For each state fiscal year ending after June 30, 1997 and before June 30, 2002, reimbursement in the form of a single payment, equal to the difference between:

(a) The amount of Medicaid payments to the hospital made pursuant to the Medicaid reimbursement provisions under Article 15 of the Indiana Code, excluding DSH payments made pursuant to Indiana Code 12-15-16 and 12-15-19, for services provided by the hospital during the state fiscal year; and

(b) an amount equal to the lesser of the following:

(i) the hospital's customary charges for the services described in (a) above; or

(ii) a reasonable estimate by the Office of the amount that would have been paid for those services under Medicare payment principles.

(2) For each state fiscal year ending after June 30, 2002, reimbursement in the form of a single payment, equal to the difference between:

(a) The amount of Medicaid payments to the hospital made pursuant to the Medicaid reimbursement provisions under Article 15 of the Indiana Code, excluding DSH payments made pursuant to Indiana Code 12-15-16 and 12-15-19, for services provided by the hospital during the state fiscal year, and

(b) an amount equal to 100 percent of a reasonable estimate by the Office of the amount that would have been paid for those services under Medicare payment principles.

(3) The payment adjustment identified in (1) and (2) above shall be made after the close of the applicable state fiscal year.

(4) Notwithstanding the foregoing, subject to the applicable payment limits under 42 CFR 447.272, the office may enter into agreements with hospitals, individually or in combination, to permit hospitals to receive lesser or greater adjustments, made after the close of the applicable state fiscal year, up to, but not to exceed the difference between:

(a) The aggregate amount of Medicaid payments to all hospitals made pursuant to the Medicaid reimbursement provisions under Indiana Code 12-15, excluding DSH payments made pursuant to Indiana Code 12-15-16 and 12-15-19, for services provided by all hospitals during the state fiscal year; and

(b) The aggregate amount, as reasonably estimated by the office, that all hospitals would have been paid for those services under Medicare payment principles.

However, the office may not enter into an agreement with a hospital if, in doing so, another hospital that is not a party to the agreement or that has not otherwise consented to the office's agreement, will receive under (2) above an amount less than what the hospital would have otherwise received under the formula set forth in (2).

EFFECTIVE DATE

Subject to approval by HCFA, these payment adjustments identified in 1 above, are to be effective on or after April 1, 1998. Payments being made beginning effective April 1, 1998 for SFYE June 30, 1998 and thereafter shall be paid by this methodology.

Payment adjustments up to 150 percent of a reasonable estimate of the amount that would be paid for services under Medicare payment principles (identified in 2 above) will only apply on or after April 1, 2001. For the state fiscal year ending on June 30, 2001, the state may adjust payments, under this section, to each Municipal Hospital eligible for such payment adjustment in an amount not to exceed one-fourth of the amount equal to 150 percent of a reasonable estimate of the amount that would be paid for services under Medicare payment principles. For state fiscal years ending after June 30, 2001, the state may reimburse, under this section, each Municipal Hospital eligible for a payment adjustment in an amount up to 150 percent of a reasonable estimate that would be paid for services under Medicare payment principles.

Supplemental Payments to Privately-owned Hospitals

I. General

A Privately-owned Hospital means an acute care hospital that is (i) licensed under IC 16-21, and (ii) Privately-owned and operated in accordance with 42 CFR 447.272(a)(3) and 42 CFR 447.321(a)(3). In addition to regular claims payments and any other payment adjustments to which they are entitled, each hospital that is a Privately-owned Hospital may receive an additional inpatient Medicaid supplemental amount for each state fiscal year ending after June 30, 2003, which shall not exceed the inpatient charge limitations pursuant to 42 CFR 447.271 and the applicable inpatient upper payment limit in accordance 42 CFR 447.272.

II. Inpatient Supplemental Payment Pool

The office will calculate a Inpatient Supplemental Payment Pool for each state fiscal year ending after June 30, 2003. This Inpatient Supplemental Payment Pool will include the inpatient Medicaid supplemental amount, which is an amount equal to the difference between the aggregate of actual Medicaid payments made to all Privately-owned Hospitals for Medicaid inpatient hospital services (excluding Medicaid disproportionate share payments made pursuant to IC 12-15-16, 12-15-17, and 12-15-19), and the office's reasonable estimate of the amount that would have been paid for those services using Medicare payment principles, subject to limits imposed by 42 CFR 447.271 and 42 CFR 447.272. The Inpatient Supplemental Payment Pool will be equal to the inpatient Medicaid supplemental amount.

III. Payment Methodology

For each state fiscal year ending after June 30, 2003, the Inpatient Supplemental Payment Pool will be established and distributed to Privately-owned Hospitals in the following manner:

(1) An amount equal to the lesser of (i) the amount of the Inpatient Supplemental Payment Pool; or (ii) five million dollars ($5,000, 000), will be paid to a Privately-owned Hospital that has in excess of seventy thousand (70,000) Medicaid inpatient days.

(2) Following the payment under (1) above, if there is an amount remaining in the Inpatient Supplemental Payment Pool after the payment under (1) above has been made, that remaining amount will be paid to all Privately-owned Hospitals on a pro rata basis based upon the number of each Privately-owned Hospital's Medicaid inpatient days. For purposes of this Section III (2) the non-federal share of such payments will not exceed the amount transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b). Privately-owned Hospitals with larger numbers of Medicaid inpatient days will receive a higher proportion of the amount remaining in the Inpatient Supplemental Payment Pool than Privately-Owned Hospitals having smaller numbers of Medicaid inpatient days. The amount of a payment shall be determined and distributed after the end of each state fiscal year.

(3) In the event the entirety of the aggregate Inpatient Supplemental Payment Pool is not distributed after the payments indicated in (1) and (2) above have been made, the remaining amount will be paid on a pro rata basis to any Privately-owned Hospital that enters into an agreement with the office for such payment, based on each Privately-owned Hospital's Medicaid weighted inpatient days. For Children's hospitals (as identified by the office), weighted Medicaid inpatient days will be calculated by taking Medicaid days and multiplying them by 120%, consistent with the Medicaid DRG add-on. In addition, all hospitals' Medicaid days (including Children's hospitals) will be weighted further by their Medicaid Case Mix. The amount(s) of a Privately-owned Hospital's payment(s) under this clause (3) will not exceed the amount of the remaining Inpatient Supplemental Payment Pool.

Adjustments

Notwithstanding III (2) above, the office may enter into an agreement with any Privately-owned Hospital whereby the Privately-owned Hospital waives payments described in III (2) above or accepts a lesser or greater amount than provided in III (2) above, subject to the hospital's charge and payment limitations as described in 42 CFR 447.271, and 42 CFR 447.272. However, the office may not enter into an agreement with a Privately-owned Hospital if, in doing so, another Privately-owned Hospital that is not a party to the agreement or that has not otherwise consented to the office's agreement will receive an amount less than what the hospital would have otherwise received under the formula set forth in III (2).

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Rule 19 Ownership and Control Disclosures

405 IAC 1-19-1 Information to be disclosed

Sec. 1. (a) In accordance with and in addition to 42 CFR 455, Subpart B and 42 CFR 1002, Subpart A, as amended, the following disclosure requirements apply to all providers of Medicaid services and shall be disclosed in accordance with this rule:

(1) The name and address of each person with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of five percent (5%) or more.

(2) Whether any of the persons named, in compliance with subdivision (1), is related to another as spouse, parent, child, or sibling.

(3) The name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest. This requirement applies to the extent that the disclosing entity can obtain this information by requesting it in writing from the person. The disclosing entity must:

(A) keep copies of all these requests and the responses to them;

(B) make them available to the office upon request; and

(C) advise the office when there is no response to a request.

(4) The name, address, and Social Security number of any agent or managing employee.

(b) Any document or agreement, stipulating ownership interests or rights, duties, and liabilities of the entity or its members, required to be filed with the secretary of state, whether it be a single filing or a periodic filing, shall also be filed with the office or its fiscal agent. In the case of a partnership, the partnership agreement, if any, and any amendments thereto, shall be filed with the office immediately upon creation or alteration of the partnership.

(c) long term care facility provider shall comply with notification requirements set forth in 405 IAC 1-20 for change of ownership.

(d) the office may suspend payment to an existing provider or reject a prospective provider's application for participation if the provider fails to disclose ownership or control information as required by this rule and 405 IAC 1-14.6-5.

405 IAC 1-19-2 Time and manner of disclosure

Sec. 2. (a) Any disclosing entity that is a long term care facility must supply the information specified in this rule to the Indiana state department of health at the time it is surveyed.

(b) Any disclosing entity that is not a long term care facility must supply the information specified in this rule to the office or its fiscal agent at any time there is a change in ownership or control.

(c) Any new provider must supply the information specified in this rule at the time of filing a complete application.

(d) Providers are required to notify the office upon such time as the information specified in this rule changes within forty-five (45) days of the effective date of change in such form as the office shall prescribe. Long term care providers involved in a change of ownership shall provide notification in accordance with 405 IAC 1-20. New nursing facility providers are required to notify the office in accordance with this rule and 405 IAC 1-14.6-5.

Psychiatric Residential Treatment Facility Services

For purposes of this section, "Psychiatric residential treatment facility" (PRTF) means a PRTF licensed under *470 IAC 3-13* and meeting the requirements set forth in *405 IAC 5-20-3.1.*

Reimbursement for Medicaid-covered psychiatric residential treatment facility services is made in accordance with the following prospective reimbursement methodology. The prospective per diem shall constitute full reimbursement. There shall be no year-end cost settlement payments.

Covered inpatient psychiatric facility services for individuals under twenty-one (21) years of age provided in PRTFs shall be reimbursed in accordance with the following:

(1) PRTFs shall be reimbursed for services provided to Medicaid recipients based upon the lower of:

(A) the PRTF prospective per diem rates calculated by the Office or

(B) the usual and customary daily charges billed for the psychiatric treatment of eligible recipients

(2) The applicable PRTF payment per diem rates determined in section (1) shall provide reimbursement for all Medicaid-covered services provided in the psychiatric residential treatment facility except for those costs described in section (3). Providers will include, and rates will be determined using, only those allowable costs set out in Medicaid PRTF provider cost reporting instructions and update bulletins.

(3) The per diem rates determined in section (1) shall exclude costs incurred for pharmaceutical services and physician services provided to eligible recipients. Medicaid reimbursement for costs incurred for pharmaceutical services provided to eligible recipients shall be paid separate and apart from the PRTF per diem rates and in accordance with the reimbursement policies described in *405 IAC 5-24.* Medicaid reimbursement for costs incurred for physician services provided to eligible recipients shall be paid separate and apart from the PRTF per diem rates and in accordance with the reimbursement policies described in 405 IAC 5-25.

(4) All costs utilized to determine the prospective per diem rates in section (1)(A) shall be subject to reasonability standards as set forth in the *Medicare Provider Reimbursement Manual,* CMS-Pub. 15-1, Chapter 25.

(5) The per diem rates determined in section (1) shall exclude such costs unrelated to providing psychiatric residential services including, but not limited to the following:

(A) group education including elementary and secondary education
(B) advertising or marketing
(C) non-psychiatric specialty programs

(6) Medicaid reimbursement for Medicaid-covered psychiatric services provided to recipients residing in a psychiatric residential treatment facility shall be limited to the payments described in *405 IAC 1-21.* Medicaid reimbursement for Medicaid-covered services not related to the recipient's psychiatric condition is available, separate from the PRTF per diem, only in instances where those services are performed at a location other than the PRTF.

(7) The established per diem rates for psychiatric residential treatment facilities shall be reviewed annually by the OMPP or its contractor by using the most recent, reliable claims data and adjusted cost report data to reflect changes in treatment patterns, technology, and other factors that may change the cost of efficiently providing inpatient psychiatric services, and adjusted as necessary, in accordance with this section.

PRTFs shall file a cost report annually using a uniform cost report form prescribed by the Office of Medicaid Planning and Policy (OMPP). The OMPP or its contractor may audit or review the cost reports as it deems necessary.

REIMBURSEMENT FOR SERVICES PROVIDED BY PHYSICIANS, LIMITED LICENSE PRACTITIONERS, AND NON-PHYSICIAN PRACTITIONERS

I. A. Summary of the Resource-Based Relative Value Scale (RBRVS) reimbursement methodology

All services provided by physicians, limited license practitioners, and non-physician practitioners will be reimbursed according to a statewide fee schedule based on a Resource-Based Relative Value Scale (RBRVS). This includes services provided by:

Physicians and Limited License Practitioners

- doctors of medicine,
- osteopaths,
- physician or primary care group practices,
- optometrists,
- podiatrists,
- dentists who are oral surgeons,
- chiropractors, and
- health service providers in psychology.

Non-Physician Practitioners

- audiologists,
- physical, occupational, respiratory, and speech therapists,
- licensed psychologists,
- independent laboratory or radiology providers,
- advance practice nurses,
- dentists who are not oral surgeons.
- board certified behavior analysts
- credentialed registered behavior technicians
- licensed pharmacists

Other Licensed or Certified Practitioners

- physician assistants,
- licensed independent practice school psychologist,
- licensed clinical social worker,
- licensed martial and family therapist,
- licensed mental health counselor,
- person holding a master’s degree in social work, marital and family therapy, or mental health counseling,
- licensed clinical addiction counselors
- certified registered nurse anesthetists, and
- anesthesiologist assistants
- community health workers

Other Licensed or Certified Practitioners are required to work under the direct supervision of a physician, except licensed clinical social workers, licensed marital and family therapists, licensed mental health counselors, and licensed clinical addiction counselors. Other Licensed Practitioners or Certified Practitioners, except physician assistants, certified registered nurse anesthetists, licensed clinical social workers, licensed marital and family therapists, licensed mental health counselors, and licensed clinical addiction counselors, must bill under the supervising physician's provider number. Except as otherwise noted in the plan, state-developed fee schedule rates for these services are the same for both governmental and private providers. All rates and effective dates are published on the agency’s website at in.gov/Medicaid.

Effective for services provided on or after February 1, 2015, the components of the RBRVS methodology used to develop the fee schedule include the July 2014 Medicare Physician Fee Schedule (MPFS) non-facility Relative Value Units (RVUs), the 2014 MPFS Geographic Practice Index (GPCI) for Indiana, and the 2014 MPFS conversion factor. The RVUs are adjusted using the following 20 14 Medicare locality GPCI values to reflect work, practice, and malpractice costs in Indiana: Work: 1.000, Practice Expense: 0.922, Malpractice: 0.615.

To determine the payment rate for each procedure under the RBRVS fee schedule, the Indiana-specific RVU for each procedure is multiplied by the conversion factor according to the following calculation: Payment Amount (Indiana RVU x Indiana Medicaid Conversion Factor). For services prior to February 1, 2015, the Indiana Medicaid conversion factor is $28.61, which was developed using Indiana Medicaid claims data from fiscal year 1992 and specific policy assumptions relative to the Indiana Medicaid program. Effective for services provided on or after February 1, 2015, the Indiana Medicaid conversion factor is $26.8671, which equals 75% of the 2014 MPFS conversion factor of $35.8228. These rates are published at the State's website, in.gov/Medicaid.

Effective for services provided on or after January 1, 2024, the components of the RBRVS methodology used to develop the Medicaid professional fee schedule include the Medicare Physician Fee Schedule (MPFS) non-facility Relative Value Units (RVUs), the MPFS Geographic Practice Index (GPCI) for Indiana, and the MPFS conversion factor published annually by the centers for Medicare and Medicaid Services (CMS). The Medicaid professional fee schedule will be reviewed annually, taking into account the MPFS non-facility RVUs, GPCIs for Indiana, and the conversion factor published by CMS that take effect January 1 of the calendar year preceding the Medicaid rate effective date and adjusted as necessary. For procedures without Medicare fee schedule values, reimbursement rates will be reviewed and adjusted at such time as Medicare-based rates are adjusted, taking into account the level of Medicare fee schedule changes. These rates are published at the State's website, in.gov/Medicaid.

I.B. Summary of exceptions to the RBRVS reimbursement methodology

The reimbursement rates for antepartum HCPCS codes 59425 and 59426 are the rates calculated as described above, divided by the expected number of visits. The expected number of visits is 5 for 59425 and 7 for 59426.1.

1. The reimbursement rates for anesthesiology procedures were developed using the total base and time units for each procedure multiplied by the Indiana Medicaid conversion factor for anesthesiology, $13.88. Effective for services provided on or after February 1, 2015, the Indiana Medicaid conversation factor for anesthesiology procedures will be $16.26, which is 75% of the 2014 Medicare anesthesiology conversion factor for Indiana of $21.68.

The calculation is: Anesthesia reimbursement rate (Base Units + Time Units +Additional Units for age (if applicable) + Additional Units for physical status modifiers (as applicable)) x anesthesia conversion factor. Base units were assigned to all anesthesia CPT codes (00100 through 01999) based on the 2002 relative values as published by the American Society of Anesthesiologists. Effective for services provided on or after February 1, 2015, base units for anesthesia CPT codes (001000 through 01999) are based on the 2014 Medicare anesthesia base units. Additional base units are added for age and physical status as applicable. A member younger than one year old or older than 70 years old will receive one (1.0) additional base unit. Physical status modifier P3 (severe systemic disease) receives one (1.0) additional base unit, P4 (severe systemic disease that is a constant threat to life) receives two (2.0) additional base units, and P5 (moribund patient not expected to survive without operation) receives three (3.0) additional base units. If CPT code 99140 is billed to denote an emergency, two (2.0) additional base units are added for physical status modifiers Pl through P5. No additional base units are added for physical status modifier P6.

Effective for services provided on or after January 1, 2024, the base and time units used for the Indiana anesthesiology fee schedule will be reviewed annually, taking into account the anesthesiology fee schedules published by CMS that take effect January 1 of the calendar year preceding the Medicaid rate effective date and adjusted as necessary. For procedures without Medicare fee schedule values, reimbursement rates will be reviewed and adjusted at such time as Medicare-based rates are adjusted, taking into account the level of Medicare fee schedule changes. All rates are published at the State's website, in.gov/Medicaid

Time units are converted from the actual time reported on the claim at the rate of one unit for each 15 minute period or fraction thereof. Anesthesia time begins when the anesthesiologist begins preparing the patient for anesthesia care and ends when the anesthesiologist is no longer in personal attendance.

Medical direction of two, three, or four anesthesia procedures is reported using modifier QK and is reimbursed at 30% of the allowable physician rate. Separate reimbursement is not available for anesthesia administered by the same provider performing the surgical procedure.

2. The fee schedule amounts for services of dentists in calendar year 1994 were developed based on fiscal year 1992 charges and the percentage difference between physician and LLP submitted charges for fiscal year 1992 and RBRVS fee schedule amounts. Effective August 1, 1995, to determine the Medicaid allowable amount for which the 1992 charges are not available, Medicaid sets reimbursement rates for most dental procedures equal to 100% of the 75th percentile of the rates reported by the American Dental Association for the East North Central Region (ADA-ENC). The ADA-ENC-based rates may be adjusted annually for inflation, using the Consumer Price Index — Urban, Dental (CPI-UD). The Medicaid agency may set reimbursement for specific dental procedures using a different methodology in order to preserve access to the service.

The five percent (5%) reduction in rates paid to providers in accordance with the methods described in Attachment 4.19-B for dental services provided on or after April 1, 2010 is extended through December 31, 2013.

Effective for services provided on or after January 1, 2024, reimbursement for services of dentists will be set at a percentile, or a percentage thereof, using a published survey of dental market data. All rates are published at the State's website, in.gov/Medicaid.

3. For telemedicine services provided through IATV technology, a facility fee for the originating site (where the patient is located at the time health care services through telemedicine are provided to the individual) is reimbursed at the lesser of the provider's billed charge or the maximum allowance established by the Office of Medicaid Policy and Planning. The reimbursement rate is paid for one unit per encounter. Effective for dates of service on or after January 1, 2024, the rate will be reviewed and adjusted at such time as Medicare-based rates are adjusted, taking into account the level of Medicare fee schedule changes.

If a health care provider's presence at the originating site is determined to be medically necessary by the provider at the distant site, separate reimbursement is available for the appropriate evaluation and management code for the service provided.

The maximum allowance for reimbursement to the distant site (where the provider is located while providing health care services through telemedicine) is based on specific Evaluation and Management (E&M) and End Stage Renal Disease codes and paid as if a traditional encounter were performed.

Except as otherwise noted in the plan, state-developed fee schedule rates for telemedicine services are the same for both governmental and private providers. All rates are published at the State's website, in.gov/Medicaid.

4. Effective for services provided on or after July 1, 2021, the Medicaid allowed amount for COVID-19 monoclonal antibody infusion administration and COVID-19 vaccine administration will be equal to Indiana Medicare’s allowed amount for these services.

5. Effective for dates of service on or after July 1, 2021, EMT's under the directions of the physician will be reimbursed for appropriate and medically necessary medical care when an ambulance is dispatched, and treatment is provided to the patient without the patient being transported to another site. Reimbursement for treat-no-transport will be made for Healthcare Common Procedure Coding System (HCPCS) code A0998 at the Indiana Medicaid physician fee schedule rate for Current Procedural Terminology (CPT) code 99203.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for governmental and private physicians. All rates are published on the agency's website, at in.gov/Medicaid.

6. Beginning with dates of service on or after September 1, 2022, Medicaid will provide stand-alone general pediatric vaccination counseling as part of the early and periodic screening, diagnostic, and treatment (EPSDT) benefit. Effective for dates of service on or after January 1, 2024, the rate will be reviewed and adjusted at such time as Medicare-based rates are adjusted, taking into account the level of Medicare fee schedule changes. All rates are published at the State's website, in.gov/Medicaid.

7. Effective for dates of service on or after January 1, 2024, the Medicaid reimbursement rates for applied behavior analysis (ABA) therapy are equal to the Indiana Medicaid Practitioner Fee Schedule rates in effect for that date of service. The Medicaid reimbursement rates are established by the Office based on provider cost information that includes direct care wages, fringe benefits, and non-wage related costs. Wage data from the U.S. Bureau of Labor Statistics is used to supplement provider wage data. Reimbursement rates will be reviewed every four years and adjusted as necessary by the office. For years not subject to a rate review a two percent rate adjustment will be made subject to budget approval.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of ABA therapy services. The agency’s rates are published at the State’s website, in.gov/Medicaid.

II. Application of reimbursement methodology for services provided by physicians and limited license practitioners (LLPs)

1. Reimbursement for services provided by physicians and limited license practitioners (LLPs), except for services described in subdivisions two (2) through six (6) below, will be equal to the lower of:

   ·the provider's submitted charges for the procedure, or
   ·the established Medicaid RBRVS physician fee schedule allowance for the procedure.

2. Services provided by assistant surgeons will be reimbursed at twenty percent (20%) of the Medicaid RBRVS physician amount for the procedure and cosurgeons at sixty-two and one-half percent (62.5%) of the RBRVS fee schedule amount for the procedure.

3. Reimbursement for all services is subject to the global surgery policy as defined by the Centers for Medicare and Medicaid Services for the Medicare Part B fee schedule for physician services.

4. Reimbursement for services provided by physicians and LLPs is subject to the policy for supplies and services incident to other procedures as defined by the by the Centers for Medicare and Medicaid Services for the Medicare Part B fee schedule for physician services.

5. Separate reimbursement will not be made for radiologic contrast material, except for low osmolar contrast material (LOCM) used in intrathecal, intravenous, and intra-arterial injections.

6. Reimbursement for services provided by physicians and LLPs is subject to the site-of-service payment adjustment. Procedures performed in an outpatient setting that are normally provided in a physician's office will be paid at eighty percent (80%) of the Medicaid RBRVS physician fee schedule amount for the procedure.

7. Payments for services to an out-of-state-provider will be negotiated on a case-by-case basis to obtain the lowest possible rate, not to exceed 100% of the provider’s reasonable and customary charges, and may differ from the reimbursement methodology or amounts set out in the Indiana Administrative Code when such payments are required because the services are not available in-state or are necessary due to unique medical circumstances requiring care that is available only from a limited number of qualified providers.

III. Application of the RBRVS reimbursement methodology for services provided by non-physician practitioners (NPPs)

1. Reimbursement for services provided by non-physician practitioners (NPPs), except services described below, will be equal to the lower of:
   ·the submitted charge for the procedure, or
   ·the established Medicaid RBRVS physician fee schedule amount for the procedure.
2. Outpatient mental health services provided by:
   a licensed psychologist, or an advance practice nurse who is a licensed, registered nurse with a master’s degree in nursing with a major in psychiatric or mental health nursing from an accredited school of nursing in a physician-directed outpatient mental health facility will be reimbursed at seventy-five percent (75%) of the Medicaid RBRVS physician fee schedule amount for that procedure.

3. Services provided on or after February 1, 2015 by independently practicing respiratory therapists (42 CFR 440.60), physical therapists' assistants (42 CFR 440.110) and advance practice nurses (42 CFR 440.166) will be reimbursed at seventy-five percent (75%) of the Medicaid RBRVS physician fee schedule amount for that procedure. State developed fee schedule rates are the same for both public and private providers of these services.

4. Services provided for dates of service on or after July 1, 2018 by a certified community health worker and supervised by a physician, health services provider in psychology, advanced practice nurse, physician assistant, dentist, podiatrist, or chiropractor shall be reimbursed at fifty percent (50%) of the Medicaid RBRVS physician fee schedule amount for that procedure.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and privately employed providers. All rates are published at in.gov/Medicaid.

IV. Application of the RBRVS reimbursement methodology for services provided by other licensed practitioners

1. Certified registered nurse anesthetists (CRNAs) and anesthesiologist assistants (AAs) are reimbursed at 60% of the allowable physician rate.

2. Physician assistants are reimbursed at 75% of the allowable physician rate.

3. Outpatient mental health services provided by:

   A licensed independent practice school psychologist, a licensed clinical social worker, a licensed marital and family therapist, a licensed mental health counselor, a licensed clinical addiction counselor, or a person holding a master's degree in social work, marital and family therapy, or mental health counseling in a physician-directed outpatient mental health facility will be reimbursed at seventy-five percent (75%) of the Medicaid RBRVS physician fee schedule amount for that procedure.

V. Laboratory services

For laboratory procedures not included in the Medicare Part B fee schedule for physician services, reimbursement is based on the Medicare clinical laboratory fee schedule and is paid on a per test basis. The fee schedule rate for each laboratory procedure does not exceed the current Medicare fee schedule amount. Medicaid clinical diagnostic laboratory fee schedules comply with Section 1903(i)(7) that limits Medicaid payments for clinical diagnostic lab services to the amount paid by Medicare for those services on a per test basis. The Medicaid lab fee schedule will be reviewed annually, taking into account the Medicare lab fee schedule rates published by CMS that take effect January 1 of each calendar year and adjusted as necessary. For procedures without Medicare fee schedule values, reimbursement rates will be reviewed and adjusted at such time as Medicare-based rates are adjusted, taking into account the level of Medicare fee schedule changes.

V. Access to Care Adjustments for Services Provided by Medical School Faculty Physicians and Practitioners

1. Beginning April 1, 2015, the office will make adjustments to payments, as necessary, for services provided by eligible physicians and practitioners to Medicaid recipients in order to maintain adequate access to primary and specialty physician and practitioner services as required by 42 USC 1396a(a)(30) and 42 CFR 447.204 and to compensate eligible physicians and practitioners for their additional costs incurred in providing services to Medicaid patients. The office will make adjustments to payments ("Medicaid Payment Adjustments") as follows:

   a. Medicaid Payment Adjustments to eligible physicians and practitioners

      (1) Medicaid Payment Adjustments will be made by the office to eligible physicians and practitioners. To be an eligible physician or practitioner, the physician or practitioner must be:

         i. A faculty physician with an in-state medical school or one of the following types of practitioners:
            a. Certified Registered Nurse Anesthetist
            b. Nurse Practitioner
            c. Physician Assistant
            d. Certified Nurse Midwife
            e. Clinical Social Worker
            f. Clinical Psychologist
            g. Optometrist
         ii. Licensed by the State of Indiana;
         iii. An enrolled Indiana Medicaid provider; and
         iv. Employed by or affiliated with an eligible health institution.

      Eligible health institutions are: (a) Indiana University Health, Inc. and its affiliates and (b) Health and Hospital Corporation of Marion County and its affiliates.

      (2) Subject to 42 CFR 447.10 and (3) below, Medicaid Payment Adjustments will be made quarterly by the office, with an annual reconciliation, in an amount not to exceed the difference between Indiana Medicaid RBRVS fee schedule for eligible physicians and practitioners and in accordance with state plan attachment 4.19-B page 1, 1a, 1a.1, 1b and 1c for practitioners, and the Enhanced Payment, as defined in b.(4) below. Eligible physicians and practitioners who receive Medicaid payments as authorized by attachment 4.19-B, Page 1c.4b through d in the state plan shall also receive these Medicaid Payment Adjustments provided they meet the office's applicable performance standards as discussed in (3) below. Eligible practitioners will also be required to meet the office's performance standards.

      (3) The amounts of the Medicaid Payment Adjustments to eligible physicians and practitioners are subject to the office's performance standards. The office may adjust the eligible physician and practitioner Medicaid Payment Adjustments based upon the office's review and the eligible physicians' and practitioners' satisfaction of the office's performance standards in order to ensure access to care for Medicaid recipients. An annual review will be conducted to measure and evaluate whether eligible physicians and practitioners have met performance standards. The results of the annual review will be applied to the quarterly payments for the following calendar year. No less than annually, the office will report the results of the annual review to CMS.

b. Medicaid Payment Adjustment Calculation

(1) Calculate the Average Commercial Rate: For each procedure code for which the payment adjustments will be made ("eligible procedure codes"), compute the average commercial rate by CPT Code, and modifier if applicable, including patient share amounts, by the top five payers during the defined base period.

(2) Calculate the Medicaid Payment Ceiling: Multiply the Average Commercial Rate as determined in Paragraph (1) above, by the number of times each eligible procedure code, and modifier if applicable, was paid in the base period for Medicaid beneficiaries, to eligible physicians and practitioners, as reported in the claims data. Calculate the Total Medicaid Payment Ceiling by summing the product of each eligible procedure code.

(3) Calculate the Average Commercial Rate as a Percentage of Medicare, for all eligible physicians and practitioners

i. Calculate Total Medicare Payments: Multiply the Medicare non-facility rate per procedure code by the number of times each eligible procedure code, and modifier if applicable, was paid for Medicaid beneficiaries during the base period as reported in the claims data. Add the product for all eligible procedure codes, to equal the Total Medicare Payments.

ii. Divide the Medicaid Payment Ceiling by Total Medicare Payments. This ratio expresses the Average Commercial Rate as a Percentage of Medicare.

iii. The Average Commercial Rate as a Percentage of Medicare will be rebased/updated at least every three (3) years.

(4) Determination of Medicaid Payment Adjustment for each eligible physician or practitioner

i. Determine the Enhanced Payment:
For Eligible Physicians and Practitioners: Multiply the Average Commercial Rate as a Percentage of Medicare by the Medicare rate for each eligible procedure code, and modifier if applicable. Sum the product for all eligible procedure codes to equal the Enhanced Payment.

ii. Determine the Medicaid Payment Adjustment Prior to Application of Performance Standards: the Medicaid Payment Adjustment Prior to Application of Performance Standards, for eligible physicians and practitioners, shall equal the Enhanced Payment less all Medicaid payments for eligible procedure codes paid in the applicable period for Medicaid beneficiaries to eligible physicians and practitioners, as reported in the claims data.

iii. The Medicaid Payment Adjustment is calculated by multiplying the Medicaid Payment Adjustment Prior to Application of Performance Standards by the applicable factor for the eligible physician or practitioner's achievement of the performance standards as averaged by respective group practice.

iv. Performance standards as established by the office and effective beginning April 1, 2015, are described in the following table.

Performance Metric	Performance Target	Data and Monitoring
1. Percent of new patients seen in clinics in less than 7 days.	≥ 35%	• All physician group practices of eligible health institutions. • Monthly reporting of internal performance data with auditing / data checks as necessary.
2. Median lag time for clinic visits in all specialties.	≥ 55% of new patients seen within 3 weeks of request	• All physician group practices of eligible health institutions. • Monthly reporting of internal performance data with auditing / data checks as necessary.
3. Median time for patient to see a provider in the Emergency Department.	≤ 40 minutes	• All hospital emergency department facilities of the eligible institutions. • Data as reported to Medicare.gov for Hospital Compare per satisfaction survey schedule with auditing / data checks as necessary.
4. Patient Satisfaction: Patients who reported YES, they would definitely recommend the hospital or clinic.	≥ 70%	• All physician group practices, emergency departments, and outpatient clinics of eligible institutions. • Data as reported to Medicare.gov for Hospital Compare and Physician Compare per satisfaction survey schedule with auditing / data checks as necessary.

VII. Payment Adjustment To Physicians Who Specialize In Primary and Preventive Care Services

Effective July 1, 2007 the office will make a one-time payment adjustment to physicians that provide primary and preventative care services. The physicians subject to this adjustment include family practitioners, general practitioners, obstetricians/gynecologists, general internists, and general pediatricians. For purposes of this adjustment, the office has identified seventy-five (75) procedures considered to be primary and preventative care services, including evaluation and management procedures, certain delivery procedures, and preventative medicine procedures. The procedure code ranges are as follows: 59409-59410, 59514-59515, 59612, 59614, 59620, 59622, 99201-99205, 99211-99215, 99217-99223, 99231-99236, 99238-99239, 99241-99245, 99251-99255, 99281-99285, 99291-99296, 99298-99299, 99318, 99354-99357, 99381-99387, and 99391-99397.

The practice settings include services provided in the office, urgent care facility, inpatient hospital, outpatient hospital, emergency department, and ambulatory surgical center.

In determining the amount of the payment adjustment under this provision, the office shall examine historical utilization from physicians. The payment adjustment will be computed as follows:

1) A percentage increase will be applied to the current Medicaid fee for the seventy-five (75) primary and preventative care services procedures, including evaluation and management procedures, certain delivery procedures, and preventative medicine procedures. Medicaid payments under this state plan amendment for FFY 2008 shall be based on historic claims paid between January 1, 2006 and March 31, 2007 ("Period 1"), and April 1, 2007 and August 31, 2007 ("Period 2"). The percentage payment increase for Period 1 claims shall be 23.68%, and the percentage for Period 2 claims shall be 37.52%. The resulting fee shall be limited to the Medicare fee in effect during 2007 for Indiana providers.
2) Historic claims for Periods 1 and 2 will be re-priced based on the service fee percentage increase identified above. Claims with third party payments or spend down amounts will be excluded.
3) The payment adjustment amount is equal to the difference between the original payment amount and the re-priced payment amount determined in step 2, and will be paid in a one-time lump sum payment to all five physician specialty practitioners, both governmental and private providers, providing these services. No payment adjustments will be made for services rendered after FFY 2008.

VIII. RBRVS Payment Reductions

The five percent (5%) reduction of all reimbursement to chiropractors and podiatrists for services provided on or after January 1, 2011 that has been calculated under methods described in Attachment 4.19-B is extended through December 31, 2013. The RBRVS rates are published at the State's website www.indianamedicaid.com.

The five percent (5%) reduction of all reimbursement to speech/hearing therapists, audiologists, optometrists, opticians, independent laboratory providers, and independent radiology providers, for services provided on or after July 1, 2011, that has been calculated under methods described in Attachment 4.19-B shall be extended through December 31, 2013. The RBRVS rates are published at the State's website www.dianamedicaid.com.

IX. Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415

Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS.

☐ The rates reflect all Medicare site of service and locality adjustments.

☒ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.

☒ The rates reflect all Medicare geographic/locality adjustments.

☐ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code:_____

The state will develop a fee schedule using the most recent annual Medicare physician fee schedule rates for calendar years 2013 and 2014. The state will not make mid-year updates to the rates. Qualifying evaluation and management codes will be reimbursed at the lesser of billed charges or the Medicare physician fee schedule rates applicable in calendar years (CYs) 2013 and 2014, or if greater, the payment rates that would be applicable in those calendar years using the CY2009 Medicare physician fee schedule conversion factor.

Method of Payment

☐ The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.

☒ The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on the date of service as published in the agency's fee schedule described in Attachment 4.19-B, page 1c.4b Physician Services of the State plan and the minimum payment required at 42 CFR 447.405.

Supplemental payment is made: ☐ monthly ☒ quarterly

Primary Care Services Affected by this Payment Methodology

☐ This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.

☒ The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes).

99339, 99340, 99358, 99359, 99360, 99363, 99364, 99366,99367, 99368, 99374, 99375, 99377, 99378, 99379, 99380, 99401, 99402, 99403, 99404, 99406, 99407, 99411, 99412, 99420, 99429, 99441, 99442, 99443, 99444, 99450, 99455, 99456, 99466, 99467, 99485, 99486, 99487, 99488, 99489, 99495, 99496

(Primary Care Services Affected by this Payment Methodology – continued)

☒ The state will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added).

99224 added 1/1/2011, 99225 added 1/1/2011, and 99226 added 1/1/2011

The state will not make an increased payment under this SPA for the following code that does not have Medicare RVUs and for which CMS will not develop a Medicare-like rate: 99499

Physician Services – Vaccine Administration

For calendar years (CYs) 2013 and 2014, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate in effect in CYs 2013 and 2014 or, if higher, the rate using the CY 2009 conversion factor.

☐ Medicare Physician Fee Schedule rate

☒ State regional maximum administration fee set by the Vaccines for Children program

☒ Rate using the CY 2009 conversion factor

Documentation of Vaccine Administration Rates in Effect 7/1/09

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

☐ The imputed rate in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which

encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is:_____.

☐ A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate is: _____.

☒ Alternative methodology to calculate the vaccine administration rate in effect 7/1/09:
To impute the payment rate in effect at 7/1/09 for code 90460, the state will use the payment rate in effect on 7/1/09 for code 96372. This payment rate is $12.94.

For vaccination administration, the State will make payment for the following codes under this SPA: 90471, 90472, 90473, and 90474. For VFC vaccine administration, reimbursement will be the lesser of the state regional maximum administration fee set by the VFC program or the Medicare physician fee schedule rates in effect in CYs 2013 and 2014 (or, if greater, the payment rates that would be applicable in those calendar years using the CY 2009 Medicare physician fee schedule conversion factor). For non-VFC vaccine administration, reimbursement will be the lesser of billed charges or the Medicare physician fee schedule rates in effect in calendar years (CY) 2013 and 2014 (or, if greater, the payment rates that would be applicable in those calendar years using the CY 2009 Medicare physician fee schedule conversion factor).

Effective Date of Payment

E & M Services
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014 but not prior to December 31, 2014. All rates are published at the state's website www.indianamedicaid.com.

Vaccine Administration
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014 but not prior to December 31, 2014. All rates are published at the state's website www.indianamedicaid.com.

Reimbursement for Medically Necessary School Nursing Services

Reimbursement for medically necessary school nursing services provided by a nurse who is employed by or under contract with a school corporation that participates in Medicaid will be paid on a fee-for-service basis. Medically necessary school nursing services are similar in nature to HHA nursing services, Medically necessary school nursing services rates will be set using the same rate methodology currently in place for home health nursing services. Payment will be based on the lower of the provider's submitted charge or the established rate. The unit of service will be 15 minutes.

The state-developed fee schedule rate is available only to Indiana Medicaid enrolled local educational agencies (LEAs) which provide medically necessary school nursing services pursuant to a Medicaid enrolled student's educational program or plan as required by the Individuals with Disabilities Education Act (IDEA) or Section 504 of the federal Rehabilitation Act of 1973. 29 U.S.C. 794.. All rates are published on the State's website at: www.indianamedicaid.com.

Pharmacy Services

Reimbursement for covered federal legend drugs and for covered non-legend (OTC) drugs is at acquisition cost plus professional dispensing fee, as follows:

Federal legend Drugs

Payment is based on the lowest of:

(A) The National Average Drug Acquisition Cost (NADAC) as published by CMS pursuant to 42 U.S.C 1396r-8(f) plus the professional dispensing fee;

(B) The state maximum allowable cost (MAC) as determined by the office plus the professional dispensing fee;

(C) The federal upper limit (FUL) as determined by CMS pursuant to 42 C.F.R. 447.514 plus the professional dispensing fee;

(D) The wholesale acquisition cost (WAC) according to the office's drug database file contracted from a nationally recognized source such as Medi-Span or First DataBank, minus a percentage as determined by the office through analysis of the dispensing cost survey or other methodology approved by CMS, plus the professional dispensing fee. The purpose of the percentage is to ensure that the applicable WAC rate sufficiently reflects the actual acquisition cost of the provider. The WAC shall be considered only if there is no applicable NADAC, FUL, or state MAC rate;

(E) The provider's submitted charge, representing the provider's usual and customary charge for the service.

Non-legend (OTC) Drugs

Payment is based on the lowest of:

(A) State OTC MAC plus professional dispensing fee;

(B) The provider's submitted charge, representing the provider's usual and customary charge for the service.

The professional dispensing fee that is reimbursed to pharmacy providers is determined based on a cost of dispensing survey that is performed every two years. The survey identifies costs associated with the dispensing function of prescription services, regardless of product or setting. Indiana Medicaid has selected a single dispensing fee of $10.48, which is the weighted mean cost of dispensing prescriptions to Indiana Medicaid members, inclusive of both specialty and non-specialty pharmacies.

Indiana Medicaid 340B Policy For Indiana Health Coverage Programs:

For drugs purchased through the 340B program, reimbursement will be at the provider's actual acquisition cost plus the professional dispensing fee.

For drugs purchased outside the 340B program, reimbursement will be as described under the heading "Federal Legend Drugs", above

Drugs acquired through the 340B drug pricing program and dispensed by 340B contract pharmacies are not covered.

Drugs Acquired at the Federal Supply Schedule (FSS):

If providers obtain drugs acquired at the federal supply fee schedule, Indiana Medicaid will reimburse at no more than the actual acquisition cost plus the professional dispensing fee.

Drugs Acquired at Nominal Price (Outside of 340B or FSS):

If providers obtain drugs acquired at nominal cost, Indiana Medicaid will reimburse at no more than the actual acquisition cost plus the professional dispensing fee. .

Encounter Rates (Drugs Dispensed by IHS/Tribal Facilities Under Encounter Rates):

All Indian Health Service, tribal and urban Indian pharmacies would be reimbursed an applicable encounter rate by Indiana Medicaid, regardless of their method of purchasing. Indiana does not have any Tribal Facilities billing for pharmacy services at this time.

Drugs Not Distributed by a Retail Community Pharmacy and Distributed Primarily Through the Mail (Such as Specialty Drugs):

Same policy as applies to drugs distributed by a retail community pharmacy. Indiana Medicaid has selected a single dispensing fee of $10.48, which is the weighted mean cost of dispensing prescriptions to Indiana Medicaid members, inclusive of both specialty and non-specialty pharmacy services.

Drugs Not Distributed by a Retail Community Pharmacy (Such as a Long-Term Care Facility):

Same policy as applies to drugs distributed by a retail community pharmacy. Indiana Medicaid has selected a single dispensing fee of $10.48, which is the weighted mean cost of dispensing prescriptions to Indiana Medicaid members, inclusive of both specialty and non-specialty pharmacy services.

Physician Administered Drugs

Physician-administered drugs are considered a physician service under Indiana Medicaid; as such, information regarding physician–administered drugs is contained in the physician services section of the state plan. Please refer to Attachment 4.19-B page 1f.

Blood Factor / Clotting Factor from Specialty Pharmacies, Hemophilia Treatment Centers, Centers of Excellence:

Indiana Medicaid will reimburse for blood factor / clotting factor products using the same methodology as for federal legend drugs.

Investigational Drugs:

Investigational drugs, when deemed medically necessary on a case-by-case review basis, will be reimbursed at the actual acquisition cost plus the professional dispensing fee.

Physician-administered Drugs

Reimbursement for physician-administered drugs shall be one hundred five percent (105%) of the published wholesale acquisition cost (WAC) of the benchmark National Drug Code (NDC). For National Drug Codes without a published wholesale acquisition cost, the reimbursement for physician-administered drugs shall be one hundred six percent (106%) of the average sales price (ASP) payment amount as published by the Centers for Medicare and Medicaid Services (CMS). If neither the wholesale acquisition cost nor the average sales price are available, other pricing metrics may be used as determined by the office. The rates determined in accordance with this section shall be effective for services provided on or after May 1, 2010. These rates are published in provider bulletins, which are accessible through the agency's website. The State's website, www.indianamedicaid.com, allows providers access to all provider bulletins.

State of Indiana

1905(a)(29) Medication-Assisted Treatment (MAT)

Unbundled Prescribed Drugs and Biologicals

The reimbursement for unbundled prescribed drugs and biologicals used to treat opioid use disorder will be reimbursed using the same methodology as described for Pharmacy Services located in Attachment 4.19-B, pages 1d and 1e, for drugs that are dispensed or administered.

Application of the RBRVS reimbursement methodology for services provided by non-physician practitioners (NPPs)

The effective date for all rates, the applicable fee schedules as well as a link to their electronic publication can be found on page 1b-1c of Attachment 4.19-B of the State Plan. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Medicaid services listed above. Services for both ABP and non-ABP beneficiaries utilize the same rates unless otherwise noted in the plan. All applicable procedure code listings and/or rates are published on the State's website at www.indianamedicaid.com.

Application of the RBRVS reimbursement methodology for services provided by other licensed practitioners

The effective date for all rates, the applicable fee schedules as well as a link to their electronic publication can be found on page 1c of Attachment 4.19-B of the State Plan. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Medicaid services listed above. Services for both ABP and non-ABP beneficiaries utilize the same rates unless otherwise noted in the plan. All applicable procedure code listings and/or rates are published on the State's website at www.indianamedicaid.com.

Community Mental Health Centers

The effective date for all rates, the applicable fee schedules as well as a link to their electronic publication can be found on page 5a of Attachment 4.19-B of the State Plan. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Medicaid services listed above. Services for both ABP and non-ABP beneficiaries utilize the same rates unless otherwise noted in the plan. All applicable procedure code listings and/or rates are published on the State's website at www.indianamedicaid.com.

Upper Payment Limit Demonstration

The effective date for all rates, the applicable fee schedules as well as a link to their electronic publication can be found on page 2 of Attachment 4.19-B of the State Plan. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Medicaid services listed above. Services for both ABP and non-ABP beneficiaries utilize the same rates unless otherwise noted in the plan. All applicable procedure code listings and/or rates are published on the State's website at www.indianamedicaid.com.

Outpatient Hospital Services

The effective date for all rates, the applicable fee schedules as well as a link to their electronic publication can be found on page 2 of Attachment 4.19-B of the State Plan. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Medicaid services listed above. Services for both ABP and non-ABP beneficiaries utilize the same rates unless otherwise noted in the plan. All applicable procedure code listings and/or rates are published on the State's website at www.indianamedicaid.com.

Opioid Treatment Services

The effective date for all rates, the applicable fee schedules as well as a link to their electronic publication can be found on page 5c of Attachment 4.19-B of the State Plan. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Medicaid services listed above. Services for both ABP and non-ABP beneficiaries utilize the same rates unless otherwise noted in the plan. All applicable procedure code listings and/or rates are published on the State's website at www.indianamedicaid.com.

Intensive Outpatient Treatment (IOT)

The effective date for all rates, the applicable fee schedules as well as a link to their electronic publication can be found on page 5d of Attachment 4.19-B of the State Plan. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Medicaid services listed above. Services for both ABP and non-ABP beneficiaries utilize the same rates unless otherwise noted in the plan. All applicable procedure code listings and/or rates are published on the State's website at www.indianamedicaid.com.

Fee Schedule Rates for Free Standing Clinic Services, Ambulatory Surgical Centers, and Outpatient Hospital Services are the same for governmental and private providers except as otherwise noted in the Plan. The agency's fee schedule rates were set on various dates and are in effect for services provided on or after April 1, 2010. All rates and effective dates are published on the agency's website at www.indianamedicaid.com.

CLINIC SERVICES

FREE STANDING CLINIC SERVICES

Freestanding clinic services are reimbursed on a fee for service basis according to the Indiana Medicaid fee schedule rates. The rates paid to freestanding renal dialysis clinics for services provided on or after July I, 2011 are subject to a 5% reduction. The 5% rate reduction will remain in effect through December 31, 2013.

AMBULATORY SURGICAL CENTERS

As applicable, services provided by free-standing Ambulatory Surgical Centers (ASC) are reimbursed in accordance with outpatient hospital services as described below.

COMMUNITY MENTAL HEALTH CENTERS

Services provided by a community mental health centers on or after August 1, 2017 that are enrolled qualified clinics approved by the state shall be reimbursed by the Medicaid RBRVS fee schedule, or percentage thereof, of the practitioner employed or contracted with the clinic. Except as otherwise noted in the plan, the rates are the same for both governmental and private community mental health centers. All rates are published at www.indianamedicaid.com.

UPPER PAYMENT LIMIT DEMONSTRATION

Federal regulations (42 CFR §447.321) require that the payment system not pay more for clinic services than a reasonable estimate of what Medicare would pay for Medicaid equivalent services.

OUTPATIENT HOSPITAL SERVICES

The reimbursement methodology for all covered outpatient hospital services shall be subject to the lower of the submitted charges for the procedure or the established fee schedule allowance for the procedure as provided in this section. Services shall be billed in accordance with provider manuals and update bulletins.

(a) Reimbursement for outpatient surgical procedures performed in a hospital or provider-based ambulatory surgical center will be based on the Indiana Medicaid statewide allowed amounts for that service. Surgical procedures shall be classified into a group corresponding to the Medicare ambulatory surgical center (ASC) methodology and shall be paid a rate established for each ASC payment group. The Office of Medicaid Policy and Planning will classify outpatient surgical procedures not classified into an ASC group by Medicare into one of the nine (9) ASC groups designated by Medicare, or additional payment groups.

(b) Payments for provider-based emergent care that do not include surgery and that are provided in an emergency department, treatment room, observation room, or clinic will be based on the 2003 statewide fee schedule amounts for services provided on or after April 1, 2004.

(c) Payments for provider-based non-emergent care that do not include surgery and that are provided in an emergency department, treatment room, observation room, or clinic will be based on the 2003 statewide fee schedule amounts for services provided on or after April 1, 2004.

(d) The fixed fees for laboratory procedures are based on the Medicare fee schedule amounts and are paid on a per test basis. The fee schedule rate for each laboratory procedure does not exceed the current Medicare fee schedule amount. Reimbursement for the technical component of radiology procedures shall be based on the Indiana Medicaid physician fee schedule amounts for the technical component of radiology services.

(e) Reimbursement allowances for all outpatient hospital procedures not addressed elsewhere in this section, for example, therapies, testing, etc., will be based on the 2003 Indiana Medicaid statewide fee schedule amounts for services provided on or after April 1, 2004.

(f) Payments will not be made for outpatient hospital services occurring within three (3) calendar days preceding an inpatient admission for the same or related diagnosis. The office may exclude certain services or categories of service from this requirement. Such exclusions will be described in provider manuals and update bulletins.

The established rates for hospital outpatient reimbursement shall be reviewed annually by the Office of Medicaid Policy and Planning and adjusted no more frequently than every second year and in accordance with this section to ensure that revisions contain appropriate incentives for provision of primary and preventive care.

Outpatient Hospital Services

The rates paid to outpatient hospital providers for services provided on and after January 1, 2010, and in accordance with methods described in Attachment 4.19-B in the Outpatient Hospital Services section, excluding ambulatory surgical center services, are subject to a 5% reduction. The 5% rate reduction will remain in effect through December 31, 2013. The rates paid to outpatient hospital providers, excluding ambulatory surgical center services, for services provided on and after January 1, 2014 through June 30, 2021 are subject to a 3% reduction.

Indiana outpatient hospital rates will result in aggregate payments that reasonably approximate the upper payment limits but do not result in payments in excess of the upper payment limits at 42 CFR 447.321.

The state uses a cost based outpatient hospital upper payment limit methodology whereby the Medicare cost-to-charge ratio is multiplied by Medicaid covered outpatient charges and summed by hospital class. Medicaid claims detail information is grouped by revenue code. The appropriate cost report cost center is determined for each revenue code. The cost-to-charge ratio used is obtained from the CMS 2552, Worksheet C, Part I, Column 11, Lines 50-98. The upper payment limit is trended for inflation using a hospital market basket index, prorated quarterly, and applied to Medicaid charges only. The upper payment limit is trended for volume, applied to both Medicaid payments and charges.

The following sections of the State Plan do not apply for the period beginning July 1, 2011:

- Limitations on payments for an individual claim to the lesser of the amount computed or billed charges.
- Medicaid Outpatient Payments for Safety net Hospitals
- Medicaid Hospital Reimbursement Add-On Payment Methodology to Compensate Hospitals that Deliver Hospital Care for the Indigent Program Service.
- Municipal Hospital Payment Adjustments
- Supplemental Payments to Privately-Owned Hospitals

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of outpatient hospital services. The agency's rates were set as of November 1, 2016 and are effective for all services provided on or after that date. All rates are published at the State's website, www.indianamedicaid.com.

Freestanding Birthing Center Services

Covered freestanding birthing center services provided on or after January 1, 2017, shall be reimbursed in accordance with this section.

(1) Payment of a facility delivery fee shall be made to the birthing center for facility services. The facility delivery fee is a global fee that includes all services and supplies relating to the delivery. The facility delivery fee is an equivalent daily rate of the inpatient DRG base payment, as of the date of service, for an uncomplicated delivery.

(2) Payment of a facility labor management fee shall be made to the facility for those situations when the patient is transferred to a hospital before the delivery. The facility labor management fee is equal to the Indiana ASC rate which is closest to but not exceeding 1/3 of the facility delivery fee in effect on the date of service.

(3) Payment for the professional services of physicians and certified nurse midwives shall be made apart from the facility delivery fee and facility labor management fee in accordance with the established reimbursement methodology for physicians and certified nurse midwife services as indicated in Attachment 4.19B Page 1, Section I.A of the State Plan.

Outpatient Hospital Services (cont.)

Skin Substitutes

Covered skin substitutes provided on or after November 1, 2016, shall be reimbursed in accordance with this section.

Reimbursement for skin substitutes is equal to the lower of the provider's submitted charges, not to exceed the provider's usual and customary charges, or the Medicaid allowable amount. The Medicaid allowable amount is a single reimbursement rate applicable to all covered skin substitutes. The reimbursement rate is calculated based on claims and cost report data to determine the average cost for covered skin substitutes.

Except as otherwise noted in the state plan, the state-developed fee schedule rate for these services is the same for both governmental and private providers. The agency's fee schedule rate is published on the agency's website at www.indianamedicaid.com.

Children's Hospitals

Effective July 1, 2023, through July 1, 2025, reimbursement for outpatient hospital services provided by a children's hospital located in a state bordering Indiana will be reimbursed at a rate that is 130% of the Medicaid reimbursement rate. To be eligible, the children's hospital must be located in Illinois, Kentucky, Michigan, or Ohio. Additionally, the children's hospital must be either:

1) A freestanding general acute care hospital that is designated by the Medicare program as a children's hospital or furnishes inpatient and outpatient health care services to patients who are predominantly individuals less than nineteen (19) years of age; or

2) A facility located within a freestanding general acute care hospital that is designated by the Medicare program as a children's hospital or furnishes inpatient and outpatient health care services to patients who are predominantly individuals less than nineteen (19) years of age.

Other Provider-Preventable Conditions

Effective for services provided on or after July 1, 2012, the State identifies the following other provider-preventable conditions, as defined at 42 CFR 447.26(b), for non-payment under Section 4.19B:

(1) wrong surgical or other invasive procedure performed on a patient;

(2) surgical or other invasive procedure performed on the wrong body part;

(3) surgical or other invasive procedure performed on the wrong patient.

In compliance with 42 CFR 447.26(c), the State provides:

(1) That no reduction in payment for a provider preventable condition (PPC) will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

(2) That reductions in provider payment may be limited to the extent that the following apply:

    (a) The identified PPC would otherwise result in an increase in payment.

    (b) The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the PPC.

(3) Assurance that non-payment for PPCs does not prevent access to services for Medicaid beneficiaries.

MEDICAID OUTPATIENT PAYMENTS FOR SAFETY-NET HOSPITALS

"Safety-net hospital", for purposes of this section, means an acute care hospital, licensed under IC 16-21, the Indiana hospital licensure statute, and qualified under Section II.E. of this plan as a disproportionate share hospital.

A. For the state fiscal years ending on or after June 30, 2000, safety-net hospitals with more than 150 interns and residents, located in a city with a population of over 600,000, and safety-net hospitals which are the sole disproportionate share hospital in a city located in a county having a population of more than four hundred thousand (400,000) but less that seven hundred thousand (700,000), which hospitals are also historical disproportionate share hospitals, shall receive reimbursement, subject to the terms of subsection (B) of this section, in an amount calculated by the office from the hospital's cost report filed with the office for the hospital's fiscal period ending during the state fiscal year, equal to the difference between:

(1) the amount of Medicaid payments to the hospital, excluding payments under Section III of this Plan, for Medicaid outpatient services provided by the hospital during the hospital's fiscal year, and

(2) an amount equal to the lesser of the following:

(A) The hospital's customary charges for the services described in subdivision (1).

(B) A reasonable estimate by the office of the amount that would be paid for the services described in subdivision (1) under Medicare payment principles.

The office may also make payments to all other safety-net hospitals in the manner provided in subsection A. of this section, subject to the provisions of subsection B. of this section.

B. If the amount available to pay the outpatient safety-net amount is insufficient to pay each hospital the full amounts calculated above, payments to the hospitals will be reduced by an amount that is proportionate to the amount of the deficiency.

C. (1) For the Eligibility Period** beginning July 1, 2001, outpatient safety-net hospitals, meeting the office's Medicaid safety-net criteria as described in A. above (the "office's Medicaid outpatient safety-net criteria"), limited to those hospitals defined as historical disproportionate share providers under Attachment 4.19A, Section II(F) of this plan and those hospitals not defined as historical disproportionate share providers but meeting the office's Medicaid outpatient safety-net criteria for the Eligibility Period ending on June 30, 2001, will receive outpatient safety-net payments equal to 100% of the amount determined in A. and B. above (the "outpatient safety-net amount"). For later Eligibility Periods, hospitals receiving payment adjustments pursuant to this subsection (1) will be subject to (2), (3), (4) and (5) below, as applicable .

(2) For the Eligibility Periods beginning after June 30, 2001, an outpatient safety-net hospital, whether a historical disproportionate share provider or a hospital which is not a historical disproportionate share provider, receiving a Medicaid outpatient safety-net payment adjustment in the amount of 100% of the outpatient safety-net amount, will continue to receive Medicaid outpatient safety-net payment adjustments in the amount of 100% of the outpatient safety-net amount for subsequent Eligibility Periods in which it meets the office's Medicaid outpatient safety-net criteria, unless the hospital has a lapse in meeting the office's Medicaid outpatient safety-net criteria for an Eligibility Period. A hospital that has a lapse in meeting the office's Medicaid outpatient safety-net criteria for an Eligibility Period shall be subject to (3),(4), and (5) below, as applicable, for later Eligibility Periods.

(3) For the Eligibility Periods beginning after June 30, 2001, if an outpatient safety-net hospital, including historical disproportionate share providers and hospitals which are not historical disproportionate share providers, has a lapse in meeting the office's Medicaid outpatient safety-net criteria for any Eligibility Period, the hospital will receive Medicaid outpatient safety-net payment adjustments equal to 0% of its hospital-specific limit for that Eligibility Period. However, upon a later Eligibility Determination† by the office, if the hospital is able to meet the office's Medicaid outpatient safety-net criteria for the Eligibility Period for which the later Eligibility Determination applies, the hospital's Medicaid outpatient safety-net payment adjustment will be calculated as set forth in (2), (4) or (5) of this Section C., as applicable.

(4) Except as set forth in (1) above, for Eligibility Periods beginning after June 30, 2001, outpatient safety-net hospitals, including hospitals defined as historical disproportionate share providers and hospitals which are not defined as historical disproportionate share providers,

(a) licensed under IC 16-21,

(b) meeting the office's Medicaid outpatient safety-net criteria for the current Eligibility Period, and

(c) which did not meet the office's Medicaid outpatient safety-net criteria for the prior Eligibility Period,

will receive Medicaid outpatient safety-net payment adjustments equal to 33 1/3% of their outpatient safety-net amount.

(5) Except as set forth in (2) above, after the Eligibility Period beginning on July 1, 2001, each time the office makes an Eligibility Determination, an outpatient safety-net hospital, including historical disproportionate share providers and hospitals which are not historical disproportionate share providers,

(a) meeting the office's Medicaid outpatient safety-net criteria for two consecutive Eligibility Periods will receive a Medicaid outpatient safety-net payment adjustment equal to 66 2/3% of its hospital-specific limit; or

(b) meeting the office's Medicaid outpatient safety-net criteria for three (or more) consecutive Eligibility Periods will receive a Medicaid outpatient safety-net payment adjustment equal to 100% of its hospital-specific limit.

(6 If the amount available to pay the outpatient safety-net amount is insufficient to pay each hospital the full amounts calculated above, payments to the hospitals will be reduced by an amount that is proportionate to the amount of the deficiency.

This new payment methodology will only apply for Medicaid services on or after April 1, 2000, but will be calculated as set forth in this section. For the state fiscal year ending on June 30, 2000, the state may reimburse, under this section, each safety-net hospital eligible for such reimbursement in an amount not to exceed one-fourth of the amount calculated under the formula described in this section. For state fiscal years ending after June 30, 2000, the state may reimburse, under this section, each safety-net hospital eligible for such reimbursement in an amount up to one hundred percent (100%) of the amount calculated under the formula described in this section.

** The term "Eligibility Period" is defined at Attachment 4.19 A, Section II(P) of this plan.
† The term "Eligibility Determination" is defined at Attachment 4.19A, Section II(O) of this plan.

MUNICIPAL HOSPITAL PAYMENT ADJUSTMENTS

I. AUTHORITY

In compliance with Section 1902 (a)(13)(A), Section 1903 (w)(3), and Section 1903 (w)(6) of the Act, the Indiana Medicaid program (the "Office") adopts the following definitions and methodologies to identify and make payment adjustments to Municipal Hospitals.

II. DEFINITIONS

"Non-State Government-Owned Or Operated Hospital" has the following meaning: a health care facility providing inpatient and outpatient hospital services that is: (1) licensed as an acute care hospital under Indiana Code 16-21; and (2) is established and operated as a non-state governmental hospital under Indiana Code 16-22-2, Indiana Code 16-22-8 or Indiana Code 16-23.

"Municipal Hospital" has the following meaning: a non-state government-owned or operated health care facility providing inpatient and outpatient hospital services that is: (1) licensed as an acute care hospital under Indiana Code 16-21; and (2) is established and operated as a non-state governmental hospital under Indiana Code 16-22-2, or Indiana Code 16-23.

"Medicaid Payments" are all payments made to Municipal Hospitals by on or behalf of the Office pursuant to the Medicaid reimbursement provisions under Article 15 of the Indiana Code. This includes, but is not limited to, claim specific payments for outpatient Medicaid services, non-claim specific additional Medicaid payments such as the Medicaid Hospital Care for the Indigent (HCI) add-on payments, and the payment adjustments provided for in this state plan amendment. This does not include the Disproportionate Share Hospital (DSH) payments made pursuant to Indiana Code 12-15-16 and 12-15-19, which contain the methodologies used to determine and distribute DSH payments.

"Medicaid Services" are those outpatient services provided by a Municipal Hospital that are reimbursable under the Medicaid program.

III. PAYMENT ADJUSTMENTS

A Municipal Hospital ("hospital") shall receive, in addition to its allowable regular Medicaid claims payments to which it is entitled, a payment adjustment calculated in the following manner:

(1) For each state fiscal year ending after June 30, 2000, reimbursement in the form of a single payment, equal to the difference between:

(a) The amount of Medicaid payments to the hospital made pursuant to the Medicaid reimbursement provisions under Article 15 of the Indiana Code, excluding DSH payments made pursuant to Indiana Code 12-15-16 and 12-15-19, for services provided by the hospital during the state fiscal year; and

(b) an amount equal to 100 percent of a reasonable estimate by the Office of the amount that would have been paid for those service under Medicare payment principles.

(2) The payment adjustment identified above shall be made after the close of the applicable state fiscal year.

(3) Notwithstanding the foregoing, subject to the applicable payment limits under 42 CFR 447.321, the office may enter into agreements with hospitals, individually or in combination, to permit hospitals to receive lesser or greater payment adjustments, made after the close of the applicable state fiscal year, up to, but not to exceed the difference between:

(a) The aggregate amount of Medicaid payments to all hospitals made pursuant to the Medicaid reimbursement provisions under Indiana Code 12-15, excluding DSH payments made pursuant to Indiana Code 12-15-16 and 12-15-19, for services provided by all hospitals during the state fiscal year; and

(b) The aggregate amount, as reasonably estimated by the office, that all hospitals would have been paid for those services under Medicare payment principles.

However, the office may not enter into an agreement with a hospital if, in doing so, another hospital that is not a party to the agreement or that has not otherwise consented to the office's agreement, will receive under (1) above an amount less than what the hospital would have otherwise received under the formula set forth in (1).

Outpatient Hospital Medicaid Upper Payment Limit Test

As required by 42 CFR 447.321, the office will compute an upper payment limit test on an annual basis. Aggregate payments to categories of facilities may not exceed 100 percent of a reasonable estimate of what would have been paid using Medicare payment principles.

The office will estimate Medicare payments using the Medicare Ambulatory Payment Classification (APC) for hospitals under 42 CFR 419. The upper payment limit test will use Medicare payment rates and policies in effect for the period of the upper payment limit test. Hospitals will be categorized by their organizational type under 42 CFR 447.321, including privately owned and operated, non-state government owned or operated, and state owned or operated facilities. In computing estimated Medicare payments, the office will include estimated Medicare payments for allowable bad debt under 42 CFR 413.80. Estimated Medicare payments for outpatient graduate medical education will not be considered under the outpatient upper payment limit test.

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Supplemental Payments to Privately-owned Hospitals

I. General

A Privately-owned Hospital means an acute care hospital that is (i) licensed under IC 16-21, and (ii) Privately-owned and operated in accordance with 42 CFR 447.272(a)(3) and 42 CFR 447.321(a)(3). In addition to regular claims payments and any other payment adjustments to which they are entitled, each hospital that is a Privately-owned Hospital may receive an additional outpatient Medicaid supplemental amount for each state fiscal year ending after June 30, 2003, which shall not exceed the outpatient upper payment limit in accordance 42 CFR 447.321.

II. Outpatient Supplemental Payment Pool

The office will calculate an Outpatient Supplemental Payment Pool for each state fiscal year ending after June 30, 2003. This Outpatient Supplemental Payment Pool will include the outpatient Medicaid supplemental amount, which is an amount equal to the difference between the aggregate of actual Medicaid payments made to all Privately-owned Hospitals for Medicaid outpatient hospital services (excluding Medicaid disproportionate share payments made pursuant to IC 12-15-16, 12-15-17, and 12-15-19), and the office's reasonable estimate of the amount that would have been paid for those services using Medicare payment principles, subject to limits imposed by 42 CFR 447.321. The Outpatient Supplemental Payment Pool will be equal to the amount of the outpatient Medicaid supplemental amount.

III. Payment Methodology

For each state fiscal year ending after June 30, 2003, the Outpatient Supplemental Payment Pool will be established and distributed to Privately-owned Hospitals in the following manner:

(1) An amount equal to the lesser of (i) the amount of the Supplemental Payment Pool; or (ii) five million dollars ($5,000, 000), will be paid to a Privately-owned Hospital that has in excess of seventy thousand (70,000) Medicaid inpatient days.

(2) Following the payment under (1) above, if there is an amount remaining in the Outpatient Supplemental Payment Pool after the payment under (1) above has been made, that remaining amount will be paid to all Privately-owned Hospitals on a pro rata basis based upon the number of each Privately-owned Hospital's Medicaid inpatient days. For purposes of this Section III (2) the non-federal share of such payments will not exceed the amount transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b).Privately-owned Hospitals with larger numbers of Medicaid inpatient days will receive a higher amount of the amount remaining in the Outpatient Supplemental Payment Pool than Privately-Owned Hospitals having smaller numbers of Medicaid inpatient days. The amount of a payment shall be determined and distributed after the end of each state fiscal year.

(3) In the event the entirety of the aggregate Outpatient Supplemental Payment Pool is not distributed after the payments indicated in (1) and (2) above have been made, the remaining amount will be paid on a pro rata basis to any Privately-owned Hospital that enters into an agreement with the office for such payment, based on each Privately-owned Hospital's Medicaid weighted inpatient days. For Children's hospitals (as identified by the office), weighted Medicaid inpatient days will be calculated by taking Medicaid days and multiplying them by 120%, consistent with the Medicaid DRG add-on. In addition, all hospitals' Medicaid days (including Children's hospitals) will be weighted further by their Medicaid Case Mix. The amount(s) of a Privately-owned Hospital's payment(s) under this clause (3) will not exceed the amount of the remaining Outpatient Supplemental Payment Pool..

Adjustments

Notwithstanding III (2) above, the office may enter into an agreement with any Privately-owned Hospital whereby the Privately-owned Hospital waives payments described in III (2) above or accepts a lesser or greater amount than provided in III (2) above, subject to the hospital's payment limitations as described in 42 CFR 447.321. However, the office may not enter into an agreement with a Privately-owned Hospital if, in doing so, another Privately-owned Hospital that is not a party to the agreement or that has not otherwise consented to the office's agreement will receive an amount less than what the hospital would have otherwise received under the formula set forth in III (2).

MEDICAID HOSPITAL REIMBURSEMENT ADD-ON PAYMENT METHODOLOGY TO COMPENSATE HOSPITALS THAT DELIVER HOSPITAL CARE FOR THE INDIGENT PROGRAM SERVICE

In order to be eligible for and to receive a payment under the Indiana Hospital Care for the Indigent Care (HCI) program, a hospital must (1) be enrolled in and be providing services to patients enrolled in the Indiana Medicaid program during the state fiscal year for which payment is being made; and (2) have an audited cost report from the most recent common state fiscal year for which audited cost reports are on file with the office for all potentially eligible hospitals on June 30 of a preceding state fiscal year, unless extenuating circumstances exist. Hospitals that are no longer accepting Medicaid and HCI patients shall not receive payment under this section. Reimbursement under this program will be in the form of Medicaid add-on payments. The Medicaid add-on payments will provide additional reimbursement to eligible hospitals for the Medicaid-covered hospital services the hospitals provide to Medicaid enrollees. The amount and availability of the add-on payments will be limited by the upper payment limit imposed under 42 C.F.R. §§ 447.321, the amount of services rendered to Medicaid and HCI patients, and the rates for outpatient hospital services as stated in Attachment 4.19-B, Page 2 of this state plan. The add-on payments will be calculated and paid using the formula set forth below.

An eligible hospital for HCI purposes is defined as an acute care hospital licensed under Indiana Code 16-21, as defined and interpreted in the disproportionate share payment section of the Indiana Medicaid state plan amendment, and as defined and interpreted under the prior Medicaid HCI add-on payment methodology.

PAYMENT FORMULA

In accordance with I.C. 12-15-15-9.6, for each state fiscal year beginning July 1, 2003 and thereafter, the total Medicaid HCI add-on payments to hospitals for a state fiscal year shall not exceed an amount equal to all amounts transferred from the hospital care for the indigent fund to the Medicaid indigent care trust fund, including amounts attributable to each county's *ad valorem* HCI property tax levy, for a state fiscal year. A Medicaid add-on payment due to an eligible hospital must be based on a formula that provides additional Medicaid reimbursement for outpatient hospital services the hospital provides to Medicaid enrollees. The amount and availability of a Medicaid add-on payment for a hospital will be limited by the upper payment limits imposed under 42 CFR § 447.321. Variations in the amount of Medicaid add-on payments paid to eligible hospitals will be based upon the amount of outpatient hospital services an eligible hospital provides to Medicaid enrollees, the hospital's HCI patient case-load, and the amount of funds, including a county's *ad valorem* HCI property tax levy, transferred to the state hospital care for the indigent fund by each county to which one or more of the eligible hospital's HCI claims are attributed.

STEP 1: For each eligible hospital, the Office of Medicaid Policy and Planning ("office") shall identify the outpatient hospital services the hospital provided to Medicaid enrollees during the state fiscal year.

STEP 2: For each eligible hospital, the office shall calculate the amount of Medicaid reimbursement paid to the hospital for covered outpatient hospital services the hospital provided to Medicaid enrollees identified in STEP 1.

STEP 3: For each eligible hospital, the office shall calculate an amount equal to the amount calculated under STEP 3F of the following formula:

STEP 3A: Identify:

(1) Each eligible hospital that provided necessary emergency medical care during the state fiscal year to an individual who qualifies under IC 12-16-3.5 et seq. and the rules promulgated thereunder, and;

(2) the county of residence of the individual or, if the individual was not a resident of Indiana or the individual's Indiana county of residence cannot be ascertained, the county where the onset of the medical condition that necessitated the individual's emergency medical care occurred.

STEP 3B: For each county identified in (2) of STEP 3A, identify:

(1) each eligible hospital that provided care described in (1) of STEP 3A attributed to the county during the state fiscal year; and

(2) the total amount (using the office's fee for service reimbursement rates) of all eligible hospital episodes of care described in (1) of STEP 3A attributed to the county during the state fiscal year.

STEP 3C: For each county identified in (2) of STEP 3A, identify the amount of the county's HCI funds, including its HCI *ad valorem* property taxes, transferred from the hospital care for the indigent fund to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b).

STEP 3D: For each eligible hospital identified in (1) of STEP 3A, with respect to each county identified in (2) of STEP 3A, calculate the hospital's percentage share of the county's HCI funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b). Each hospital's percentage share is based on the total amount (using the office's fee for service reimbursement rates) of the hospital's care described in (1) of STEP 3A attributed to the county during the state fiscal year, calculated as a percentage of the total amount (using the office's fee for service reimbursement rates) of all hospital care described in (1) of STEP 3A attributed to the county during the state fiscal year.

STEP 3E: For each hospital identified in (1) of STEP 3A, with respect to each county identified in (2) of STEP 3A, multiply the hospital's percentage share calculated under STEP 3D by the amount of the county's HCI funds transferred from the hospital care for the indigent fund to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b).

STEP 3F: Determine the sum of all amounts calculated under STEP 3E for each eligible hospital identified in (1) of STEP 3A with respect to each county identified in (2) of STEP 3A.

STEP 4: Subject to STEP 5 and STEP 6, the office shall pay to each eligible hospital a Medicaid add-on payment equal to the amount calculated for the hospital under STEP 3F and, in doing so, shall allocate the amount of the payment to each of the Medicaid covered hospital services identified for the hospital under STEP 1.

STEP 5: The office's allocation of a payment described in STEP 4 for a hospital's Medicaid-covered outpatient service shall be limited to an amount not to exceed either (1) the amount that, when combined with the amount of reimbursement previously paid for the service as calculated under STEP 2, does not exceed the upper payment limit for outpatient hospital services under 42 C.F.R. § 447.321; or (2) the amount attributable to the hospital's outpatient hospital services identified in STEP 1 that are rendered to an individual described in STEP 3(A)(1).

STEP 6: For any eligible hospital: (1) which receives a payment under STEP 4 that is less than the total amount (using the office's fee for service reimbursement rates) of the hospital's care in (1) of STEP 3A above during the state fiscal year; and (2) which could receive additional reimbursement for the services identified for the hospital under STEP 1 above without exceeding any applicable upper payment limits under 42 CFR § 447.321, the office shall calculate an amount equal to the amount calculated for the hospital under STEP 6H below:

STEP 6A: Identify each county whose transfer of HCI funds to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) for the state fiscal year was less than the total amount (using the office's fee for service reimbursement rates) of all hospital care identified in (1) in STEP 3A above attributed to the county during the state fiscal year.

STEP 6B: For each county identified in STEP 6A, calculate the difference between the amount of HCI funds of the county transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) and the total amount (using the office's fee for service reimbursement rates) of all hospital care identified in (1) of STEP 3A above attributed to the county during the state fiscal year.

STEP 6C: Calculate the sum of the amounts calculated for the counties under STEP 6(B).

STEP 6D: Identify each hospital: (1) which receives a payment under STEP 4 above that is less than the total amount (using the office's fee for service reimbursement rates) of the hospital's care in (1) of STEP 3A above during the state fiscal year; and (2) which could receive additional reimbursement for the services identified for the hospital under STEP 1 above without exceeding any applicable upper payment limit under 42 CFR § 447.321.

STEP 6E: Calculate for each hospital identified in STEP 6D the difference between the hospital's payment under STEP 4 above and the total amount (using the office's fee for service reimbursement rates) of the hospital's care in (1) of STEP 3A above during the state fiscal year.

STEP 6F: Calculate the sum of the amounts calculated for each of the hospitals under STEP 6E.

STEP 6G: For each hospital identified in STEP 6D, calculate the hospital's percentage share of the amount calculated under STEP 6F. Each hospital's percentage share is based on the amount calculated for the hospital under STEP 6E calculated as a percentage of the sum calculated under STEP 6F.

STEP 6H: For each hospital identified in STEP 6D, multiply the hospital's percentage share calculated under STEP 6G by the sum calculated under STEP 6C.

STEP 7: Subject to STEP 8, the office shall pay to each eligible hospital identified in STEP 6 a Medicaid add-on payment equal to the amount calculated for the hospital under STEP 6H and, in doing so, shall allocate the amount of the payment to each of the hospital services identified for the hospital under STEP 1.

STEP 8: The office's allocation of a payment described in STEP 7 for a hospital's Medicaid-covered outpatient service shall be limited to an amount that, when combined with the amount of reimbursement previously paid for the service as calculated under STEP 2 and STEP 4, does not exceed either (1) the amount of the upper payment limit for outpatient hospital services under 42 C.F.R. § 447.321; or (2) the amount attributable to the hospital's outpatient hospital services identified in STEP 1 that are rendered to an individual described in STEP 3(A)(1).

Total non-federal share of payments to hospitals under this program for each state fiscal year may not exceed the amount equal to the product calculated when the amount transferred to the Medicaid indigent care trust fund by counties is multiplied by the state Medicaid medical assistance percentage for the state fiscal year for which the payments are made.

In the event there are insufficient state matching funds to pay each hospital the amounts calculated, the amount paid to each hospital will be reduced proportionate to the amount of the deficiency of funds. Payments shall be made prior to December 15 that next succeeds the end of the state fiscal year.

EFFECTIVE DATE Subject to approval by CMS, these payments are to be effective on July 1, 2003.

RURAL HEALTH CLINIC SERVICES

Effective for services provided prior to January 1, 2001, and pursuant to 42 CFR 447.371, Indiana Medicaid will reimburse rural health clinic services in the following manner:

a. The rural health clinic services including independent health clinics as defined in Section 440.20 (b), will be reimbursed at the reasonable cost rate per visit determined by the designated regional Medicare contractor. Each certified clinic will directly provide the contractor with the required cost data as needed to determine the all-inclusive rate for the particular clinic at the beginning of the report period.

b. Rural health clinics referred to as provider clinics, which are an integral and subordinate part of a hospital, skilled nursing facility, or home health agency will be reimbursed by the same rate setting method used for the parent facility.

Payments made according to a cost reimbursement rate per visit will be subject to reconciliation after the close of the reporting period, in accordance with 42 CFR 405.2427. Indiana will use the final rate determined by the intermediary based on actual cost and visits for the reporting period.

c. The "other ambulatory services," as described by 42 CFR 440.20 (c), are those services Indiana will reimburse in addition to "rural health clinic services." Examples are: transportation, durable medical equipment, prosthetic devices, eye glasses, prescribed drugs, physical therapy and related services, optometric services, chiropractic services, podiatry services, dental services (including those services rendered in conjunction with the EPSDT Program), and others listed in the State Plan and covered by the Indiana Medicaid Program in other settings.

Indiana Medicaid will reimburse for such services according to its customary method of payment. The rate for these services will be determined on a fee for service basis as in other settings under the State Plan, but will not exceed the upper limits as required by 42 CFR 447. If other reimbursement options become available at a later date, Indiana Medicaid reserves the right to re-evaluate and change its present method.

Effective January 1, 2001, in accordance with Section 702(b)(aa)(3) of BIPA of 2000, Indiana Medicaid will provide for payment for services provided by Rural Health Clinics in an amount (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the center or clinic of furnishing all covered RHC services and those ambulatory services previously paid on a fee-for-service basis during the provider's fiscal years 1999 and 2000. The rate per visit from each applicable cost report year will be inflated and averaged using the MEI. The per visit rate will take into account applicable limits that are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness as the Secretary prescribes in regulations under section 1833(a)(3), or, in the case of services to which such regulations do not apply, the same methodology used under section 1833(a)(3), adjusted to take

into account any increase or decrease in the scope of such services furnished by the center or clinic during the provider's fiscal year 2000, and increased by the percentage increase in the most current quarterly historical MEI (as defined in section 1842(I)(3)) applicable to primary care services (as defined in section 1842(I)(4)) for that fiscal year. This Prospective Payment System rate will be increased annually beginning January 1, 2002 by the percentage increase in the MEI and adjusted to take into account any increase or decrease in the scope of such services furnished by the RHC.

Until 1999 and 2000 cost reports are finalized and received by the office, Indiana Medicaid will provide for payment using an interim prospective payment rate to Rural Health Clinics in the following manner:

> The interim PPS rate will be established from rates paid during years 1999 and 2000. These amounts will be indexed (inflated) for MEI for each year and then a simple average of these two inflated amounts will be the rate paid.

In compliance with Section 702(b)(aa)(6)(B), a reconciliation back to January 1, 2001 will be performed to reconcile the interim PPS rate to the final PPS rate.

The establishment of an initial year rate for new providers certified after January 1, 2001, shall be determined in accordance with Section 702(b)(aa)(4) of BIPA 2000, taking into consideration geographic location, Medicaid utilization and similarity of services. In the absence of comparable data, the new clinic may be required to submit historical data in order to arrive at an initial rate. The rates for the fiscal years following the initial year will be determined as described in the paragraph above. Rural Health Clinics will receive supplemental payments under the APM for all COVID vaccine administration services. The payment to Rural Health Clinics for standalone COVID-19 vaccine-only visits will be equivalent to the Medicare COVID-19 vaccine administration rate. Rural Health Clinics will receive their provider-specific PPS rate plus the Medicare COVID-19 vaccine administration rate when a COVID-19 vaccine is administered as part of a billable encounter visit. Effective November 1, 2022, long-acting reversible contraception (LARC) will be reimbursed according to the Medicaid professional fee schedule. All rates are published on the agency's website at www.in.gov/medicaid/.

The office will provide for a supplemental payment for Rural Health Clinics furnishing services pursuant to a contract between the clinic and a managed care entity (as defined in section 1932(a)(1)(B)), in accordance with Section 702(b)(aa)(5), effective for services provided on or after January 1, 2001. The supplemental payments will be calculated based on the provider's base rate, as adjusted for MEI and any change in the scope of service, multiplied by the number of valid RHC encounters, deducting any payments made by the managed care entity for those encounters. Supplemental payments will be made no less frequently than every four months. The provider is responsible for submitting the managed care claims to the office or its contractor for calculation of the supplemental payment.

> Field audits may be conducted annually on a selected number of Rural Health Clinics.

HOSPICE SERVICES

I. Levels of Care

a. Reimbursement for Medicaid hospice care services are made in accordance with the rates published by CMS annually. Medicaid hospice reimbursement rates are based on Medicare reimbursement rates and methodologies, adjusted to disregard offsets attributable to Medicare coinsurance amounts. The rates will be adjusted for regional differences in wages using the hospice wage index published by CMS.

b. With the exception of payment for physician services Medicaid reimbursement for hospice services will be made at one of six (6) predetermined rates for each day in which a Medicaid **member** is under the care of the hospice provider. The reimbursement amounts are determined within each of the following categories:

(1) Routine home care- Days 1-60.
(2) Routine home care- Days over 60.
(3) Continuous home care.
(4) Inpatient respite care.
(5) General inpatient hospice care.
(6) Service Intensity Add-On

c. **Service Intensity Add-On (SIA):**
Effective for hospice services with dates of service on or after January 1, 2016, a service intensity add-on payment will be made for a visit by a social worker or a registered nurse (RN), when provided during routine home care provided in the last 7 days of a Medicaid member's life. The SIA payment is in addition to the routine home care rate. The SIA Medicaid reimbursement will be equal to the Continuous Home Care hourly payment rate (as calculated annually by CMS), multiplied by the amount of direct patient care hours provided by an RN or social worker for up to four (4) hours total that occurred on the day of service, and adjusted by the appropriate hospice wage index published by CMS. The following conditions must be met to qualify for the SIA payment:
(1) The day is a routine home care level of care day,
(2) The day occurs during the last 7 days of life and the Medicaid member is discharged deceased, and
(3) Direct patient care is provided by a Registered Nurse or a Social Worker that day.

d. Routine Home Care. The hospice will be paid at **one of** the routine home care rate for each day the **member** is at home, under the care of the hospice provider, and not receiving continuous home care. **Medicaid reimbursement for routine home care will be made at one (1) of two (2) all-inclusive per diem rates:**

(1) Higher base payment for the first 60 days of hospice care.
(2) Reduced base payment for days 61 and over of hospice care.
(3) A minimum of sixty (60) days gap in hospice services is required to reset the counter which determines which payment category a participant is qualified for.

e. Continuous Home Care. Continuous home care is to be provided only during a period of crisis. A period of crisis is defined as a period in which a patient requires continuous care which is primarily nursing care to achieve palliation and management of acute medical symptoms. Care must be provided by either a registered nurse or a licensed practical nurse and a nurse must provide care for over half the total period of care. A minimum of eight (8) hours of care must be provided during a twenty four (24) hour day which begins and ends at midnight. This care need not be continuous and uninterrupted. The continuous home care rate is divided by twenty four (24) hours in order to arrive at an hourly rate. For every hour or part of an hour of continuous care furnished, the hourly rate will be reimbursed to the hospice provider for up to twenty four (24) hours a day.

f. Inpatient Respite Care. The hospice provider will be paid at the inpatient respite care rate for each day that the **member** is in an approved inpatient facility and is receiving respite care. Respite care is short term inpatient care provided to the **member** when necessary to relieve the family **members** or other persons caring for the **member**. Respite care may be provided only on an occasional basis. Payment for respite care may be made for a maximum of five (5) consecutive days at a time including the date of admission but not counting the date of discharge. Payment for the sixth and any subsequent days is to be made at the routine home care rate. For the day of discharge, the appropriate home care rate, routine or continuous, is paid unless the patient dies as an inpatient.

g. General Inpatient Care. Subject to the limitations below, the hospice provider will be paid at the general inpatient hospice rate for each day the **member** in an approved inpatient hospice facility and is receiving **services related to the terminal illness. The member must require general inpatient care for pain control or acute or chronic symptom management that cannot be managed in other settings. Documentation in the member's record must clearly explain the reason for admission and the member's condition during the stay in the facility at this level of care. No other fixed payment rate (i.e., routine home care) will be made for a day on which the patient receives general hospice inpatient care. Services provided in the inpatient setting must conform to the hospice patient's plan of care. The hospice provider is the professional manager of the patient's care, regardless of the physical setting of that care or the level of care. If the inpatient facility is not also the hospice provider, the hospice provider must have a contract with the inpatient facility delineating the roles of each provider in the plan of care.**

h. Additional amount for Nursing Facility Residents. When hospice care is furnished to an individual residing in a nursing facility, pay the hospice an additional amount on routine home care and continuous home care days to take into account the room and board furnished by the facility. This amount is determined in accordance with the rates established under Section 1902(a)(13) of the Act . The additional amount paid to the hospice on behalf of an individual residing in a nursing facility must equal 95 percent of the per diem rate that you would have paid to the nursing facility for that individual in that facility under your State plan.

i. When routine home care or continuous home care is furnished to a **member** who resides in a nursing facility, the nursing facility is considered the **member's** home.

j. Reimbursement for inpatient respite care is available only for a **member** resides in a private home. Reimbursement for inpatient respite care is not available for a **member** who resides in a nursing facility.

k. Reimbursement for the service intensity add-on (SIA) is available only for routine home care provided in a member's home or in a nursing facility, when a Medicaid member is residing in the nursing facility.

l. When a member is receiving general inpatient or inpatient respite care, the applicable inpatient rate (general or respite) is paid for the date of admission and all subsequent inpatient days, except the day on which the patient is discharged. For the day of discharge, the appropriate home care rate is paid unless the patient dies as an inpatient. In the case where the member is discharged deceased, the applicable inpatient rate (general or respite) is paid for the date of discharge.

II. Limitations on Payments for Inpatient Care

a. Payments to a hospice for inpatient care must be limited according to the number of days of inpatient care furnished to Medicaid **members**. During the twelve (12) month period beginning November 1 of each year and ending October 31 of the next year, the aggregate number of inpatient days (both general inpatient days and inpatient respite care days) for any given hospice provider may not exceed twenty percent (20%) of the total number of days of hospice care provided to all Medicaid **members** during the same period by the designated hospice provider or its contracted agent or agents. For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice provider receives payment at a home care rate will not be counted as inpatient days.

b. The limitations on payment for inpatient days are as follows:
(1) The maximum number of allowable inpatient days will be calculated by multiplying the total number of a provider's Medicaid hospice days by twenty percent (20%).
(2) If the total number of days of inpatient care to Medicaid hospice **members** is less than or equal to the maximum number of inpatient days computed in subdivision (1), then no adjustment is made.
(3) If the total number of days of inpatient care to Medicaid hospice **members** is greater than the maximum number of inpatient days computed in subdivision (1), then the payment limitation will be determined by the following method:
(A) Calculating the ratio of the maximum allowable inpatient days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care that was made.
(B) Multiplying excess inpatient care days by the routine home care rate.
(C) Adding together the amounts calculated in clauses (A) and (B).
(D) Comparing the amount in clause (C) with total reimbursement made to the hospice provider for inpatient care during the cap period. The amount by which total reimbursement made to the hospice provider for inpatient care for Medicaid **members** exceeds the amount calculated in clause (C) is due from the hospice provider.

III. Reimbursement for Physician Services

a. The basic payment rates for hospice care represent full reimbursement to the hospice provider for the costs of all covered services related to the treatment of the **member's** terminal illness, including the administrative and general activities performed by physicians who are employees of or working under arrangements made with the hospice provider. These activities would generally be performed by the physician serving as the medical director and the physician member of the hospice interdisciplinary group. Group activities include participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies. The costs for these services are included in the reimbursement rates for hospice care.

b. Reimbursement for a hospice employed physician's direct patient services that are not rendered by a hospice volunteer is made in accordance with the usual Medicaid reimbursement methodology for physician services. These services will be billed by the hospice provider under the Medicaid hospice provider number. The only physician services to be billed separately from the hospice per diem are direct patient care services. Laboratory and x-ray services relating to the terminal condition are included in the hospice daily rate.

c. Reimbursement for an independent physician's direct patient services that are not rendered by a hospice volunteer is made in accordance with the usual Medicaid reimbursement methodology for physician services. These services will not be billed by the hospice provider under the hospice provider number. The only services to be billed by an attending physician are the physician's personal professional services. Costs for services such as laboratory or x-rays are not to be included on the attending physician's billed charges to Medicaid when those services relate to the terminal condition. These costs are included in the daily rates paid and are expressly the responsibility of the hospice provider.

d. Volunteer physician services are excluded from Medicaid reimbursement. However, a physician who provides volunteer services to a hospice may be reimbursed for non-volunteer services provided to hospice patients. In determining which services are furnished on a volunteer basis and which are not, a physician must treat Medicaid patients on the same basis as other hospice patients. For example, a physician may not designate all physician services rendered to non-Medicaid patients as volunteered and at the same time seek payment for all physician services rendered to Medicaid patients.

HOME HEALTH SERVICES

Home health agencies will be reimbursed for covered services provided to Medicaid members through standard, statewide fee schedule rates, as follows:

(1) one overhead rate per provider visit, per member, per day; plus

(2) the staffing rate multiplied by the number of billing units spent in the performance of billable patient care activities;

to equal the total payment per visit.

Retroactive payment will be required when any of the following occur:

(1) A field audit identifies overpayment by Medicaid.
(2) The provider knowingly receives overpayment of a Medicaid claim from the Office. In this event, the provider must:
    (A) complete appropriate Medicaid billing adjustment forms; and
    (B) reimburse the Office for the amount of the overpayment.

The staffing and overhead billing units for HHA services are as follows:

Home Health Service	Billing unit
Overhead	One unit per provider visit per member per day
Registered Nurse (RN)	Hourly
Licensed Practical Nurse (LPN)	Hourly
Home Health Aide	Hourly
Physical Therapist	15-minute increments
Occupational Therapist	15-minute increments
Speech Pathologist	15-minute increments

Medicaid fee schedule rates effective July 1, 2017 were determined using data from provider cost reports.

All fee schedule rates are available through the agency's website at www.indianamedicaid.com. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of home health care.

HOME HEALTH CARE SERVICES - TELEHEALTH MONITORING

Approved telehealth services are reimbursed separately from other HHA services. The unit of reimbursement for home health telehealth is one calendar day.

(1) The provider may bill a one-time amount of $14.45 per beneficiary for an initial face-to-face visit necessary to train the beneficiary to appropriately operate the telehealth equipment.

(2) The Provider may bill the daily rate of $9.84 for each day the telehealth monitoring equipment is used by a registered nurse (RN) to monitor and manage the client's care in accordance with the written order from a physician.

Rates for telehealth monitoring services shall not be adjusted annually.

All equipment and software cost associated with the telehealth monitoring services must be separately identified on the provider's annual cost report so that it may be removed from the calculation of overhead costs.

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Retroactive payment will be required when any of the following occur:

(1) A field audit identifies overpayment by Medicaid.
(2) The provider knowingly receives overpayment of a Medicaid claim from the Office. In this event, the provider must:
    (A) complete appropriate Medicaid billing adjustment forms; and
    (B) reimburse the Office for the amount of the overpayment.

New rates set on July 1, 2008, shall be:
(1) effective on July 1; and
(2) annually adjusted thereafter based upon the most recently submitted financial and statistical documentation as filed by all providers of services who billed Medicaid for services provided during the cost report period.

All fee schedules are available through the agency's website at www.indianamedicaid.com. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of home health care. The agency's fee schedule rate was set as of July 1, 2017 and is effective for services provided on or after that date.

HOME HEALTH CARE SERVICES – TELEHEALTH MONITORING

Approved telehealth monitoring services are reimbursed separately from other HHA services. The unit of reimbursement for home health telehealth is one calendar day.

(1) The provider may bill a one-time amount of $14.45 per beneficiary for an initial face-to-face visit necessary to train the beneficiary to appropriately operate the telehealth equipment.

(2) The Provider may bill the daily rate of $9.84 for each day the telehealth monitoring equipment is used by a registered nurse (RN) to monitor and manage the client's care in accordance with the written order from a physician.

Rates for telehealth monitoring services shall not be adjusted annually.

All equipment and software cost associated with the telehealth monitoring services must be separately identified on the provider's annual cost report so that it may be removed from the calculation of overhead costs.

Medical Supplies, Equipment, and Appliances Suitable for Use in the Home

Medical Supplies
Reimbursement for medical supplies is equal to the lower of the provider's submitted charges, not to exceed the provider's usual and customary charges, or the Medicaid allowable amount. For medical supplies provided on or after July 1, 2013 through January 31, 2021, the Medicaid allowable amount is the Medicaid fee schedule amount in effect on July 1, 2013. If this amount is not available, the Medicaid allowable shall be determined as follows:

(1) The Indiana Medicare fee schedule amount adjusted by a multiplier of eight-tenths (0.8), if available. If this amount is not available, then
(2) The average acquisition cost of the item adjusted by a multiplier of one and two-tenths (1.2), if available. If this amount is not available, then
(3) The manufacturer's suggested retail price adjusted by a multiplier of seven-and-one-half-tenths (0.75). If this amount is not available, then
(4) The invoice cost of the item adjusted by a multiplier of one and two-tenths (1.2).

For medical supplies provided on or after February 1, 2021 through December 31, 2023, the Medicaid allowable amount is the Medicaid fee schedule amount in effect on January 31, 2021. If this amount is not available, the Medicaid allowable shall be:

(1) The Indiana Medicare fee schedule amount adjusted by a multiplier of eight-tenths (0.8), if available. If this amount is not available, then
(2) The manufacturer's suggested retail price adjusted by a multiplier of seven-and-one-half-tenths (0.75). If this amount is not available, then
(3) The invoice cost of the item adjusted by a multiplier of one and two-tenths (1.2). If this amount is not available, then
(4) The average acquisition cost of the item adjusted by a multiplier of one and two-tenths (1.2).

For medical supplies provided on or after January 1, 2024, the Medicaid rate will be reviewed annually, taking into account the lowest non-zero Indiana Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule amount or competitive bidding single payment amount that takes effect January 1 of the calendar year preceding the Medicaid rate effective date and adjusted as necessary.

For medical supplies Medicare designates as a capped rental item but does not have a Medicare purchase price, the Medicaid allowable amount for the purchase price shall be the lowest non-zero Indiana Medicare rental rate adjusted by a multiplier of ten (10).

For medical supplies without Medicare fee schedule rates, reimbursement rates will be reviewed and adjusted at such time as Medicare-based rates are adjusted, taking into account the level of Medicare fee schedule changes.

For medical supplies without an established fee schedule rate, the Medicaid allowable amount shall be:

(1) The manufacturer's suggested retail price adjusted by a multiplier of seven-and-one-half-tenths (0.75). If this amount is not available, then
(2) The invoice cost of the item adjusted by a multiplier of one and two-tenths (1.2). If this amount is not available, then

(3) The average acquisition cost of the item adjusted by a multiplier of one and two-tenths (1.2).

For medical supplies provided on or after February 1, 2021 that are subject to Section 1903 (i)(27) of the Social Security Act, the Medicaid allowable shall be the lowest non-zero Indiana Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule amount or competitive bidding single payment amount effective as of January 1 of each year and updated on an annual basis, if available. For medical supplies that are subject to Section 1903 (i)(27) of the Social Security Act and Medicare designates as a capped rental item but does not have a Medicare purchase price, the Medicaid allowable for the purchase price shall be the lowest non-zero Indiana Medicare rental rate adjusted by a multiplier of ten (10).

All reimbursement for medical supplies provided on or after July 1, 2011 thru December 31, 2013 that has been calculated under methods described above shall be reduced by five percent (5%), except for blood glucose monitors, diabetic test strips, items with rates based on acquisition cost, and items with payment based on the manufacturer's suggested retail price.

Except as otherwise noted in the plan, state-developed fee schedule rates for these services are the same for both governmental and private providers. The agency's fee schedule rates are published on the agency's website at www.indianamedicaid.com.

Incontinence Supplies
Reimbursement for incontinence supplies (including diapers, briefs, catheters, trays, tape, gloves and ostomy/colostomy supplies) is based on the contract price established through competitive bidding in accordance with section 1915(a)(I)(B) of the Act and regulations at 42 CFR 431.54(d).

Medical Supplies, Equipment, and Appliances Suitable for Use in the Home

Medical Equipment
Medical equipment (ME) means equipment that can withstand repeated use and includes, but is not limited to, the following items: prosthetics, orthotics, beds, canes, walkers, crutches, wheelchairs, traction equipment, and oxygen and oxygen equipment.

Reimbursement for ME is equal to the lower of the provider's submitted charges, not to exceed the provider's usual and customary charges, or the Medicaid allowable amount. For ME provided on or after July 1, 2013 through January 31, 2021, the Medicaid allowable amount is the Medicaid fee schedule amount in effect on June 30, 2013. If this amount is not available, the Medicaid allowable shall be the amount determined as follows:

(1) The Indiana Medicare fee schedule amount, if available. If this amount is not available, then
(2) The average acquisition cost of the item adjusted by a multiplier of one and two-tenths (1.2), if available. If this amount is not available, then
(3) The manufacturer's suggested retail price adjusted by a multiplier of seven-and-one-half-tenths (0.75). If this amount is not available, then
(4) The invoice cost of the item adjusted by a multiplier of one and two-tenths (1.2).

For ME provided on or after February 1, 2021 through December 31, 2023, the Medicaid allowable amount is the Medicaid fee schedule amount in effect on January 31, 2021. If this amount is not available, the Medicaid allowable shall be:

(1) The Indiana Medicare fee schedule amount, if available. If this amount is not available, then
(2) The manufacturer's suggested retail price adjusted by a multiplier of seven-and-one-half-tenths (0.75). If this amount is not available, then
(3) The invoice cost of the item adjusted by a multiplier of one and two-tenths (1.2). If this amount is not available, then
(4) The average acquisition cost of the item adjusted by a multiplier of one and two-tenths (1.2).

For ME provided on or after January 1, 2024, the Medicaid rate will be reviewed annually, taking into account the lowest non-zero Indiana Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule amount or competitive bidding single payment amount that takes effect January 1 of the calendar year preceding the Medicaid rate effective date and adjusted as necessary.

For ME that Medicare designates as a capped rental item but does not have a Medicare purchase price, the Medicaid allowable for the purchase price shall be:

(1) The lowest non-zero Indiana Medicare rental rate divided by one-and-one-half-tenths (0.15) for power wheelchairs, or
(2) The lowest non-zero Indiana Medicare rental rate adjusted by a multiplier of ten (10) for all other capped rental ME.

For ME without Medicare fee schedule rates, reimbursement rates will be reviewed and adjusted at such time as Medicare-based rates are adjusted, taking into account the level of Medicare fee schedule changes.

For ME without an established fee schedule rate, the Medicaid allowable amount shall be:

(1) The manufacturer's suggested retail price adjusted by a multiplier of seven-and-one-half-tenths (0.75). If this amount is not available, then
(2) The invoice cost of the item adjusted by a multiplier of one and two-tenths (1.2). If this amount is not available, then
(3) The average acquisition cost of the item adjusted by a multiplier of one and two-tenths (1.2).

For ME provided on or after February 1, 2021 that is subject to Section 1903 (i)(27) of the Social Security Act, the Medicaid allowable shall be the lowest non-zero Indiana Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule amount or competitive bidding single payment amount effective as of January 1 of each year and updated on an annual basis, if available. For ME that is subject to Section 1903 (i)(27) of the Social Security Act and Medicare designates as a capped rental item but does not have a Medicare purchase price, the Medicaid allowable for the purchase price shall be:

(1) The lowest non-zero Indiana Medicare rental rate divided by one-and-one-half-tenths (0.15) for power wheelchairs, or
(2) The lowest non-zero Indiana Medicare rental rate adjusted by a multiplier of ten (10) for all other capped rental ME.

Reimbursement for hearing aids is equal to the lower of the provider's submitted charges, not to exceed the provider's usual and customary charges, or the Medicaid allowable amount. For hearing aids provided on or after July 1, 2011 through December 31, 2023, the Medicaid allowable amount is the Medicaid fee schedule amount in effect on June 30, 2011. For hearing aids provided on or after January 1, 2024, the Medicaid rate will be reviewed and adjusted at such time as Medicare-based rates for ME are adjusted, taking into account the level of Medicare fee schedule changes. For hearing aids without a fee schedule rate, the Medicaid allowable shall be the amount determined as follows:

(1) The average acquisition cost of the item adjusted by a multiplier of one and two-tenths (1.2), if available. If this amount is not available, then
(2) The manufacturer's suggested retail price adjusted by a multiplier of seven-and-one-half-tenths (.75).

Reimbursement rates for binaural hearing aids will be twice the monaural rate.

Reimbursement of a hearing aid dispensing fee is available. The dispensing fee is a one-time dispensing fee. The dispensing fee may be billed only in conjunction with a hearing aid procedure code that has an established fee schedule amount. The dispensing fee includes all services related to the initial fitting and adjustment of the hearing aid, orientation of the patient, and instructions on hearing aid use. The dispensing fee reimbursement rate is effective for hearing aids dispensed on or after July 1, 2011.

All reimbursement for ME and hearing aids provided on or after July 1, 2011 thru December 31, 2013, that has been calculated under methods described above shall be reduced by five percent (5%), except for blood glucose monitors, ME and hearing aids with rates based on acquisition cost, items with payment based on the manufacturer's suggested retail price, and the hearing aid dispensing fee.

Except as otherwise noted in the plan, state-developed fee schedule rates for these services are the same for both governmental and private providers. The agency's fee schedule rates are published on the agency's website at https://www.in.gov/medicaid/

FEDERALLY QUALIFIED HEALTH CENTERS

Effective for services provided prior to January 1, 2001, and in accordance with Section 6404 of the Omnibus Budget Reconciliation Act of 1989, Indiana Medicaid will pay 100 percent of the costs that are reasonable and related to the cost of furnishing Federally Qualified Health Center (FQHC) services and will meet the requirements of Section 6303 of the *State Medicaid Manual* regarding payment for FQHC services.

Indiana reimburses FQHC services at interim reimbursement rates established by the agency, subject to a retrospective cost settlement process. Interim payment will be based upon and cover the reasonable costs of providing services to Medicaid beneficiaries. Such costs are not to exceed the reasonable costs as determined by the applicable Medicare cost reimbursement principles set forth in 42 CFR Part 413.

Effective January 1, 2001, in accordance with Section 702(b)(aa)(6) of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, Indiana Medicaid will provide for payment under an alternative payment methodology to FQHCs for services described in section 1905(a)(2)(C). The alternative payment methodology is 100 percent of the costs that are reasonable and related to the cost of furnishing FQHC services, meeting the requirements of Section 6303 of the *State Medicaid Manual*, the *FQHC Cost Reporting Guidelines for Indiana Medicaid* manual (February 7, 2000) regarding payment for FQHC services, and all applicable reimbursement policies in effect on December 31, 2000.

Effective January 1, 2002, in accordance with Section 702(b)(aa)(3) of BIPA, Indiana Medicaid will provide for payment for services provided by FQHCs in an amount (calculated on a per visit basis) that is equal to 100 percent of the average of the costs to the center or clinic for furnishing all Medicaid covered services during fiscal years 1999 and 2000. The rate per visit from each

rate will take into account productions screens and applicable limits, (based on the provider's fiscal years ending 1999 and 2000) which are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness as the Secretary prescribes in regulations under section 1833(a)(3), or, in the case of services to which such regulations do not apply, the same methodology used under section 1833(a)(3), adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during the provider's fiscal year 2001, and increased by the percentage increase in the most current quarterly historical MEI (as defined in section 1842(I)(3)) applicable to primary care services (as defined in section 1842(i)(4)) for that fiscal year. This Prospective Payment System rate will be increased annually beginning January 1, 2002 by the percentage increase in the MEI and adjusted to take into account any increase or decrease in the scope of such services furnished by the FQHC.

In the event a final settlement has not been reached on the provider's 1999 and 2000 FQHC cost reports by December 31, 2001, the alternative methodology may be extended for a period of not more than 180 days. If cost reports have not been finalized after a period of not more than 180 days, an interim prospective payment system rate equal to the most recent rate on file will be used to reimburse FQHC services until such time that the cost reports are final. This interim PPS rate will be adjusted annually beginning January 1, 2003 by the MEI.

In conformance with Section 702(b)(aa)(6)(B) of BIPA, a reconciliation will be performed to ensure that each center or clinic received reimbursement for such services in an amount that is at least equal to the amount that would have been paid under the Prospective Payment System described in Section 702(b)(aa) of BIPA.

The establishment of an initial year rate for new providers certified after January 1, 2001, shall be determined in accordance with Section 702(b)(aa)(4) of BIPA 2000, taking into consideration geographic location, Medicaid utilization and similarity of services. In the absence of comparable data, the new clinic may be required to submit historical cost data in order to arrive at an initial rate. The rates for the fiscal years following the initial year will be determined as described above. Federally Qualified Health Centers will receive supplemental payments under the APM for all COVID vaccine administration services. The payment to FQHCs for standalone COVID-19 vaccine-only visits will be equivalent to the Medicare COVID-19 vaccine administration rate. FQHCs will receive their provider-specific PPS rate plus the Medicare COVID-19 vaccine administration rate when a COVID-19 vaccine is administered as part of a billable encounter visit. Effective November 1, 2022, long-acting reversible contraception (LARC) will be reimbursed according to the Medicaid professional fee schedule. All rates are published on the agency's website at www.in.gov/medicaid/.
The office will provide for a supplemental payment for FQHCs furnishing services pursuant to a contract between the clinic and a managed care entity (as defined in section 1932(a)(1)(B)), in accordance with Section 702(b)(aa)(5), effective for services provided on or after January 1, 2002. The supplemental payments will be calculated based on the provider's base rate, as adjusted for MEI and any change in scope of service, multiplied by the number of valid FQHC encounters, deducting any payments made by the managed care entity for those encounters. Supplemental payments will be made no less frequently than every four months. The provider is responsible for submitting the managed care claims to the Office or its contractor for calculation of the supplemental payment.

Field audits may be conducted annually on a selected number of Federally Qualified Health Centers.

In accordance with Section 1902(bb)(6) of the Social Security Act, as amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, Indiana Medicaid will provide for payment under an alternative payment methodology to Federally Qualified Health Centers (FQHCs) for the integration of primary and behavioral health care services, and for the achievement of performance measures, effective for FQHC fiscal years which include dates of service occurring July 1, 2009 and after. To qualify for the alternative payment methodology, the FQHC must implement a care plan that fully integrates primary and behavioral health care services at the FQHC. The FQHCs primary and behavioral health integration plan must be approved by the Office of Medicaid Policy and Planning (the Office) and the Department of Mental Health and Addiction (DMHA). The integration plan must incorporate the following characteristics:

- Incorporation of screening and evaluation processes to identify targeted patient population
- Establishment of appropriate levels of behavioral health staffing
- Physical integration of the provision of primary and behavioral health care together at the same FQHC location
- Performance of medical and behavioral health care services by the staff of the FQHC
- Provision of behavioral health services limited to patients 18 years of age and older
- Full integration of medical records, billing, and other data relating to primary and behavioral health care services
- Ongoing monitoring of the integration plan through data collection and evaluation

The Office and DMHA will develop performance measures to monitor the effectiveness of the integration plan. Performance measures will address the extent to which operational goals are met and will be based on the following objectives:

1. Increase the proportion of the adults screened in a primary care setting for identification of behavioral health needs;
2. For adults found in need of behavioral health services, increase the proportion of individuals assessed for level and type of service needs using a standardized assessment process in the primary care setting;
3. For adults needing a low to moderate level of behavioral health services, increase the numbers that receive these services in primary care settings;
4. For adults receiving behavioral health services in a primary care setting, demonstrate improved clinical outcomes following treatment.

Performance measures will be established based on an FQHC's specific integration plan, its experience related to each of the above objectives, and its capacity to provide behavioral health services.

Reimbursement under the alternative payment methodology will consist of two components:

1. An adjustment to the FQHC's Prospective Payment System (PPS) rate
2. Performance incentive payments limited to an established annual amount for each participating FQHC

The rate adjustment will be determined by the Office as an add-on to the FQHC's existing PPS rate of no more than the budgeted cost per encounter for delivery of the new services based on an approved integration plan and budget. After the adjusted PPS rate is set, it will be updated in the same manner as the PPS rates for other FQHCs.

Performance incentive payments will be available up to a maximum amount established for each FQHC based on the FQHC's integration plan, utilization data, and the extent to which the integration plan addresses the State's goals. The maximum amount of performance payments that may be distributed annually to each FQHC with an approved integration plan will be established by the Office prior to implementation of the plan. The maximum annual amount available for an FQHC's performance payments will not exceed 8.5% of the provider's gross cost for Medicaid as reported on their most recent Medicaid cost report on file with the Office as of the date the alternative payment methodology (APM) agreement between OMPP and the FQHC is approved. Once established, the maximum annual performance payment amount for an FQHC will remain constant for the duration of the approved integration plan. Actual performance payments will be tied to the FQHC's achievement of the objectives as determined through specific measures established by the Office and DMHA, and agreed to by the FQHC. Performance payments will be paid no more often than quarterly.

The Office and the FQHC must agree in writing to the alternative payment methodology. The alternative payment methodology must provide payment in an amount which is at least equal to reimbursement under the Indiana Medicaid Prospective Payment System (PPS) for FQHCs.

The Office will provide for a supplemental payment for FQHCs furnishing services pursuant to a contract between the clinic and a managed care entity. The supplemental payments will be calculated based on the provider's rate determined under the alternative payment methodology, as adjusted for inflation using the Medicare Economic Index (MEI) and any change in the scope of service, multiplied by the number of valid FQHC encounters, deducting any payments made by the managed care entity for those encounters. Supplemental payments will be made no less frequently than every four (4) months. The provider is responsible for submitting the managed care claims to the Office or its contractor for calculation of the supplemental payment.

Reimbursement to nursing facilities for residents who elect to receive Hospice Care:

An additional per diem amount will be paid directly to the hospice provider for room and board of hospice residents receiving routine or continuous care services in a certified nursing facility. In this context, the term "room and board" includes all assistance in the activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervision and assisting in the use of durable medical equipment and prescribed therapies.

The room and board rate will be ninety-five percent (95%) of the lowest per diem reimbursement rate Indiana Medicaid would have paid to the nursing facility for any resident for those dates of service on which the recipient was a resident of that facility.

Medicaid payment to the nursing facility for nursing facility care for the hospice resident is discontinued when the resident makes an election to receive hospice care. Any payment to the nursing facility for furnishing room and board to hospice patients is made by the hospice provider under the terms of its agreement with the nursing facility.

The additional amount for room and board is not available for recipients receiving inpatient respite care or general inpatient care.

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Targeted Case Management

7. Targeted case management (TCM) for individuals who, through a blood lead screening conducted in accordance with the EPSDT periodicity schedule, are found with a confirmed elevated blood lead level as defined by the Centers for Disease Control and Prevention (CDC)

Reimbursement Methodology:

Rate(s):
The rate for reimbursement of lead case management services is a fee-for-service rate. The statewide rate was derived by using the average cost of salary, fringe benefits, for employed and contracted registered nurse and social worker case managers. The cost rate of 8% includes the indirect costs and transportation.

Unit Definition:
A unit of service is equivalent to fifteen (15) minutes. Minutes of service provided to a specific individual can be accrued over one calendar day. The number of units that may be billed during a day is equivalent to the total number of minutes of Targeted Case Management provided during the day for a specific individual divided by fifteen minutes plus one additional unit if the remaining number of minutes is eight or greater.

Claims Payment Process:
Providers will submit claims to the Local Health Departments (LHD). The LHD will submit claims, via the Medicaid Management Information System (MMIS) claims processing system, for adjudication. Providers of TCM may not bill more than 26, 15-minute units per recipient, per rolling twelve (12) month period of time. If additional units of TCM are medically necessary, the provider must submit a prior authorization request for additional units of service.

The State developed fee schedule rates are the same for both governmental and private providers of targeted case management services. The State developed fee schedule rate for environmental lead investigations is effective for services provided on or after June 18, 2009. All rates are published on *www.indianamedicaid.com.*

Transportation

Payment will be based upon the lower of the provider's submitted charge or the fee schedule rate established by the State for the service billed. Base rate is defined as the allowed payment amount for a one-way trip, not including mileage. Mileage payments are made for loaded miles, defined as the number of miles the Medicaid member is transported in the vehicle. Reimbursement for covered transportation services will be as follows:

Non-emergency Ground Transportation:

A non-emergency medical transportation (NEMT) broker is reimbursed a monthly capitated payment for each Indiana Medicaid FPS member.

Meals and Lodging: Meals and lodging reimbursement is based on the rate established by the Indiana State Legislature paid to Indiana state employees for travel-related expenses.

For dates of service on or after January 1, 2024, the office shall pay for the transportation services not covered by the emergency transportation section below at the lower of:

1. The provider's submitted charge; or

2. The allowable amount for that procedure code in the Indiana Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is equal to the Medicare urban rate for Indiana, if available, that takes effect January 1 of the calendar year preceding the Medicaid rate effective date.

3. If the Medicare urban rate for Indiana is not available, the allowable amount is equal to the Indiana Medicaid Practitioner Fee Schedule rate in effect for that date of service, adjusted for inflation as determined by the office.

Emergency Transportation:

Medicaid pays for emergency medical transportation services at the lower of:

1. The provider's submitted charge; or

2. The allowable amount for that procedure code in the Indiana Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is calculated based upon a survey of billed charges statewide utilization data.

For dates of service on or after July 1, 2023, Medicaid pays for emergency medical transportation services at the lower of:

1. The provider's submitted charge; or

2. The allowable amount for that procedure code in the Indiana Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is equal to the Medicare urban rate for Indiana as of each January 1, if available.

For dates of service on or after January 1, 2024, Medicaid pays for emergency medical transportation services at the lower of:

1. The provider's submitted charge; or

2. The allowable amount for that procedure code in the Indiana Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is equal to the Medicare urban rate for Indiana, if available, that takes effect January 1 of the calendar year preceding the Medicaid rate effective date.

3. If the Medicare urban rate for Indiana is not available, the allowable amount is equal to the Indiana Medicaid Practitioner Fee Schedule rate in effect for that date of service, adjusted for inflation as determined by the office. For procedure code A0225, the allowable amount is equal to the Indiana Medicaid Practitioner Fee Schedule rate for procedure code A0427.

Payments for Government Ambulance Transportation Services

Qualified in-state government ambulance transportation service providers are reimbursed for the actual incurred costs of providing ambulance services to eligible Medicaid beneficiaries. Each provider must certify its expenditures as eligible for federal financial participation in order to settle to actual incurred costs for Medicaid ambulance transportation services. The CMS approved Medicaid cost report form 2552-10 or the non-hospital government ambulance cost report form is due from ambulance providers five months after the end of the provider's fiscal year. An initial settlement will be processed within eighteen months of receiving an approved cost report. A final settlement will be processed within twenty-four months of receiving the approved cost report. The payments will be paid to each provider in an amount based on the provider's reconciled costs for providing ambulance transportation services to Medicaid recipients, less amounts already paid to the provider for ambulance transportation services under the state plan. Reconciled costs will be calculated using CMS-approved cost reporting methods approved by the office. Government providers are required to comply with cost allocation principles found in OMB Circular A-87. In instances where cost allocation principles in OMB A-87 conflict with CMS 15-1, government providers must always use the OMB A-87 principles. For purposes of these payments, effective for services provided on or after January 1, 2011, costs shall be calculated as follows:

A. For hospital-based governmental ambulance transportation providers, costs will be calculated using the most recent hospital cost report on file with the office. Hospital-based provider cost reports must be submitted to the office no later than the last day of the fifth month following the provider's fiscal year end.

B. For non-hospital-based governmental ambulance transportation providers, costs will be calculated using the most recent CMS-approved cost report on file with the office. Non-hospital-based governmental transportation providers will submit the Indiana Medicaid Freestanding Governmental Ambulance Provider Cost Report that is prepared in accordance with a cost reporting methodology developed by the office that complies with OMB Circular A-87 and utilizes the Federal Transit Administration (FTA) Uniform System of Accounts, or other accounting system determined to be appropriate by the office. Cost reports must also comply with Medicare reasonable cost principles. Non-hospital-based provider cost reports must be submitted to the office no later than the last day of the fifth month following the provider's fiscal year end.

Payments will be the amounts calculated under Step Four of the following formula:

Step One: Determine the amount of each provider's charges and Medicaid reimbursement for claims incurred during the provider's fiscal year and adjudicated to a paid status through the MMIS.

Step Two: Determine the amount of each provider's reconciled costs for the provider's fiscal year for providing ambulance transportation services for Medicaid eligible persons. Cost for the provider's fiscal year will be calculated by multiplying the provider's charges identified in Step One by the cost-to-charge ratio from the cost report on file with the office corresponding to the fiscal year under consideration.

Step Three: Subtract the Medicaid reimbursement amount determined in Step One from the cost calculated in Step Two. If Medicaid reimbursement exceeds cost calculated in Step Two, an overpayment has been made. The office will recover the overpayment in compliance with the requirements of section 1903(d)(2) of the Social Security Act.

Step Four: If the amount calculated in Step Three is greater than zero, the provider will receive a payment equal to the amount calculated in Step Three multiplied by the Federal Medical Assistance Percentage (FMAP) rate for Indiana in effect at the time of the payment.

Community Mental Health Rehabilitation Services

Payment will be based upon the lower of the provider's submitted charge or the OMPP maximum allowance for the procedure billed. Maximum allowances are established by the Department of Mental Health based upon a review of like charges by similar providers throughout the State. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Community Mental Health Rehabilitation Services. The agency's fee schedule rate was set as of 7-1-2010 and is effective for services provided on or after that date. All rates are published on the agency's website at www.indianamedicaid.com.

Item 9D. Rehabilitation

1. Psychosocial Rehabilitation Services

Psychosocial rehabilitation services in a clubhouse setting provided on or after August 15, 2016 shall be reimbursed according to this section.

Payment for psychosocial rehabilitation services will be based on a blended payment rate that includes the Medicaid covered services that are components of psychosocial rehabilitation. The Medicaid covered psychosocial rehabilitation service components are: Individual Skills Training and Development and Group Skills Training and Development.

The psychosocial rehabilitation services blended payment rate is based on established individual Medicaid rehabilitation payment rates for the Medicaid covered service components, weighted to reflect utilization of these services in the psychosocial rehabilitation model. The rate does not include costs related to room and board or other unallowable facility costs.

The state will review the rate annually and rebase as necessary to assure the rates are economic and efficient. Providers will maintain data relating to the provision of covered psychosocial rehabilitation services, including the date of service, beneficiary information, and the nature and volume of services. Utilization information comprised of these data elements was used in the development of the rate and will be used by the state in the periodic review of the rate. The state will monitor the provision of covered psychosocial rehabilitation services under the blended rate to ensure that beneficiaries receive the quantity and intensity of services required to meet their psychosocial rehabilitative needs.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of psychosocial rehabilitation services. The agency's rates, as of August 15, 2016, are published at the State's website, www.indianamedicaid.com.

Item 9D. Rehabilitation

2. Opioid Treatment Services

Opioid treatment services provided by an Opioid Treatment Program (OTP) on or after July 1, 2023 shall be reimbursed according to this section.

Payment for opioid treatment services will be based on 100% of Medicare payment rates. Services considered opioid treatment services are: U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medication, the dispensing and administration of MAT medications, toxicology testing, individual and group therapy, intake activities, and periodic assessments.

Payment for these services is to be reimbursed via an applicable weekly reimbursement bundle utilized by Medicare or may be separately reimbursable when not all service components of the weekly bundle have been administered. Additionally, other services not defined as OTP services may be reimbursable by an opioid treatment program provider if deemed appropriate by the Office of Medicaid Policy and Planning (OMPP).

The state will review the rate annually and rebase as necessary to assure the rate is economic and efficient and in accordance with Medicare payment. Providers will maintain data relating to the provision of covered opioid treatment services, including the date of service, beneficiary information, and the nature and volume of services. The state will monitor the provision of covered opioid treatment services to ensure that beneficiaries receive the quantity and intensity of services required to meet their opioid treatment service needs.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of opioid treatment services.

Item 13D. Rehabilitation

Intensive Outpatient Treatment (IOT)

Payment for IOT will be based on blended payment rates that are for the Medicaid covered services found on Addendum 3.1-A Item 13.d Rehabilitative Services for Intensive Outpatient Treatment (IOT). The Medicaid covered service components are:

- Individual/Family Therapy; Group Therapy;
- Skills Training;
- Medication Training and Support;
- Peer Recovery Services; and
- Care Coordination

IOT blended payment rates are based on established individual Medicaid payment rates for the Medicaid covered service components, adjusted to reflect utilization of these services in the IOT model. The rates do not include costs related to room and board or other unallowable facility costs.

The state will periodically monitor the actual provision of IOT services paid under a blended rate to ensure that the beneficiaries receive the types, quantity, and intensity of services required to meet their medical needs and to ensure that the rates remain economic and efficient based on the services that are actually provided as part of the blended rate.

Effective for dates of service on or after January 1, 2024, rates will be reviewed and adjusted at such time as Medicare-based rates are adjusted, taking into account the level of Medicare fee schedule changes.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of IOT services. The agency's rates are published at the State's website, in.gov/Medicaid.

DISPROPORTIONATE SHARE HOSPITAL PAYMENTS
OUTPATIENT HOSPITAL SERVICES

I. AUTHORITY

In compliance with Section 1902 (a)(13)(A) of the Act, and specifically the mandates of section 4112 (OBRA 1987), P.L. 100-203, the Indiana Medicaid program adopts the following definitions and methodologies to identify and make payments to hospitals to take into account the situation of such providers which serve a disproportionate number of low-income patients with special needs.

II. DEFINITIONS

(A) "Acute Care Hospital" has the following meaning: "Any institution, place, building, or agency represented and held out to the general public as ready, willing, and able to furnish care, accommodations, facilities, and equipment, for the use, in connection with the services of a physician, of persons who may be suffering from deformity, injury, or disease, or from any other condition, from which medical or surgical services would be appropriate for care, diagnosis, or treatment." The term does not include a state mental health institution or a private psychiatric institution, nor does it include convalescent homes, boarding homes, homes for the aged or freestanding health facilities licensed for long term care such as nursing facilities.

(B) "State Mental Health Institution" has the following meaning: "A state-owned or state-operated institution for the observation, care, treatment, or detention of an individual; and under the administrative control of the department of mental health." This group of providers is commonly referred to as state hospitals.

(C) "Private Psychiatric Institution" has the following meaning: "An acute care inpatient facility, properly licensed for the treatment of persons with mental illness." This group of providers is commonly referred to as private psychiatric hospitals.

(D) "Disproportionate Share Hospital" has the following meaning: An Acute Care Hospital, State Mental Health Institution, or Private Psychiatric Institution:

(1) whose Medicaid Inpatient Utilization Rate is at least one standard deviation above the Statewide Mean Medicaid Inpatient Utilization Rate for such provider hospitals receiving Medicaid payments in Indiana; or

(2) whose low income utilization rate exceeds twenty-five percent (25%); and

(i) has at least two (2) obstetricians with staff privileges, who have agreed to provide obstetric services to individuals entitled to such services under the Indiana Medicaid state plan. For a hospital located in a rural area (as defined in Section 1886 of the Social Security Act), the term obstetrician includes a physician with staff privileges at the hospital to perform nonemergency obstetric procedures. Provision (i) does not apply to a hospital the inpatients of which are predominately individuals under 18 years of age; or which did not offer nonemergency obstetric services as of December 21, 1987.

(E) "Significant Disproportionate Share Hospital" has the following meaning: An Acute Care Hospital, State Mental Health Institution or Private Psychiatric Institution which meets all criteria outlined in (D)(2) above.

(F) "Medicaid Inpatient Utilization Rate" for a provider, has the following meaning: A fraction (expressed as a percentage) for which:

(1) the numerator is the provider's total Medicaid inpatient days and hospital care for the indigent program inpatient days in a cost reporting period; and

(2) the denominator is the total number of the provider's inpatient days in that same cost reporting period.

where inpatient days includes days provided by an acute care subprovider of the provider and also includes inpatient days attributable to Medicaid beneficiaries from other states.

(G) "Statewide Mean Medicaid Inpatient Utilization Rate" has the following meaning: A fraction (expressed as a percentage) for which:

(1) the numerator is the total of all Medicaid enrolled hospital providers' Medicaid Inpatient Utilization Rates in a cost reporting period; and

(2) the denominator is the total number of all such Medicaid enrolled provider hospitals.

In calculating the Statewide Mean Medicaid Inpatient Utilization Rate, the Medicaid agency shall not include the Medicaid Inpatient Utilization Rates of providers who are determined to be Significant Disproportionate Share Hospitals and who are receiving significant disproportionate share payments.

(H) A provider's "Low Income Utilization Rate" is the sum of:

(1) a fraction (expressed as a percentage) for which:

(A) the numerator is the sum of the following for a cost reporting period:

(i) the total Medicaid inpatient revenues paid to the provider; plus

(ii) the amount of the cash subsidies received directly from state and local governments, including payments made under the hospital care for the indigent program; and

(B) the denominator is the total amount of the provider's revenues for inpatient services (including cash subsidies) in the same cost reporting period; and

(2) a fraction (expressed as a percentage) for which:

(A) the numerator is the total amount of the provider's charges for inpatient services that are attributable to care provided to indiviuals who have no source of payment or third party or personal resources in a cost reporting period; and

(B) the denominator is the total amount of charges for inpatient services in the same cost reporting period.

The numerator in clause (2)(A) shall not include contractual allowances and discounts other than for indigent patients not eligible for medical assistance under an approved Medicaid state plan.

III. PAYMENT ADJUSTMENTS

A. Outpatient Disproportionate Share Adjustment

Disproportionate Share Hospitals that are operating as Acute Care Hospitals shall receive, in addition to their allowable regular claims payments and any other payment adjustments to which they are entitled, a disproportionate share payment adjustment for outpatient services calculated against the regular outpatient claims payments equal to:

> The provider's Medicaid inpatient utilization rate less one (1) standard deviation from the Statewide Mean Medicaid Inpatient Utilization Rate, times ninety five percent (95%) plus two and one-half percent (2.5%).

Disproportionate share payment adjustments for outpatient services shall only be made from revenues contained in the Medicaid Indigent Care Trust Fund.

B. Outpatient Significant Disproportionate Share Adjustment

Significant Disproportionate Share Hospitals that are operating as Acute Care Hospitals shall receive, in addition to their allowable regular claims payments and any other payment adjustment to which they are entitled, a disproportionate share payment adjustment for outpatient services calculated against the regular outpatient claims payment equal to:

> The provider's Medicaid inpatient utilization rate less one (1) standard deviation from the Statewide Mean Medicaid Inpatient Utilization Rate, times ninety five percent (95%) plus two and one-half percent (2.5%), plus
>
> The percentage add-on specified for significant disproportionate share providers at 42 U.S.C. 1385ww(d) (5) (F) (iii) which for the period 7-1-90 through 9-30-91 is 30% and for the period 10-1-91 forward until the next legislated change, is 35%.

Significant Disproportionate Share Payment adjustments for outpatient services shall only be made from revenues contained in the Medicaid Indigent Care Trust Fund.

IV. OUTPATIENT DISPROPORTIONATE SHARE PAYMENT ADJUSTMENT EXAMPLES

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Example 1--Hospital qualifies as a regular disproportionate share hospital

Facts------Hospital's Medicaid inpatient utilization rate = 28%

One Standard Deviation from the Statewide Mean Medicaid Inpatient Utilization rate = 15%

Disproportionate Share Payment formula "The provider's Medicaid inpatient utilization rate less one standard deviation from the Statewide Mean Medicaid Inpatient Utilization Rate, times 95% plus 2.5%"

Medicaid inpatient claim reimbursement $1000.00

Solution--------28% minus 15% = 13.00%
13% times .95 = 12.35%
12.35% plus 2.5% = 14.85%
14.85% times $1000 = **$148.50 disp. share payment**

****

Example 2--Same hospital qualifies additionally as a significantly disproportionate share hospital

Facts------Same as those in example 1 (add the following)

Date of inpatient claim 10-10-91

Inpatient Significant Disproportionate Share adjustment percentage is 35%

Solution---35.00% times $1000 = **$350.00 sig. disp. share payment**
from example 1 above **$148.50 disp. share payment**
$498.50 total disp. share payment

****

V. EFFECTIVE DATE

Subject to approval by HCFA, these payment adjustments are to be effective for services provided on or after July 1, 1991. All appropriate assurances required by federal regulations are being submitted with this Medicaid state plan amendment.

Rule 19 Ownership and Control Disclosures

405 IAC 1-19-1 Information to be disclosed

Sec. 1. (a) In accordance with and in addition to 42 CFR 455, Subpart B and 42 CFR 1002, Subpart A, as amended, the following disclosure requirements apply to all providers of Medicaid services and shall be disclosed in accordance with this rule:

(1) The name and address of each person with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of five percent (5%) or more.

(2) Whether any of the persons named, in compliance with subdivision (1), is related to another as spouse, parent, child, or sibling.

(3) The name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest. This requirement applies to the extent that the disclosing entity can obtain this information by requesting it in writing from the person. The disclosing entity must:
   (A) keep copies of all these requests and the responses to them;
   (B) make them available to the office upon request; and
   (C) advise the office when there is no response to a request.

(4) The name, address, and Social Security number of any agent or managing employee.

(b) Any document or agreement, stipulating ownership interests or rights, duties, and liabilities of the entity or its members, required to be filed with the secretary of state, whether it be a single filing or a periodic filing, shall also be filed with the office or its fiscal agent. In the case of a partnership, the partnership agreement, if any, and any amendments thereto, shall be filed with the office immediately upon creation or alteration of the partnership.

(c) long term care facility provider shall comply with notification requirements set forth in 405 IAC 1-20 for change of ownership.

(d) the office may suspend payment to an existing provider or reject a prospective provider's application for participation if the provider fails to disclose ownership or control information as required by this rule and 405 IAC 1-14.6-5.

405 IAC 1-19-2 Time and manner of disclosure

Sec. 2. (a) Any disclosing entity that is a long term care facility must supply the information specified in this rule to the Indiana state department of health at the time it is surveyed.

(b) Any disclosing entity that is not a long term care facility must supply the information specified in this rule to the office or its fiscal agent at any time there is a change in ownership or control.

(c) Any new provider must supply the information specified in this rule at the time of filing a complete application.

(d) Providers are required to notify the office upon such time as the information specified in this rule changes within forty-five (45) days of the effective date of change in such form as the office shall prescribe. Long term care providers involved in a change of ownership shall provide notification in accordance with 405 IAC 1-20. New nursing facility providers are required to notify the office in accordance with this rule and 405 IAC 1-14.6-5.

Diagnostic Services

Environmental Lead Investigations

Reimbursement is provided for a one-time, on-site environmental lead investigation of a child's home or primary residence for a child with elevated blood lead level. This environmental lead investigation will be provided by a licensed risk assessor or licensed lead inspector, certified by a local health department. These services must be provided through coordination with the local health department (LHD).

Medicaid fees paid by other states and providers' costs (when available) will be considered when establishing a rate. ***Except as otherwise noted in the plan, the State developed fee schedule rates are the same for both governmental and private contracted providers of lead investigation services. The State developed fee schedule rate for environmental lead investigations is effective for services provided on or after June 18, 2009. All rates are published on www.indianamedicaid.com.***

Limitations on reimbursement:

Medicaid reimbursement for an environmental lead investigation ***is available for a licensed risk assessor's or inspector's time and activities performed during the one-time on-site investigation of the poisoned child's home or primary residence. The reimbursement rate includes the time associated with collection of specimens and associated paperwork. Medicaid reimbursement is not available for the testing of environmental substances such as water, paint, or soil which are sent to a laboratory for analysis.***

Initial Comprehensive Environmental Lead Investigation may include the following:

(A) Visual assessment of the probable contaminated site,
(B) Interview of the occupants,
(C) Dust examination,
(D) On-site X-ray fluorescence (XRF) analysis of lead paint content, and
(E) Collection of soil sample.

All Environmental Lead Investigations include the following:

Assessment of lead hazards from any structural source by a licensed risk assessor or inspector to include:

(A) A complete assessment including recommendations to mitigate identified lead hazards.

(B) A written report to the family and the owner if the family does not own the site of contamination.

Identification of lead hazards from any nonstructural sources by licensed risk assessors or inspector to include:

(A) Identification and evaluation of nonstructural exposure sources within the individual's environment.

(B) Presentation of the environmental investigation results, including recommendations for reducing or eliminating exposure.

A written report must be provided to the family, owner of the contaminated site, and Local Health Department.

Methods and Standards for Establishing Payment Rates

1. Services Provided Under Section 1915(i) of the Social Security Act. For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates*):

☑	HCBS Case Management – Care Coordination
	Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private agency providers of Adult Day Services. The agency's fee schedule rate effective on October 1, 2018, is for services provided on or after that date. All rates are published on the agency's website at www.indianamedicaid.com.
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☑	HCBS Adult Day Health
	Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private agency providers of Adult Day Services. The agency's fee schedule rate effective on October 1, 2018, is for services provided on or after that date. All rates are published on the agency's website at www.indianamedicaid.com.
☑	HCBS Habilitation
	Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private agency providers of Habilitation and Support. The agency's fee schedule rate effective on October 1, 2018, is for services provided on or after that date. All rates are published on the agency's website at www.indianamedicaid.com. Home and Community Based (HCB) Habilitation and Support – Individual Setting HCB Habilitation and Support – Family/Couple with the Recipient Present (Individual Setting) HCB Habilitation and Support – Family/Couple without the Recipient Present (Individual Setting) HCB Habilitation and Support – Group Setting HCB Habilitation and Support – Family/Couple with Recipient Present (Group Setting) HCB Habilitation and Support – Family/Couple without Recipient Present (Group Setting)
☑	HCBS Respite Care
	Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of Respite Care. The agency's fee schedule rate effective on October 1, 2018, is for services provided on or after that date. All rates are published on the agency's website at www.indianamedicaid.com.
For Individuals with Chronic Mental Illness, the following services:	

	☐	HCBS Day Treatment or Other Partial Hospitalization Services

	☐	HCBS Psychosocial Rehabilitation
	☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
☑	Other Services (specify below)	
	Therapy and Behavioral Support Services Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private agency providers of Therapy and Behavioral Support Services. The agency's fee schedule rate effective on October 1, 2018, is for services provided on or after that date. All rates are published on the agency's website at www.indianamedicaid.com. Therapy and Behavioral Support Services – Individual Setting Therapy and Behavioral Support Services – Family/Couple with Recipient Present (Individual Setting) Therapy and Behavioral Support Services – Family/Couple without Recipient Present (Individual Setting) Therapy and Behavioral Support Services – Group Setting Therapy and Behavioral Support Services – Family/Couple with Recipient Present (Group Setting) Therapy and Behavioral Support Services – Family/Couple without Recipient Present (Group Setting)	
	Addiction Counseling Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private agency providers of Addiction Counseling. The agency's fee schedule effective on October 1, 2018, is for services provided on or after that date. All rates are published on the agency's website at www.indianamedicaid.com. Addiction Counseling – Individual Setting Addiction Counseling – Family/Couple with Recipient Present (Individual Setting) Addiction Counseling – Family/Couple without Recipient Present (Individual Setting) Addiction Counseling – Group Setting Addiction Counseling – Family/Couple with Recipient Present (Group Setting) Addiction Counseling – Family/Couple without Recipient Present (Group Setting)	

	Supported Community Engagement Services Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private agency providers of Supported Community Engagement Services. The agency's fee schedule rate effective on October 1, 2018, is for services provided on or after that date. All rates are published on the agency's website at www.indianamedicaid.com.

	Medication Training and Support Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private agency providers of Medication Training and Support. The agency's fee schedule effective on October 1, 2018, is for services provided on or after that date. All rates are published on the agency's website at www.indianamedicaid.com. Medication Training and Support – Individual Setting Medication Training and Support – Family/Couple with Recipient Present (Individual Setting) Medication Training and Support – Family/Couple without Recipient Present (Individual Setting) Medication Training and Support – Group Medication Training and Support – Family/Couple with Recipient Present (Group Setting) Medication Training and Support – Family/Couple without Recipient Present (Group Setting)

Methods and Standards for Establishing Payment Rates

1. Services Provided Under Section 1915(i) of the Social Security Act. For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates*):

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
☑	HCBS Habilitation
	The Habilitation payment rate is a prospective fee-schedule rate that is based on cost and market data. The rate is comprised of cost data obtained from providers, including labor costs (salaries and fringe benefits), non-labor costs, and administrative overhead costs. The agency's fee schedule for Habilitation service was set using the same methodology that was previously applied to Habilitation service in the former 1915(c) Psychiatric Residential Treatment Facilities (PRTF) Transition Waiver. The agency's fee schedule rate will be set as of July 1, 2018, and will be effective for services provided on or after that date. Rates are published on the agency's website at www.indianamedicaid.com.

☑

	HCBS Respite Care
	The respite care payment rates are prospective fee schedule rates that are based on cost and market data. The rates are comprised of cost data obtained from providers, including labor costs (salaries and fringe benefits), non-labor costs, and administrative overhead costs. Productivity adjustments were applied to determine the total cost per billable unit of service. A cost of living adjustment was included in the rates to adjust costs from the cost period to the rate period. Labor cost was benchmarked to market data from the U.S. Department of Labor, Bureau of Labor Statistics, and labor and BLS data were averaged if the BLS data exceed the labor cost data by a predetermined threshold. Per CMS guidance, the rate will be reviewed at least every five years and adjusted as necessary to assure the rate is economic and efficient. The agency's fee schedule rates will be set as of July 1, 2018 and will be effective for services provided on or after that date. The rates will be published at the State's website, www.indianamedicaid.com. Respite care service has three (3) units of service as the basis for the fee schedule rates: 1) Respite care provided for less than ten (10) hours per day is based on a 15-minute unit of service.

	2) Respite care provided for ten (10) to twenty-four (24) hours per day is based on a daily unit of service. 3) Crisis respite care provided for eight (8) to twenty-four (24) hours per day is based on a daily unit of service.
For Individuals with Chronic Mental Illness, the following services:	
☐	HCBS Day Treatment or Other Partial Hospitalization Services
☐	HCBS Psychosocial Rehabilitation
☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
☑	Other Services (specify below)
	Wraparound Facilitation: The wraparound facilitation payment rate is a prospective fee schedule rate that is based on cost and market data. The rate is comprised of cost data obtained from providers, including labor costs (salaries and fringe benefits), non-labor costs, and administrative overhead costs. Productivity adjustments were applied to determine the total cost per billable unit of service. A cost of living adjustment was included in the rate to adjust costs from the cost period to the rate period. Labor cost was benchmarked to market data from the U.S. Department of Labor, Bureau of Labor Statistics, and labor and BLS data were averaged if the BLS data exceed the reported labor data by a predetermined threshold. Per CMS guidance, the rate will be reviewed at least every 5 years and adjusted as necessary to assure the rate is economic and efficient. The agency's fee schedule rate will be set as of July 1, 2018 and will be effective for services provided on or after that date. The rate will be published at the State's website, www.indianamedicaid.com. The unit of service for wraparound facilitation is a monthly unit.
	Training and Support for Unpaid Caregivers: The Training and Support for Unpaid Caregivers payment rates are prospective fee-schedule rates that are based on cost and market data. The rates are comprised of cost data obtained from providers, including labor costs (salaries and fringe benefits), non-labor costs, and administrative overhead costs. The agency's fee schedule for Training and Support for Unpaid Caregivers service was set using the same methodology that was previously applied to Training and Support for Unpaid Caregivers service in the former 1915(c) Psychiatric Residential Treatment Facilities (PRTF) Transition Waiver. The agency's fee schedule rate will be set as of July 1, 2018, and will be effective for services provided on or after that date. Rates are published on the agency's website at www.indianamedicaid.com.

☐	Other HCBS (*Specify*):
For Individuals with Chronic Mental Illness, the following services:	
☐	HCBS Day Treatment or Other Partial Hospitalization Services
☐	HCBS Psychosocial Rehabilitation
☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)

1915(i)State plan Home and Community-Based Services

Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section of the Soclal Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates):*

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
☒	HCBS Habilitation
	The agency's fee schedule for CMHW Habilitation service was set using the same methodology that applies to Habilitation service in the CMS approved 1915(c) Psychiatric Residential Treatment Facilities (PRTF) Transition Waiver, CMS Control Number IN.03.R02.00. Rates are published on the agency's website at www.indianamedicaid.com
☒	HCBS Respite Care
	The agency's fee schedule for CMHW Respite Care service was set using the same methodology that applies to Respite Care service in the CMS approved 1915(c) Psychiatric Residential Treatment Facilities (PRTF) Transition Waiver, CMS Control Number IN.03.R02.00. Rates are published on the agency's website at www.indianamedicaid.com
☒	Other HCBS (*Specify*): Wraparound facilitation
	To calculate the monthly Wraparound Facilitation CMHW case rate, the State analyzed the recent monthly utilization for both Wraparound Facilitation and Wraparound Technician services provided in the Community Alternative to Psychiatric Residential Treatment Facilities (CA-PRTF) Demonstration Grant (CMS Control Number IN.03.R01.05). The average utilization was multiplied by the CA-PRTF unit cost for Wraparound Facilitation ($28.75 per 15-minute unit). The final monthly rate was reduced by 10% to reflect efficiencies associated with reduced documentation requirements due to completing monthly documentation versus daily/per contact documentation. Rates are published on the agency's website at www.indianamedicaid.com
☒	Other HCBS (*Specify*): Training and Support for Unpaid Caregivers
	The agency's fee schedule for CMHW Training and Support For Unpaid Caregivers service was set using the same methodology that applies to Training and Support For Unpaid Caregivers service in the CMS approved 1915(c) Psychiatric Residential Treatment Facilities (PRTF) Transition Waiver, CMS Control Number IN.03.R02.00. Rates are published on the agency's website at www.indianamedicaid.com
☒	Other HCBS (*Specify*): Transportation
	Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private agency providers of CMHW Transportation. The agency's fee schedule rate effective on July 1, 2023, is for services provided on or after that date. All rates are published on the agency's website at www.indianamedicaid.com.

	☐	HCBS Psychosocial Rehabilitation
	☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)

Methods and Standards for Establishing Payment Rates

1. Services Provided Under Section 1915(i) of the Social Security Act. For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates*):

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
☐	HCBS Habilitation
☐	HCBS Respite Care

For Individuals with Chronic Mental Illness, the following services:

	☐	HCBS Day Treatment or Other Partial Hospitalization Services
	☐	HCBS Psychosocial Rehabilitation
	☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)

☑	Other Services (specify below)
	Behavioral & Primary Healthcare Coordination (BPHC) – Tier 1 Providers (Licensed professionals, qualified behavioral health professionals & other behavioral health Professionals as defined in Attachment 3.1i Person-Centered Planning & Service Delivery.) Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private agency providers of BPHC. The agency's fee schedule rate effective on June 1, 2019 is for services provided on or after that date. All rates are published on the agency's website at www.indianamedicaid.com.
	Behavioral & Primary Healthcare Coordination (BPHC) – Tier 2 Providers (Certified Recovery Specialists & Integrated Health Technicians as defined Attachment 3.1i Services- Behavioral and Primary Healthcare Coordination.) Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private agency providers of BPHC. The agency's fee schedule rate effective on June 1, 2019, is for services provided on or after that date. All rates are published on the agency's website at www.indianamedicaid.com.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Indiana

METHODS AND STANDARD FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State Plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State Plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP."

   For specific Medicare services that are not otherwise covered by this State Plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in item 1 of this attachment (see 3. below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below and designated with the letters "MR."

3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in item 1 of this attachment, for those groups and payments listed below and designated with the letter "NR."

4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in item 1 of this attachment (see 3. above).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Indiana

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

QMBs:	Part A	NR	Deductibles	NR	Coinsurance
	Part B	NR	Deductibles	NR	Coinsurance
Other Medicaid Recipients	Part A	NR	Deductibles	NR	Coinsurance
	Part B	NR	Deductibles	NR	Coinsurance
Dual Eligible (QMB Plus)	Part A	NR	Deductibles	NR	Coinsurance
	Part B	NR	Deductibles	NR	Coinsurance

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Indiana

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

1. Cross-over claims filed by Medicaid providers are reimbursed as set out in this section.

   If the Medicare payment amount for a claim exceeds or equals the Medicaid allowable amount for that claim, Medicaid reimbursement will be zero.

   If the Medicaid allowable amount for a claim exceeds the Medicare payment amount for that claim, Medicaid reimbursement is the lesser of:

   (a) the difference between the Medicaid allowable amount minus the Medicare payment amount; or
   (b) the Medicare coinsurance and deductible, if any, for the claim.

For purposes of cross-over reimbursement, a claim is the same as an ICN (Individual Claim Number) which is the payment requested on one paper document or electronic record for services provided during a particular date range for which there are one or more revenue or HCPCs codes.

405 IAC 5-13-6

Sec. 6. (a) Medicaid reimbursement is available for reserving beds in an ICF/MR for Medicaid recipients, at one-half (1/2) the regular per diem rate, when one (1) of the following conditions is present:

(1) Hospitalization must be ordered by the physician for treatment of an acute condition that cannot be treated in the facility. The total length of time allowed for payment of a reserved bed for a single hospital stay shall be fifteen (15) days. If the recipient requires hospitalization longer than the fifteen (15) consecutive days, the recipient must be discharge from the facility. If the recipient is discharged from the ICF/MR following a hospitalization in excess of fifteen (15) consecutive days, the ICF/MR is still responsible for appropriate discharge planning if the ICF/MR does not intend to provide ongoing services following the hospitalization for those individuals who continue to require ICF/MR level of services. A physician's order for hospitalization must be maintained in the recipient's file at the facility. Upon discharge from the hospital, the individual J.H retains readmission rights to the ICF/MR.

(2) A leave of absence must be for therapeutic reasons, as prescribed by the attending physician and as indicated in the recipient's habilitation plan. The total length of time allotted for therapeutic leaves in any calendar year shall be sixty (60) days per recipient residing in an ICF/MR. The leave days need not be consecutive. If the recipient is absent for more than sixty (60) days per year, no further Medicaid reimbursement shall be available for reserving a bed for that recipient in that year. A physician's order for the therapeutic leave must be maintained in the recipient's file at the facility.

(b) Although prior authorization is not required to reserve a bed, a physician's order for the hospitalization or leave must be maintained in the recipient's file at the ICF/MR to obtain reimbursement at the reserved rate.

(c) If readmission is required, guidelines should be followed as outlined in admission procedures in section 7 and 8 of this rule.

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Payment for Reservation of Beds (continued)

In a Psychiatric Hospital:

Medicaid reimbursement is available for reserving beds in a psychiatric hospital (and not in a general acute care hospital) for Medicaid recipients at one-half the regular per diem rate under the following criteria set out in 405 IAC 1-6-9(m):

(1) Hospitalization is ordered by the physician for treatment of an acute condition that cannot be treated in the facility.
(2) The total length of time allowed for payment of a reserved bed for a single hospital stay is fifteen days. If the recipient requires hospitalization longer than fifteen consecutive days, the recipient must be discharged from the facility.
(3) A physician's order for the hospitalization must be maintained in the recipient's file at the facility.

For Hospice Recipients who reside in nursing facilities

405 IAC 5-34-12 is amended to read as follows:

Sec. 12. (a) Although it is not mandatory for providers to reserve beds, Medicaid will reimburse for reserving nursing facility beds for hospice recipients at one-half (1/2) the room and board payment provided that the criteria as set out in this SECTION are met.

(b) Hospitalization must be ordered by the hospice physician for treatment of an acute condition that cannot be treated in the nursing facility by the hospice provider. The maximum length of time allowed for payment of a reserved bed for a single hospital stay is fifteen (15) days.

(c) A leave of absence must be for therapeutic reasons, as prescribed by the hospice attending physician and as indicated in the hospice recipient's plan of care. The maximum length of time allotted for therapeutic leave in any calendar year is limited to eighteen (18) days, which need not be consecutive.

(d) Although prior authorization by the office is not required to reserve a bed, the hospice recipient's physician's order for the hospitalization or therapeutic leave must be on file in the nursing facility.

(e) In no instance will Medicaid reimburse a nursing facility for reserving nursing facility beds for hospice Medicaid recipients when the nursing facility has an occupancy rate of less than ninety percent (90%). For purposes of this rule, the occupancy rate shall be determined by dividing the total number of residents in licensed beds, excluding residential beds, in the nursing facility taken from the midnight census as of the day that a Medicaid hospice recipient takes a leave of absence, by the total number of licensed nursing facility beds, excluding residential beds.

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

Nursing Facility Reimbursement

405 IAC 1-14.7-1 Policy; Scope

Sec. 1. (a) This rule sets forth payment procedures for services rendered to members who are covered by the Indiana Health Coverage Program (IHCP) by nursing facilities. All payments referred to within this rule are contingent upon the following:

(1) Proper and current certification.

(2) Compliance with applicable state and federal statutes and regulations.

(b) The system of payment outlined in this rule is a prospective system. Cost limitations are contained in this rule and in the Indiana Medicaid Provider Reimbursement Manual (IMPRM) that establish parameters regarding the allowability of ordinary patient-related costs and define reasonable nursing facility allowable costs.

(c) Any action that results in recoupment, assessed penalty, or retrospective payment may be addressed through a retroactive reprocessing of claims or settlement process.

405 IAC 1-14.7-2 Definitions

Sec. 2. (a) The definitions in this section apply throughout this rule.

(b) "Administrative component" means the portion of the Medicaid rate that shall reimburse providers for allowable administrative services and supplies, including prorated employee benefits based on salaries and wages.

(1) Allowable administrative services and supplies are costs that are patient-related that are necessary for the operation of the nursing facility, but generally cannot be directly tied to a specific member. See the IMPRM for further details and examples of administrative services and supplies.

(2) All nursing facilities shall have their administrative component determined under this criteria and in a uniform manner in accordance with IC 12-15-14-1 per Section 6 of this rule.

(c) "Allowable per patient day cost" means the following:

(1) Legacy System - means a ratio between allowable variable cost and patient days using each provider's actual occupancy from the most recently completed desk reviewed or field audited cost report, plus a ratio between allowable fixed costs and patient days using the greater of:

(A) the minimum occupancy requirements; or

(B) each provider's actual occupancy rate from the most recently completed desk reviewed or field audited cost report.

(2) Prospective System - means a ratio between allowable cost and patient days using each provider’s actual occupancy from the most recently completed desk review or field audited cost report using the greater of:

(A) the minimum occupancy requirements; or

(B) each provider's actual occupancy rate from the most recently completed desk reviewed or field audited cost report.

(d) “Bed days available” means the number of licensed beds reported during the cost reporting period multiplied by the number of calendar days in the cost reporting period. If the number of licensed beds changed during a reporting period,

(1) the number of licensed beds reported on the cost report as of the calendar day immediately following the cost report period end shall be utilized in the calculation of the rate and the related bed days available,

(2) the provider may request in writing with the cost report submission for the weighted average of the number of beds licensed during the cost report period to be utilized in the calculation of the rate and the related bed days available, or

(3) the provider may request the office to calculate bed days available in accordance with Section 6.

(e) "Bi-annual" means a six (6) month period beginning January 1 and July 1.

(f) “Capital component” means the portion of the Medicaid rate that shall reimburse providers for the use of allowable capital-related items.

(1) Allowable capital-related items are costs that are patient-related that generally relate to a nursing facility’s physical assets and related ownership costs. See the IMPRM for further details and examples of capital-related items.

(2) All nursing facilities shall have their capital component determined under this criteria and in a uniform manner in accordance with IC 12-15-14-1 per Section 6 of this rule.

(g) "Case mix index" or "CMI" means a numerical value score that describes the relative resource use for each resident within the groups of the resident classification system prescribed by the office as described in the MDS and Case Mix Index Supportive Documentation Manual based on an assessment of each resident. The facility CMI shall be based on the resident CMI, calculated on a facility-average, time-weighted basis for the following:

(1) Medicaid residents.

(2) All residents.

(h) "Children's nursing facility" means a nursing facility that, as of January 1, 2009, has:

(1) fifteen percent (15%) or more of its residents who are under the chronological age of twenty-one (21) years; and
(2) received written approval from the office to be designated as a children's nursing facility.

(i) "Cost report" refers to a presentation of financial data, including appropriate supplemental data and accompanying notes, derived from accounting records and intended to communicate the provider's economic resources or obligations at a point in time, or changes therein for a period of time in compliance with the reporting requirements of this rule.

(j) "Delinquent MDS resident assessment" means an assessment that is inactive or expired due to exceeding maximum thresholds set by the office for filing and inclusion in the time-weighted CMI calculation. This determination is made as described for required filing in the MDS and Case Mix Index Supportive Documentation Manual.

(k) Desk review" means a review and application of these regulations to a provider submitted cost report including accompanying notes and supplemental information within the scope as defined by the office.

(l) “Direct care component” means the portion of the Medicaid rate that shall reimburse providers for allowable direct patient care services and supplies, including prorated employee benefits based on salaries and wages.
(1) Allowable direct patient care services and supplies are costs that are patient-related that generally relate to direct hands-on care or related support of the member. See the IMPRM for further details and examples of direct patient care services and supplies.
(2) All nursing facilities shall have their direct care component determined under this criteria and in a uniform manner in accordance with IC 12-15-14-1 per Section 6 of this rule.

(m) “Employee Benefits” means total allowable employee benefits costs from the most recently desk reviewed or field audited cost report excluding owners’ benefits as described in the IMPRM, unless specified otherwise.

(n) "Field audit" means a review and application of these regulations to a provider submitted cost report including accompanying notes and supplemental information within the scope as defined by the office.

(o) "Fixed costs" means the portion of each rate component that shall be subjected to the minimum occupancy requirements.

(p) "Forms prescribed by the office" means either of the following:
(1) Cost Report forms provided by the office.
(2) Substitute forms that have received prior written approval by the office.

(q) "Generally accepted accounting principles" or "GAAP" means those accounting principles as established by the Financial Accounting Standards Board.

(r) “IDOH” means the Indiana Department of Health.

(s) “Indiana Medicaid Provider Reimbursement Manual” or “IMPRM” means the policy document supporting the reporting requirements, allowable cost classifications, and calculation of the Medicaid rate.

(t) “Indirect care component” means the portion of the Medicaid rate that shall reimburse providers for allowable indirect patient care services and supplies, including prorated employee benefits based on salaries and wages.
(1) Allowable indirect patient care services and supplies are costs that are patient-related that are necessary in the care of the member, but that are not generally directly related to the provision of hands-on care. See the IMPRM for further details and examples of indirect patient care services and supplies.
(2) All nursing facilities shall have their indirect care component determined under this criteria and in a uniform manner in accordance with IC 12-15-14-1 per Section 6 of this rule.

(u) “Inflation factor” means inflating costs using the CMS Nursing Home without Capital Market Basket Index as published by IHS Markit using the time period prescribed by the office.

(v) “Legacy System” means the historic system used to calculate the Medicaid nursing facility per patient day rate at Section 6.

(w) “Medicaid patient days” means total Medicaid days from the most recently desk reviewed or field audited cost report.

(x) "Minimum data set" or "MDS" means a core set of screening and assessment elements, including common definitions and coding categories, that form the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicaid. The Indiana system shall employ the MDS 3.0 or subsequent revisions as approved by CMS as detailed in the MDS and Case Mix Index Supportive Documentation Manual.

(y) “MDS and Case Mix Index Supportive Documentation Manual” means the policy document supporting the MDS assessment instrument, MDS assessment processing, MDS supportive documentation requirements, resident classification system, and the CMI calculation.

(z) "MDS review" means a formal official verification and methodical examination and review of resident assessment data and its supporting documentation by the office or its designee.

(aa) “Nonemergency Medical Transportation” or “NEMT” means medical transportation to a covered service when needs are not immediate such as to and from a doctor’s office, the hospital, or other medical office for covered care. NEMT services provided by ambulance providers are not the financial responsibility of nursing facility providers and are not included in the nursing facility Medicaid per diem nor covered under this definition.

(bb) “Nursing Facility Census Data Collection Form” means the form designated by the office for providers to file their monthly census information.

(cc) “Ordinary patient-related costs” means costs of allowable per-diem services and supplies that are necessary in delivery of patient care by similar providers within the state. Services or supplies that Medicaid covers outside of the per-diem rate are not ordinary patient-related costs.

(dd) “Patient/member care” means those Medicaid program services delivered to a Medicaid enrolled member by a provider.

(ee) “Patient days” means total patient days, inclusive of paid leave days, from the most recently desk reviewed or field audited cost report.

(ff) “Prospective system” means the methodology used to calculate the Indiana Medicaid reimbursement per patient day rate in Section 6.

(gg) “Quality Program Manual” means the policy document supporting the calculation of the total quality score.

(hh) “Rate year” means the time period starting July 1 and ending June 30.

(ii) “RSMeans Construction Index” means the simple average of construction costs for Indiana cities listed in the Construction Cost Indexes with RSMeans Data published by Gordian.

(jj) "Reasonable allowable costs" means the price a prudent, cost-conscious buyer would pay a willing seller for goods or services in an arm's-length transaction, not to exceed the limitations set out in this rule or other policy documents.

(kk) “Rebase” means the process of reestablishing rate component medians, percentiles, prices, and reimbursement rates by incorporating the most recently completed desk or field audited qualifying Medicaid cost reports.

(ll) “Rental rate” means a simple average of the United States Treasury bond, ten (10) year amortization, constant maturity rate plus three percent (3%), in effect on the first day of the month that the index is published for each of the twelve (12) months immediately preceding the rate effective date as determined in Section 6 of this rule.

(mm) "Resident classification system" means the classification system used to classify residents into groups to determine case mix index values and reimbursement levels as supported by the MDS and Case Mix Index Supportive Documentation Manual.

(nn) "Special Care Unit (SCU) for Alzheimer's disease or dementia" means the nursing facility that meets all of the following:

(1) Has a locked, secure, segregated unit or provides a special program or special unit for residents with Alzheimer's disease, related disorders, or dementia.

(2) The facility advertises, markets, or promotes the health facility as providing Alzheimer's care services or dementia care services, or both.

(3) The nursing facility has a designated director for the Alzheimer's and dementia special care unit, who satisfies all of the following conditions:

(A) Became the director of the SCU prior to August 21, 2004, or has earned a degree from an educational institution in a health care, mental health, or social service profession, or is a licensed health facility administrator.

(B) Has a minimum of one (1) year work experience with dementia or Alzheimer's, or both, residents within the past five (5) years.

(C) Completed a minimum of twelve (12) hours of dementia specific training within three (3) months of initial employment and has continued to obtain six (6) hours annually of dementia-specific training thereafter to:

(i) meet the needs or preferences, or both, of cognitively impaired residents; and

(ii) gain understanding of the current standards of care for residents with dementia.

(D) Performs the following duties:

(i) Oversees the operations of the unit.

(ii) Ensures personnel assigned to the unit receive required in-service training.

(iii) Ensures the care provided to Alzheimer's and dementia care unit residents is consistent with in-service training, current Alzheimer's and dementia care practices, and regulatory standards.

(oo) “Therapy component” means the portion of each facility's direct costs for the provision of therapy services, including any employee benefits prorated based on total salaries and wages, rendered to Medicaid residents that are not reimbursed by other payors. All nursing

facilities shall have their therapy component determined under this criteria and in a uniform manner in accordance with IC 12-15-14-1 per Section 6 of this rule.

(pp) "Total quality score" means the sum of the quality points awarded to each nursing facility for all quality measures as described by the Quality Program Manual.

(qq) "Unsupported MDS resident assessment" means an assessment missing one (1) or more data items that are required to classify a resident pursuant to the resident classification system in accordance with the MDS and Case Mix Index Supportive Documentation Manual.

(rr) “Ventilator program” means a nursing facility that meets all of the following:

(1) The nursing facility utilizes an active, ongoing interdisciplinary approach to the resident’s care, including but not limited to participation as needed, by the physician/practitioner, pulmonologist, registered nurse, pharmacist, dietitian, speech therapist, respiratory therapist, physical and/or occupational therapist, and the resident/representative. The interdisciplinary approach shall include a physician that is board certified in pulmonary disease or critical care as recognized by either the American Board of Medical Specialties or American Osteopathic Associations, as applicable.

(2) The nursing facility has a licensed respiratory care practitioner as defined by 844 IAC 11 on-site twenty-four (24) hours per day, seven (7) days per week.

(3) The nursing facility has ventilator back-up provisions including:

(A) Internal and/or external battery back-up systems to provide a minimum of eight (8) hours of power;

(B) Sufficient emergency oxygen delivery devices (i.e., compressed gas or battery-operated concentrators;

(C) At least one (1) battery operated suction device available per every nine (9) residents on mechanical ventilator or with a tracheostomy;

(D) A minimum of one (1) resident-ready back-up ventilator available in the facility at all times;

(E) An audible, redundant external alarm system connected to emergency power and/or battery back-up and located outside the room of each resident who is ventilator-dependent for the purpose of alerting staff of resident ventilator disconnection or ventilator failure; and

(F) Ventilator equipment (and ideally physiologic monitoring equipment) connected to back-up generator power via clearly marked wall outlets.

(4) The nursing facility has a plan specific for residents who are ventilator dependent which shall specifically address total power failures (loss of power and generator), as well as other emergency circumstances.

(5) The nursing facility has a written training program, including an annual demonstration of competencies, for nursing staff (including nurse aides, registered

nurses, and licensed practical nurses) and respiratory therapy staff providing direct care services for residents who are ventilator dependent.

405 IAC 1-14.7-3 Cost Report Submission and Requirements

Sec. 3. (a) The basis of accounting under this rule is a comprehensive basis of accounting other than GAAP. All cost and charges reported on the provider's cost report shall also be recorded on the provider's financial statements. Costs and charges shall be reported on the cost report in accordance with the following authorities, in the hierarchal order listed:

(1) This rule, the IMPRM, provider bulletins, and any other policy communications.

(2) 42 CFR 413 and the Medicare Provider Reimbursement Manual, CMS 15-1.

(3) GAAP.

The burden of supporting that costs are allowable and patient-related, reasonable, and properly classified lies with the provider.

(b) The provider's cost report shall be completed in accordance with the IMPRM and submitted using cost report forms prescribed by the office. All data elements and attachments identified below shall be completed to provide full financial disclosure. A complete cost report consists of all of the following fully and properly completed items:

(1) The Medicaid cost report and supporting schedules as prescribed by the office.

(2) Medicare cost report for Medicare certified providers as prescribed by the office.

(A) Providers with a Medicare cost report with a fiscal year end other than December 31 shall provide their most recently filed Medicare cost report with the Medicare Administrative Contractor.

(B) Providers may elect to submit a Medicare/Medicaid Reconciliation form approved by the office that provides modifications to the as-filed Medicare cost report due to differences between Medicare and Medicaid allowable cost definitions and classification of costs between cost centers. A revised facility Medicare cost report that incorporates the modifications on the Medicare/Medicaid Reconciliation form shall also be submitted with the Medicare/Medicaid Reconciliation form and the as-submitted Medicare cost report.

(3) Certification by the provider that:

(A) the data are true, accurate, and related to patient care; and

(B) expenses not related to patient care have been clearly identified.

Amendments to the cost report require updated provider certifications.

(4) Certification by the preparer, if different from the provider, that the data were compiled from all information provided to the preparer by the provider and as such are true and accurate to the best of the preparer's knowledge.

(5) A copy of the working trial balance that is a direct product of the accounting system for both the nursing facility and home office (if applicable) that was used in the preparation of their submitted cost report in the format described in the IMPRM. The working trial balance shall include a summation of expense accounts that agree to the total expense amount used to prepare the trial balance crosswalk.
(6) A copy of the trial balance crosswalk document used to prepare the Medicaid cost report (facility and home office, if applicable) that contains an audit trail documenting the cost report schedule, line number, and column where each general ledger account is reported on the cost report. All costs removed from the working trial balance and not reported on the cost report is to be clearly identified in a supporting document. Any costs reported on the cost report and not verifiable on the working trial balance is to be clearly identified and supported with compelling documentation. The crosswalk shall be sorted and subtotaled by Medicaid line number and provided in the manner described in the IMPRM.
(7) A workpaper that provides a detail accounting of the amounts reported in column 24 – Provider Adjustments by line and column number. The workpaper shall distinguish costs by source such as home office, reclassification from another line, etc. The workpaper shall also distinguish whether the cost is personnel or non-personnel cost. Any cost on lines with both columns 2 (personnel) and 3 (other) shall be treated as personnel unless clearly identified.
(8) Any other documents deemed necessary by the office to accomplish full financial disclosure of the provider's operation.

(c) For cost reports ending March 31, 2023 or before, each provider shall submit a cost report to the office not later than the last day of the fifth calendar month after the close of the provider's reporting year. The cost report shall coincide with the fiscal year used by the provider to report federal income taxes. Nursing facilities that are certified to provide Medicare-covered skilled nursing facility services are required to submit a written copy of their Medicare cost report that covers their most recently completed historical reporting period.

(d) For cost report periods ending April 1, 2023 or after, providers are required to maintain a fiscal year end of December 31. Each provider shall submit a cost report to the office not later than May 31 after the close of the provider's reporting year. Refer to Section 9 for requirements regarding short-period cost reports. Nursing facilities that are certified to provide Medicare-covered skilled nursing facility services are required to submit a written copy of their Medicare cost report that covers their most recently completed historical reporting period.

(e) The Nursing Facility Census Data Collection Form is required to be submitted monthly and is due 30 days after the reporting month. The Nursing Facility Census Data Collection Form is required to be filed on the form prescribed by the office and in conformance with the instructions contained within the form.

(f) When multiple facilities or operations are owned by a single entity with a central office, the central office records shall be maintained as a separate set of records with costs and revenues separately identified and appropriately allocated to individual facilities. Each central office entity shall file a cost report coincidental with the time period for any individual facility that receives any central office allocation.

(g) Each provider shall maintain financial records for a minimum period of three (3) years after the date of submission of cost reports to the office. Copies of any financial records or supporting documentation shall be provided to the office upon request. The accrual basis of accounting shall be used in all data submitted to the office except for government operated providers that are otherwise required by law to use a different basis. The provider's accounting records shall establish a clear audit trail from their records to the costs reported on their cost reports submitted to the office.

(h) The cost report submission shall contain full disclosure and reporting of revenue, expenses, and property clearly separated between Medicaid, non-Medicaid, patient, and non-patient including, but not limited to the following:

(1) If a provider has business enterprises or activities other than those reimbursed by Medicaid under this rule, the revenues, expenses, and statistical and financial records for such enterprises or activities shall be clearly identifiable and distinguishable from the revenues, expenses, and statistical and financial records of the operations reimbursed by Medicaid;

(2) The detailed basis for allocation of expenses between nursing facility services and other services in a facility shall remain a prerogative of the provider as long as the basis is reasonably related to the allocated costs and consistent between accounting periods. The following relationships are required:

(A) Reported expenses and patient census information shall be for the same reporting period.

(B) Nursing salary allocations shall be on the basis of nursing hours worked or patient days and shall be for the reporting period except when specific identification is used based on the actual salaries paid for the reporting period.

(C) No allocation of costs between cost report line items shall be permitted.

(D) Allocation methodologies shall have a reasonable relationship to the costs they are allocating.
(E) For allocation of expenses between nursing facilities and other services, accumulated cost and/or patient days are presumed to be a reasonable allocation methodology.
(F) Any changes in the allocation or classification of costs shall be approved by the office prior to the changes being implemented, unless implementing prior period audit adjustments. Proposed changes in allocation or classification methods shall be submitted to the office for approval at least ninety (90) days prior to the provider's cost report due date.

(3) Costs and revenues shall be reported as required on the cost report forms. Allowable patient care costs shall be clearly identified.

(4) The provider shall report as patient care costs only costs that have been incurred in the provision of patient care services. The provider shall certify on all cost reports that costs not related to patient care have been separately identified on the cost report and in accordance with the IMPRM.

(i) The provider shall maintain detailed property documentation including from a related party property company to provide a permanent record of all historical costs and balances of facilities and equipment. Summaries of such documentation shall be submitted with each cost report, and a complete copy of the documentation shall be submitted to the office upon request.

(j) The provider shall report, all patient-related personnel costs and hours as well as patient related contract costs incurred to perform the function for which the provider was certified. Total personnel cost and total hours shall be reported for all employees. Hours for contracted staff are not required to be reported.

(k) Payroll records shall be maintained by the provider to substantiate the staffing costs reported to the office. The records shall indicate each employee's classification, hours worked, rate of pay, and the department or functional area to which the employee was assigned and actually worked. If an employee performs duties in more than one (1) department or functional area, the payroll records shall indicate the time allocations to the various assignments. These allocations should be supported via time studies or actual time worked.

(l) Allocation of home office costs shall be reasonable, conform to GAAP, and be consistent between years. Any change of central office allocation bases shall be approved by the office prior to the changes being implemented. Proposed changes in allocation methods shall be

submitted to the office at least ninety (90) days prior to the cost report due date. Such costs are allowable only to the extent that the central office is providing services related to patient care and the provider can demonstrate that the central office costs improved efficiency, economy, and quality of member care.

(m) Costs from non-bona fide separate related organizations, such as from operating divisions of the provider organization or central office, shall be maintained as a separate set of records with costs separately identified and appropriately allocated to individual facilities. Costs from these related organizations shall be documented and allocated using the Medicaid Home Office Cost Report Form.

405 IAC 1-14.7-4 Scope of Reviews

Sec. 4. (a) The office shall perform a desk review or field audit of the submitted cost report to determine the reasonableness, appropriate classification, and allowability of reporting. The office may request documentation to substantiate the submitted cost report.

(b) The office shall contact providers to notify them that they have been selected for a field audit.

(1) The office shall provide an Audit Notification Letter to the providers identifying all information the provider is required to submit in advance of the field audit date. Failure to submit the required information by the due date in the Audit Notification Letter shall result in the implementation of the prefield information penalty as identified at Section 12.

(2) The office shall schedule the field audit date with the provider. If the office and provider are unable to reach an agreement on a scheduled field audit date, the office shall assign a date for the field audit to begin no earlier than fifteen (15) days after the date that the provider was initially contacted to schedule the field visit. The office shall confirm the field audit date by providing a written notice identifying the date of the scheduled field audit.

(3) After assignment of a field audit date, a provider may submit a one-time request that the scheduled field audit be postponed to a later date.

(A) The office shall approve or deny the request in writing within fifteen (15) days of receiving the request.

(B) Any delay of the scheduled field audit date does not extend the due date of the required information.

(c) When a field audit indicates that the provider's records are inadequate to support data submitted to the office, or when the additional requested documentation is not provided pursuant

to the office's request, and the office is unable to complete the audit, the following actions shall be taken:

(1) The office shall provide a written notice listing all of the deficiencies in documentation;
(2) The provider shall be allowed fifteen (15) days from the date of the notice to provide the documentation and correct the deficiencies;
(3) Not earlier than fifteen (15) days from the date of the notice, the office shall give a final written notice (Follow-Up Letter) listing all of the outstanding deficiencies in documentation; and
(4) Failure to submit the required information by the due date in the written notice shall result in the implementation of the Field Work – Follow-Up Letter penalty as identified at Section 12.

405 IAC 1-14.7-5 New Provider Reimbursement

Sec. 5. (a) This section describes the treatment of nursing facility providers that have not previously been certified to participate in the Medicaid nursing facility program.

(b) Rate requests to establish an initial rate for a new provider rate shall be filed by submitting an initial rate request to the office on or before thirty (30) days after notification of the enrollment date.

(c) Initial rates shall be effective on the:
(1) enrollment date; or
(2) the date that a service is established; whichever is later.

(d) Initial rates shall be set at the sum of the following:
(1) The statewide average nursing facility quality add-on of the preceding July 1;
(2) Assessment add-on, as determined in subsection (g);
(3) NEMT add-on as determined in Section 7; and
(4) Legacy System medians at the preceding July 1 for each of the following components:
(A) direct care component:
(i) Until the provider has one full reporting quarter of MDS assessment information, the direct care component shall be multiplied by the statewide average Medicaid CMI utilized as determined for the previous July 1 rate effective date.
(ii) Once a provider has one full reporting quarter of MDS assessment information, the direct care component shall be multiplied by the facility's own facility average Medicaid CMI and updated each rate effective date

thereafter.
(B) therapy component,
(C) indirect care component,
(D) administrative component, and
(E) eighty (80) percent of capital component.

(e) A provider shall remain under the initial rate calculation process until the first annual rebase period in which the provider has a desk or field audited cost report of six (6) months or greater in length available for use in the rebase.

(f) The initial monthly quality assessment value owed to the office shall be determined based on six (6) months of patient days from the required monthly nursing facility census data collection form provider filings. The initial monthly quality assessment value owed to the office shall remain in effect until the first annual rebase period in which the provider has a desk or field audited cost report of six (6) months or greater in length available for use in the rebase. A retroactive settlement of the initial quality assessment total for all unpaid periods shall occur after the provider's assessment value is determined by the office and the fiscal intermediary has established the monthly assessment receivable.

(g) The assessment add-on is twelve dollars and twenty cents ($12.20) per patient day unless exempt from the assessment add-on as noted in 405 IAC 1-14.7-11. Once the office collects six (6) months of patient days from the required monthly nursing facility census data collection forms, the office shall establish the provider specific assessment add-on and implement on the next rate effective date.

(h) Providers are eligible to participate in the special care unit and ventilator programs and receive additional reimbursement if the qualifications in Section 2 and Section 7 are met.

405 IAC 1-14.7-6 Rate Calculation

Sec. 6. (a) The following section prescribes the detailed rate methodology calculation for each rate component.

(b) Until June 30, 2024, the rate effective date of the annual rebase shall be the first July 1 that falls after the first calendar quarter following the provider's fiscal year end. Beginning July 1, 2024, the annual rebase shall be each July 1 utilizing the most recently desk or field audited cost reports with a fiscal year ending eighteen (18) months or greater prior to the rate effective date.

(c) The annual Medicaid per patient day rate shall be calculated as the sum of the following:

(1) Prospective System rate calculated in accordance with subsection (d) multiplied by the percentage below; and

(2) Legacy System rate calculated in accordance with subsection (e) multiplied by the percentage below.

Rate Effective Date	**Prospective System Rate Percentage**	**Legacy System Rate Percentage**
Before January 1, 2025	0%	100%
January 1, 2025	17%	83%
July 1, 2025	33%	67%
January 1, 2026	50%	50%
July 1, 2026	67%	33%
January 1, 2027	83%	17%
July 1, 2027 and forward	100%	0%

(d) The Prospective System is as follows:

(1) The Prospective System rate is calculated as the sum of the following:

(A) Direct care component. This component is price based with a limit (floor) placed on provider profit and is calculated as follows:

	Table D.1 - Direct Care Component Calculation	
A.	Direct Care Per Patient Day Cost for CMI Adjustment	Value as determined in the Direct Care Per Patient Day Cost for CMI Adjustment table below (Letter F)
B.	Facility Average CMI	The facility average CMI is based on the all-resident time-weighted resident CMI, during the cost reporting period as described in the MDS and Case Mix Index Calculation Supportive Documentation Manual.
C.	Normalized Direct Care Per Patient Day Costs	A / B

D.	Average CMI for Medicaid Residents	The facility average Medicaid CMI is based on the Medicaid resident time-weighted resident CMI, for the applicable rate effective date period as described in 405 IAC 1-15-1 and the MDS and Case Mix Index Calculation Supportive Documentation Manual for additional calculation details.
E.	Total CMI Adjusted Direct Care Per Patient Day Costs	C * D
F.	Non-CMI Adjusted Direct Care Per Patient Day Cost	Valued as determined in the Non-CMI Adjusted Direct Care Per Patient Day Cost table below (Letter E)
G.	Total Direct Care Per Patient Day Cost	E + F
H.	Determination of the Statewide Price for the Normalized Direct Care Per Patient Day Cost and Non-CMI Adjusted Direct Care Per Patient Day Cost	The normalized direct care per patient day costs and the non-CMI adjusted direct care per patient day costs (Letter C + Letter F) for each provider are utilized for the percentile array. The allowable cost of the provider identified as the 85th percentile of the Medicaid day-weighted direct care component costs shall be selected as the statewide price for the two components, in accordance with subdivision (4)
I.	Average CMI for Medicaid Residents	The facility average Medicaid CMI is based on the Medicaid resident time-weighted resident CMI, for the applicable rate effective date period as described in 405 IAC 1-15-1 and the MDS and Case Mix Index Calculation Supportive Documentation Manual for additional calculation details.
J.	CMI Adjusted Direct Care Per Patient Day Cost Ceiling	Statewide Normalized Direct Care Price determined in H * I
K.	Total Direct Care Per Patient Day Ceiling	J + Statewide Non-CMI Adjusted Direct Care Price determined in H
L.	Allowable Profit	K * 0.05
M.	Direct Care Plus Profit Per Patient Day	G + L
N.	Direct Care Component	Lesser of K or M

Table D.2 - Direct Care Per Patient Day Cost for CMI Adjustment Calculation		
A.	Total Direct Care Costs for CMI Adjustment	Allowable direct care costs for CMI adjustment as described in the IMPRM
B.	Direct Care Costs for CMI Adjustment Pro Rata Employee Benefits	Allowable direct care salaries for CMI adjustment / total allowable salaries * allowable employee benefits as described by the IMPRM
C.	Excess Medical Equipment Rental Cost (negative value)	Value as determined in Excess Medical Equipment Rental Limitation Calculation table below (Letter G)
D.	Allowable Direct Care Costs for CMI Adjustment	A + B + C
E.	Patient Days or Minimum Occupancy	Patient days or 70% * bed days available, whichever is greater
F.	Direct Care Per Patient Day Cost for CMI Adjustment	D / E

Table D.3 - Excess Medical Equipment Rental Limitation Calculation		
A.	Medical Equipment Rental	Medical equipment rental cost as described in the IMPRM
B.	Patient Days	
C.	Medical Equipment Rental Per Patient Day Cost	A / B
D.	Maximum Medical Equipment Rental Per Patient Day Cost	1.50
E.	Excess Medical Equipment Rental Per Patient Day Cost	If D – C < 0 then D – C. If D – C ≥ 0 then 0.
F.	Patient Days	
G.	Excess Medical Equipment Rental Cost	E * F

Table D.4 - Non-CMI Adjusted Direct Care Per Patient Day Cost Calculation		
A.	Total Non-CMI Adjusted Direct Care Cost	Allowable non-CMI adjusted direct care costs as described in the IMPRM
B.	Non-CMI Adjusted Direct Care Pro Rata Employee Benefits	Allowable non-CMI adjusted direct care salaries / total allowable salaries * allowable employee benefits as described by the IMPRM
C.	Allowable Non-CMI Adjusted Direct Care Costs	A + B

D.	Patient Days or Minimum Occupancy	Patient days or 70% * bed days available, whichever is greater
E.	Non-CMI Adjusted Direct Care Per Patient Day Costs	C / D

(B) Therapy component. This is a provider specific component based on allowable provider Medicaid per patient day cost and is calculated as follows:

Table D.5 - Therapy Component Calculation		
A.	Total Therapy Costs	Allowable therapy cost as described in the IMPRM
B.	Therapy Pro Rata Employee Benefits	Allowable therapy salaries / total allowable salaries * allowable employee benefits as described by the IMPRM
C.	Direct Ancillary Cost Adjustment (negative value)	Value as determined in the Therapy Direct Ancillary Adjustment Calculation table below (Letter L)
D.	Allowable Therapy Costs	A + B + C
E.	Patient days	[redacted]
F.	Therapy Component	D / E

Table D.6 - Therapy Direct Ancillary Adjustment Calculation		
A.	Medicaid Ancillary Revenue	Medicaid Ancillary Revenue as described in the IMPRM
B.	Total Ancillary Revenue	Total Ancillary Revenue as described in the IMPRM
C.	Medicaid Utilization Ratio	A / B
D.	Direct Ancillary Cost from Medicaid Cost Report	Direct ancillary costs as described in the IMPRM
E.	Direct Ancillary Employee Benefits from Medicaid Cost Report	Allowable therapy salaries / total allowable salaries * allowable employee benefits as described by the IMPRM
F.	Total Direct Ancillary Costs	D + E
G.	Medicaid Direct Ancillary Costs	C * F
H.	Medicaid Patient Days	[redacted]
I.	Medicaid Direct Ancillary Costs Per Patient Day	G / H
J.	Patient Days	[redacted]
K.	Allowable Direct Ancillary Costs	I * J
L.	Direct Ancillary Cost Adjustment	K – F

The Therapy Direct Ancillary Adjustment Calculation above is performed by each therapy discipline as described by the IMPRM.

(C) Indirect component. This is a statewide price-based component and is calculated as follows:

Table D.7 - Indirect Care Component Calculation		
A.	Total Indirect Cost	Allowable indirect care cost as described in the IMPRM
B.	Indirect Care Pro Rata Employee Benefits	Allowable indirect care salaries / total allowable salaries * allowable employee benefits as described by the IMPRM
C.	Indirect Ancillary Cost Adjustment (negative value)	Value as described in the Indirect Ancillary Cost Adjustment table below (Letter L)
D.	Allowable Indirect Care Costs	A + B + C
E.	Patient Days or Minimum Occupancy	Patient days or 85% * bed days available, whichever is greater
F.	Indirect Care Per Patient Day Cost	D / E
G.	Determination of the Statewide Price for the Indirect Care Per Patient Day Cost	Indirect care per patient day costs (Letter F) for each provider is utilized for the percentile array. The allowable cost of the provider identified at the specified percentile shall be selected as the statewide price in accordance with subdivision (4) of this rule subsection. The specified percentile shall be set each July 1 at the percentile of the Medicaid day-weighted indirect care component costs necessary to achieve estimated aggregate Prospective System spending equivalent to the estimated payments calculated in the Legacy System subsection (e) below.
H.	Indirect Care Component	G

Table D.8 - Indirect Ancillary Cost Adjustment Calculation		
A.	Total Ancillary Costs Per Medicare Cost Report	Ancillary costs per the Medicare cost report as described in the IMPRM
B.	Capital Costs Per Medicare Cost Report	Capital costs per the Medicare cost report as described in the IMPRM
C.	Ancillary Costs without Capital	A - B
D.	Direct Ancillary Costs Plus Employee Benefits Per Medicare Cost Report	Direct ancillary costs + (allowable ancillary salaries / total allowable salaries * allowable employee benefits) All costs are from the Medicare cost report as described by the IMPRM

E.	Indirect Costs per Medicare Cost Report	C - D
F.	Indirect Costs as a Percentage of Direct Costs	E / D
G.	Indirect Care Component Adjustment	Value determined in Therapy Direct Ancillary Adjustment table above (Letter L) * F
H.	Total Indirect Care Costs Excluding Dietary	Indirect Care Component Calculation table above (Letters A + B) – ((allowable dietary cost) + (allowable dietary salaries / total allowable salaries * allowable employee benefits)) All costs are described by the IMPRM
I.	Total Administrative Costs	Administrative Component Calculation table below (Letters A + B)
J.	Allocation Statistic for Indirect Care Component	(H / (H + I))
K.	Allocation Statistic for Administrative Component	(I / (H + I))
L.	Indirect Care Component Adjustment (negative value)	G * J
M.	Administrative Component Adjustment (negative value)	G * K
N.	Excess Owner, Related Party, Management (ORPM) Compensation	Value as determined in the Owner, Related Party, Management (ORPM) Limitation Calculation table below (Letter I)
O.	Ratio of Excess to Administrative Costs	N / I
P.	Excess ORPM Adjustment	M * O

The Indirect Ancillary Cost Adjustment Calculation above is performed by each ancillary cost center as described by the IMPRM.

For providers that are not required by the Medicare administrative contractor to file a full Medicare cost report (low-utilization cost report), no adjustment resulting from the Indirect Ancillary Cost Adjustment shall be made and they shall be excluded from the administrative and indirect percentile calculation.

(D) Administrative Component. The component reimbursement rate is established at a statewide price based on the allowable administrative component cost of the selected Medicaid day-weighted percentile and is calculated as follows:

Table D.9 - Administrative Component Calculation		
A.	Total Administrative Cost	Allowable administrative cost as described in the IMPRM
B.	Administrative Pro Rata Employee Benefits	(Allowable administrative salaries / total allowable salaries * allowable employee benefits) + owners' benefits as described by the IMPRM
C.	Owner, Related Party, Management (ORPM) Compensation Limitation (negative value)	Value as determined in the Owner, Related Party, Management (ORPM) Limitation Calculation table below (Letter I)
D.	Ancillary Adjustment (negative value)	Value as determined in the Indirect Ancillary Cost Adjustment Calculation table above (Letters M + P)
E.	Allowable Administrative Cost	A + B + C + D
F.	Patient Days or Minimum Occupancy	Patient days or 85% * bed days available, whichever is greater.
G.	Administrative Per Patient Day Cost	E / F
H.	Determination of the Statewide Price for the Administrative Care Per Patient Day Cost	Administrative per patient day costs (Letter G) calculated with uninflated working capital interest for each provider is utilized for the percentile array. The allowable cost of the provider identified as the 50th percentile of the Medicaid day-weighted administrative component costs shall be selected as the statewide price in accordance with subdivision (4) of this rule subsection.
I.	Administrative Component	H

Table D.10 - Owner, Related Party, Management (ORPM) Limitation Calculation		
A.	ORPM Cost	ORPM costs as described in the IMPRM
B.	Plus Director Fees	Director Fees as described in the IMPRM
C.	Total Compensation Subject to Limitation	A + B
D.	Patient Days	

E.	ORPM Per Patient Day Cost	C / D
F.	ORPM Per Patient Day Cost Ceiling	$2.75 * Inflation Factor. Inflation shall be applied from 1/1/23 to the midpoint of the applicable rate year
G.	Excess ORPM Per Patient Day Cost	If F – E < 0 then F – E. If F – E ≥ 0 then 0.
H.	Patient Days	
I.	Excess ORPM Compensation	G * H

(E) Capital component. This is calculated utilizing a fair rental value allowance statewide price and provider specific other capital costs subject to an overall cost limitation and is calculated as follows:

	Table D.11 - Capital Component Calculation	
A.	Capital Per Patient Day Cost	Value determined in the Capital Per Patient Day Cost Calculation table below (Letter F)
B.	Median Capital Cost	The capital per patient day cost (Letter A) for each provider are utilized in the median calculation. The capital per patient day cost of the median provider shall be selected in accordance with subdivision (5)
C.	Profit Ceiling	B * 100%
D.	Tentative Profit Add-on	If C – A > 0, then 60% * (C – A). If (C – A) ≤ 0 then 0
E.	Total Quality Score Percentage	Calculated utilizing the scale in accordance with the Quality Program Manual
F.	Allowed Profit Add-on	D * E
G.	Capital Costs Plus Profit	A + F
H.	Overall Rate Component Limit	B * 100%
I.	Capital Component	Lesser of G or H

Table D.12 - Capital Per Patient Day Cost Calculation		
A.	Total Other Capital Costs	Allowable capital costs as described in the IMPRM
B.	Interest, Depreciation, Amortization, and Rent (negative value)	Allowable interest, depreciation, amortization, and rent costs as described in the IMPRM

C.	Fair Rental Value Allowance	Value as determined in the Fair Rental Value Allowance Calculation table below (Letter E)
D.	Allowable Capital Costs	A + B + C
E.	Patient Days or Minimum Occupancy	Patient days or 95% * bed days available, whichever is greater
F.	Capital Per Patient Day Cost	D / E

Table D.13 - Fair Rental Value Allowance Calculation		
A.	Average Inflated Historical Cost of Property of the Median Bed	The average historical cost of property per bed for each provider is utilized in the median calculation. The average historical cost of property per bed of the median provider shall be selected in accordance with subdivision (6)
B.	Total Nursing Facility Beds	Total nursing facility beds as described in the IMPRM
C.	Fair Rental Value Amount	A * B
D.	Rental Rate	Value as described in Section 2
E.	Fair Rental Value Allowance	C * D

(2) The Medicaid reimbursement system and rate component calculations in the tables above are based on the provider's allowable nursing facility cost which are annualized to a full year cost report period in recognition of the provider's allowable costs as described in the IMPRM.

(3) All allowable rate component costs as identified in the above tables shall be adjusted using the inflation factor. The inflation adjustment shall apply from the midpoint of the cost reporting period to the midpoint of the rate year, unless specifically identified otherwise.

(4) The allowable cost of the Medicaid patient day-weighted percentile as identified in the above tables shall be calculated on a statewide basis each July 1 for the direct care, indirect care, and administrative components as follows:

(A) Providers are arrayed in ascending order based on the applicable per patient day rate component costs as identified in the component calculations in the tables above which include the impact of minimum occupancy adjustments as applicable;

(B) Cumulative Medicaid patient days are calculated for each provider within the array, by adding that provider's Medicaid patient days to all the total of all Medicaid patient days within the array for preceding providers.

(C) The percentage of total cumulative Medicaid patient days for each provider within the array is calculated by dividing their cumulative Medicaid patient days by total Medicaid patient days within the array.
(D) The provider within the array whose percentage of total cumulative Medicaid patient days is equal to or immediately lesser than (if no provider is exactly equal to the Medicaid day-weighed percentile) the rate component Medicaid day-weighted percentile is selected as the allowable cost of the Medicaid patient day-weighted percentile.

(5) The allowable cost of the median patient day as identified in the above tables shall be calculated on a statewide basis each July 1 for the capital component from the most recently desk reviewed or field audited cost report:

(A) Providers are arrayed in descending order based on the applicable per patient day rate component costs as identified in the component calculations in the tables above which include the impact of minimum occupancy adjustments as applicable;
(B) Cumulative total patient days are calculated for each provider within the array, by adding that provider's patient days to all the total of all patient days within the array for preceding providers.
(C) The median patient day within the array is calculated by dividing cumulative patient days by two.
(D) The provider within the array whose total cumulative patient days is equal to or immediately greater than the median patient day is selected as the allowable cost of the median patient day.

(6) The average historical cost of property of the median bed in the above table shall be calculated on a statewide basis for facilities that are not acquired through an operating lease arrangement each July 1 as follows:

(A) Land, building, and improvements shall be adjusted for changes in valuation by inflating the reported allowable patient-related historical cost of property from the later of July 1, 1976, or the date of facility acquisition to the present based on the change in the RSMeans Construction Index.
(B) Inflated land and building historical costs are added to equipment and other historical property costs which are divided by beds to calculate the average inflated historical costs of property per bed.
(C) Providers are arrayed in descending order based on the average inflated historical costs of property per bed.
(D) Cumulative beds are calculated for each provider within the array, by adding each provider's beds to the total of all beds within the array for preceding providers.
(E) The median bed is calculated by dividing total cumulative beds by two.

(F) The provider within the array whose total cumulative beds is equal to or immediately greater than the median bed is selected as the average inflated historical costs of property per bed median.

(7) Beginning July 1, 2024, subsequent to the annual rebase, the direct care component of the Medicaid rate shall be adjusted biannually to reflect changes in the provider's case mix index for Medicaid residents. If the facility has no Medicaid residents during a 6-month period, the facility's average case mix index for all residents shall be used in lieu of the case mix index for Medicaid residents. This adjustment shall be effective on January 1 after the effective date of the annual rebase.
The case mix index for Medicaid residents in each facility shall be:

(A) updated every January 1; and

(B) used to adjust the direct care component that becomes effective on the 6-month period following the updated case mix index for Medicaid residents.

In addition, each facility's total quality score shall be redetermined bi-annually based on the criteria in the Quality Program Manual.

(8) All rate-setting parameters and components used to calculate the annual rebase, except for the case mix index for Medicaid residents in that facility and the total quality score, shall apply to the calculation of any change in Medicaid rate that is authorized under subdivision (7).

(9) Providers shall pay interest on all overpayments, consistent with IC 12-15-13-4. The interest charge shall not exceed the percentage set out in IC 6-8.1-10-1(c). The interest shall:

(A) accrue from the date of the overpayment to the provider; and

(B) apply to the net outstanding overpayment during the periods in which such overpayment exists.

(10) When the number of nursing facility beds licensed by IDOH is changed, the provider may notify the office of these changes. For the July 1 rebase, the notification of the licensed bed change shall be in writing and submitted prior to January 31 preceding the July 1 annual rebase. For the January 1 bi-annual update, the notification of the licensed bed change shall be in writing and submitted prior to July 31 preceding the January 1 bi-annual update. For notifications received by the due date, the annual rebase at July 1 and bi-annual rate at January 1 shall be calculated utilizing the new number of nursing facility licensed beds.

(e) The Legacy System is as follows:

(1) The Legacy System rate is calculated as the sum of the following:

(A) Direct care component. This is calculated utilizing provider specific costs subject to an overall cost limitation and is calculated as follows:

	Table E.1 - Direct Care Component Calculation (Non-children's Nursing Facilities)	
A.	Direct Care Per Patient Day Cost	Value as determined in the Direct Care Per Patient Day Cost table below (Letter K)
B.	Facility Average CMI	The facility average CMI is based on the all-resident time-weighted resident CMI, during the cost reporting period as described in the MDS and Case Mix Index Calculation Supportive Documentation Manual.
C.	Normalized Direct Care Per Patient Day Costs	A / B
D.	Average CMI for Medicaid Residents	The facility average Medicaid CMI is based on the Medicaid resident time-weighted resident CMI, for the applicable rate effective date period as described in 405 IAC 1-15-1 and the MDS and Case Mix Index Calculation Supportive Documentation Manual for additional calculation details.
E.	Medicaid Case Mix Adjusted Cost	C * D
F.	Median Direct Care Cost Per Case Mix Point	The direct care per patient day cost (Letter A) for each provider are utilized in the median calculation. The direct care per patient day cost of the median provider shall be selected in accordance with subdivision (4)
G.	Profit Ceiling	(F * 110%) * D
H.	Tentative Profit Add-on	If G – E > 0 then 30% * (G – E). If G – E ≤ 0 then 0.
I.	Total Quality Score Percentage	Calculated utilizing the scale in accordance with the Quality Program Manual

J.	Allowed Profit Add-on	H * I
K.	Overall Profit Limit	F * 10%
L.	Medicaid Case Mix Adjusted Costs Plus Profit	E + Lesser of J or K
M.	Overall Rate Component Limit	(F * 120%) * D
N.	Direct Care Component	Lesser of L or M

	Table E.2 - Direct Care Component Calculation (Children's Nursing Facilities only)	
A.	Direct Care Per Patient Day Cost	Value as determined in the Direct Care Per Patient Day Cost table below (Letter K)
B.	Facility Average CMI	The facility average CMI is based on the all-resident time-weighted resident CMI, during the cost reporting period as described in the MDS and Case Mix Index Calculation Supportive Documentation Manual.
C.	Normalized Direct Care Per Patient Day Costs	A / B
D.	Average CMI for Medicaid Residents	The facility average Medicaid CMI is based on the Medicaid resident time-weighted resident CMI, for the applicable rate effective date period as described in 405 IAC 1-15-1 and the MDS and Case Mix Index Calculation Supportive Documentation Manual for additional calculation details.
E.	Medicaid Case Mix Adjusted Cost	C * D
F.	Median Direct Care Cost Per Case Mix Point	The direct care per patient day cost (Letter A) for each provider are utilized in the median calculation. The direct care per patient day cost of the median provider shall be selected in accordance with subdivision (4)
G.	Profit Ceiling	(F * 110%) * D
H.	Profit Add-on	If G – E > 0 then 30% * (G – E). If G – E ≤ 0 then 0.
I.	Medicaid Case Mix Adjusted Costs Plus Profit	E + H
J.	Overall Rate Component Limit	(F * 120%) * D
K.	Direct Care Component	Lesser of I or J

Table E.3 - Direct Care Per Patient Day Cost Calculation		
A.	Total Direct Care Costs	Allowable direct care costs as described in the IMPRM
B.	Direct Care Pro Rata Employee Benefits	Allowable direct care salaries / total allowable salaries * allowable employee benefits as described by the IMPRM
C.	Excess Medical Equipment Rental Cost (negative value)	Value as determined in Excess Medical Equipment Rental Limitation Calculation table below (Letter G)
D.	Allowable Direct Care Costs	A + B + C
E.	Variable Direct Care Costs (75% of allowable direct care costs are considered variable)	D * 75%
F.	Patient Days	
G.	Variable Direct Care Costs Per Patient Day	E / F
H.	Fixed Direct Care Costs (25% of allowable direct care costs are considered fixed)	D * 25%
I.	Patient Days or Minimum Occupancy	For nursing facilities with greater than 50 beds, patient days or 90% * bed days available, whichever is greater For nursing facilities with less than 51 beds, patient days or 85% * bed days available, whichever is greater
J.	Fixed Direct Care Costs Per Patient Day	H / I
K.	Direct Care Per Patient Day Cost	G + J

Table E.4 - Excess Medical Equipment Rental Limitation Calculation		
A.	Medical Equipment Rental	Medical equipment rental cost as described in the IMPRM
B.	Patient Days	
C.	Medical Equipment Rental Per Patient Day Cost	A / B
D.	Maximum Medical Equipment Rental Per Patient Day Cost	1.50
E.	Excess Medical Equipment Rental Per Patient Day Cost	If D – C < 0 then D – C. If D – C ≥ 0 then 0.
F.	Patient Days	
G.	Excess Medicaid Equipment Rental Cost	E * F

(B) Therapy component. This is a provider specific component based on allowable provider Medicaid per patient day cost and is calculated as follows:

Table E.5 - Therapy Component Calculation		
A.	Total Therapy Costs	Allowable therapy cost as described in the IMPRM
B.	Therapy Pro Rata Employee Benefits	Allowable therapy salaries / total allowable salaries * allowable employee benefits as described by the IMPRM
C.	Direct Ancillary Cost Adjustment (negative value)	Value as determined in the Therapy Direct Ancillary Adjustment Calculation table below (Letter L)
D.	Allowable Therapy Costs	A + B + C
E.	Patient days	[redacted]
F.	Therapy Component	D / E

Table E.6 - Therapy Direct Ancillary Adjustment Calculation		
A.	Medicaid Ancillary Revenue	Medicaid Ancillary Revenue as described in the IMPRM
B.	Total Ancillary Revenue	Total Ancillary Revenue as described in the IMPRM
C.	Medicaid Utilization Ratio	A / B
D.	Direct Ancillary Cost from Medicaid Cost Report	Direct ancillary costs as described in the IMPRM
E.	Direct Ancillary Employee Benefits from Medicaid Cost Report	Allowable therapy salaries / total allowable salaries * allowable employee benefits as described by the IMPRM
F.	Total Direct Ancillary Costs	D + E
G.	Medicaid Direct Ancillary Costs	C * F
H.	Medicaid Patient Days	[redacted]
I.	Medicaid Direct Ancillary Costs Per Patient Day	G / H
J.	Patient Days	[redacted]
K.	Allowable Direct Ancillary Costs	I * J
L.	Direct Ancillary Cost Adjustment	K – F

The Therapy Direct Ancillary Adjustment Calculation above is performed by each therapy discipline as described by the IMPRM.

(C) Indirect component. This is calculated utilizing provider specific costs subject to an overall cost limitation and is calculated as follows:

	Table E.7 - Indirect Care Component Calculation	
A.	Indirect Care Per Patient Day Cost	Value as determined in the Indirect Care per Patient Day Cost table below (Letter K)
B.	Median Indirect Care Cost	The indirect care per patient day cost (Letter A) for each provider are utilized in the median calculation. The indirect care per patient day cost of the median provider shall be selected in accordance with subdivision (4)
C.	Profit Ceiling	B * 105%
D.	Tentative Profit Add-on	If (C – A) > 0 then 60% * (C – A). If (C – A) ≤ 0 then 0.
E.	Total Quality Score Percentage	Calculated utilizing the scale in accordance with the Quality Program Manual
F.	Allowed Profit Add-on	D * E
G.	Indirect Care Cost Plus Profit	A + F
H.	Overall Rate Component Limit	B * 115%
I.	Indirect Care Component	Lesser of G or H

	Table E.8 - Indirect Care Per Patient Day Cost	
A.	Total Indirect Cost	Allowable indirect care cost as described in the IMPRM
B.	Indirect Care Pro Rata Employee Benefits	Allowable indirect care salaries / total allowable salaries * allowable employee benefits as described by the IMPRM
C.	Indirect Ancillary Adjustment (negative value)	Value as described in the Indirect Ancillary Cost Adjustment table below (Letter L)
D.	Allowable Indirect Care Costs	A + B + C
E.	Variable Indirect Care Costs (63% of allowable indirect care costs are considered variable)	D * 63%
F.	Patient Days	
G.	Variable Indirect Care Costs Per Patient Day	E / F

H.	Fixed Indirect Care Costs (37% of allowable indirect care costs are considered fixed)	D * 37%
I.	Patient Days or Minimum Occupancy	For nursing facilities with greater than 50 beds, actual patient days or 90% * bed days available, whichever is greater For nursing facilities with less than 51 beds, actual patient days or 85% * bed days available, whichever is greater
J.	Fixed Indirect Care Costs Per Patient Day	H / I
K.	Indirect Care Per Patient Day Cost	G + J

Table E.9 - Indirect Ancillary Cost Adjustment Calculation		
A.	Total Ancillary Costs Per Medicare Cost Report	Ancillary costs per the Medicare cost report as described in the IMPRM
B.	Capital Costs Per Medicare Cost Report	Capital costs per the Medicare cost report as described in the IMPRM
C.	Ancillary Costs without Capital	A - B
D.	Direct Ancillary Costs Plus Employee Benefits Per Medicare Cost Report	Direct ancillary costs + (allowable ancillary salaries / total allowable salaries * allowable employee benefits) All costs are from the Medicare cost report as described by the IMPRM
E.	Indirect Costs per Medicare Cost Report	C - D
F.	Indirect Costs as a Percentage of Direct Costs	E / D
G.	Indirect Care Component Adjustment	Value determined in Therapy Direct Ancillary Adjustment table above (Letter L) * F
H.	Total Indirect Care Costs Excluding Dietary	Indirect Care Component Calculation table above (Letters A + B) – ((allowable dietary cost) + (allowable dietary salaries / total allowable salaries * allowable employee benefits)) All costs are described by the IMPRM
I.	Total Administrative Costs	Administrative Component Calculation table below (Letters A + B)
J.	Allocation Statistic for Indirect Care Component	(H / (H + I))

K.	Allocation Statistic for Administrative Component	(I / (H + I))
L.	Indirect Care Component Adjustment (negative value)	G * J
M.	Administrative Component Adjustment (negative value)	G * K
N.	Excess Owner, Related Party, Management (ORPM) Compensation	Value as determined in the Owner, Related Party, Management (ORPM) Limitation Calculation table below (Letter I)
O.	Ratio of Excess to Administrative Costs	N / I
P.	Excess ORPM Adjustment	M * O

The Indirect Ancillary Cost Adjustment Calculation above is performed by each ancillary cost center as described by the IMPRM.

For providers that are not required by the Medicare administrative contractor to file a full Medicare cost report (low-utilization cost report), the following ratios shall be utilized in lieu of the Indirect Costs as a Percentage of Direct Costs (Letter F) above.

Physical Therapy	**Speech Therapy**	**Occupational Therapy**	**Respiratory Therapy**	**X-Ray**	**Laboratory**	**Pharmacy**
23.11%	28.84%	22.15%	5.49%	2.50%	2.75%	1.60%

(D) Administrative Component. The component reimbursement rate is established at a statewide price based on the allowable administrative component cost of the median and is calculated as follows:

Table E.10 - Administrative Component Calculation		
A.	Total Administrative Cost	Allowable administrative cost as described in the IMPRM
B.	Administrative Pro Rata Employee Benefits	(Allowable administrative salaries / total allowable salaries * allowable employee benefits) + owners' benefits as described by the IMPRM

C.	Owner, Related Party, Management Compensation Limit (negative value)	Value as determined in the Owner, Related Party, Management (ORPM) Limitation Calculation table below (Letter I for applicable rate effective date)
D.	Ancillary Adjustment (negative value)	Value as determined in the Indirect Ancillary Cost Adjustment Calculation table above (Letters M + P)
E.	Allowable Administrative Cost	A + B + C + D
F.	Variable Administrative Costs (16% of allowable administrative costs are considered variable)	E * 16%
G.	Patient Days	[redacted]
H.	Variable Administrative Costs Per Patient Day	F / G
I.	Fixed Administrative Costs (84% of allowable administrative costs are considered fixed)	E * 84%
J.	Patient Days or Minimum Occupancy	For nursing facilities with greater than 50 beds, patient days or 90% * bed days available, whichever is greater For nursing facilities with less than 51 beds, patient days or 85% * bed days available, whichever is greater
K.	Fixed Administrative Costs Per Patient Day	I / J
L.	Administrative Per Patient Day Cost	H + K
M.	Determination of the Statewide Price for the Administrative Per Patient Day Cost	The administrative per patient day cost of the median provider calculated with uninflated working capital interest shall be selected in accordance with subdivision (4)
N.	Administrative Component	M

Table E.11 - Owner, Related Party, Management (ORPM) Limitation Calculation		
A.	ORPM Cost	ORPM costs as described in the IMPRM
B.	Plus Director Fees	Director Fees as described in the IMPRM
C.	Total Compensation Subject to Limitation	A + B
D.	Patient Days	[redacted]
E.	ORPM Per Patient Day Cost	C / D

F.	ORPM Per Patient Day Cost Ceiling	$2.75 * Inflation Factor. Inflation shall be applied from 1/1/23 to the midpoint of the applicable rate year
G.	Excess ORPM Per Patient Day Cost	If F – E < 0 then F – E. If F – E ≥ 0 then 0.
H.	Patient Days	
I.	Excess ORPM Compensation	G * H

(E) Capital component. This is calculated utilizing a fair rental value allowance statewide price and provider specific other capital costs subject to an overall cost limitation and is calculated as follows:

	Table E.12 - Capital Component Calculation	
A.	Capital Per Patient Day Cost	Value determined in the Capital Per Patient Day Cost Calculation table below (Letter F)
B.	Median Capital Cost	The capital per patient day cost (Letter A) for each provider are utilized in the median calculation. The capital per patient day cost of the median provider shall be selected in accordance with subdivision (4)
C.	Profit Ceiling	B * 100%
D.	Tentative Profit Add-on	If C – A > 0, then 60% * (C – A). If (C – A) ≤ 0 then 0
E.	Total Quality Score Percentage	Calculated utilizing the scale in accordance with the Quality Program Manual
F.	Allowed Profit Add-on	D * E
G.	Capital Costs Plus Profit	A + F
H.	Overall Rate Component Limit	B * 100%
I.	Capital Component	Lesser of G or H

Table E.13 - Capital Per Patient Day Cost Calculation		
A.	Total Other Capital Costs	Allowable capital costs as described in the IMPRM
B.	Interest, Depreciation, Amortization, and Rent (negative value)	Allowable interest, depreciation, amortization, and rent costs as described in the IMPRM

C.	Fair Rental Value Allowance	Value as determined in the Fair Rental Value Allowance Calculation table below (Letter E)
D.	Allowable Capital Costs	A + B + C
E.	Patient Days or Minimum Occupancy	Patient days or 95% * bed days available, whichever is greater
F.	Capital Per Patient Day Cost	D / E

Table E.14 - Fair Rental Value Allowance Calculation		
A.	Average Inflated Historical Cost of Property of the Median Bed	The average historical cost of property per bed for each provider is utilized in the median calculation. The average historical cost of property per bed of the median provider shall be selected in accordance with subdivision (5)
B.	Total Nursing Facility Beds	Total nursing facility beds as described in the IMPRM
C.	Fair Rental Value Amount	A * B
D.	Rental Rate	Value as described in Section 2
E.	Fair Rental Value Allowance	C * D

(2) The Medicaid reimbursement system and rate component calculations in the tables above are based on the provider's allowable nursing facility cost which are annualized to a full year cost report period in recognition of the provider's allowable costs as described in the IMPRM.

(3) All allowable rate component costs as identified in the above tables shall be adjusted using the inflation factor. The inflation adjustment shall apply from the midpoint of the cost reporting period to the midpoint of the rate year, unless specifically identified otherwise.

(4) The allowable cost of the median patient day as identified in the above tables shall be calculated on a statewide basis each July 1 for the direct care, indirect care, administrative, and capital component from the most recently desk reviewed or field audited cost report:

(A) Providers are arrayed in descending order based on the applicable per patient day rate component costs as identified in the component calculations in the tables above which include the impact of minimum occupancy adjustments as applicable;

(B) Cumulative total patient days are calculated for each provider within the array, by adding that provider's patient days to all the total of all patient days within the array for preceding providers.
(C) The median patient day within the array is calculated by dividing cumulative patient days by two.
(D) The provider within the array whose total cumulative patient days is equal to or immediately greater than the median patient day is selected as the allowable cost of the median patient day.

(5) The average historical cost of property of the median bed in the above table shall be calculated on a statewide basis for facilities that are not acquired through an operating lease arrangement each July 1 as follows:
(A) Land, building, and improvements shall be adjusted for changes in valuation by inflating the reported allowable patient-related historical cost of property from the later of July 1, 1976, or the date of facility acquisition to the present based on the change in the RSMeans Construction Index.
(B) Inflated land and building historical costs are added to equipment and other historical property costs which are divided by beds to calculate the average inflated historical costs of property per bed.
(C) Providers are arrayed in descending order based on the average inflated historical costs of property per bed.
(D) Cumulative beds are calculated for each provider within the array, by adding each provider's beds to the total of all beds within the array for preceding providers.
(E) The median bed is calculated by dividing total cumulative beds by two.
(F) The provider within the array whose total cumulative beds is equal to or immediately greater than the median bed is selected as the average inflated historical costs of property per bed median.

(6) Until June 30, 2024, subsequent to the annual rebase, the direct care component of the Medicaid rate shall be adjusted quarterly to reflect changes in the provider's case mix index for Medicaid residents. If the facility has no Medicaid residents during a quarter, the facility's average case mix index for all residents shall be used in lieu of the case mix index for Medicaid residents. This adjustment shall be effective on the first day of each of the following three (3) calendar quarters beginning after the effective date of the annual rebase.
(A) The case mix index for Medicaid residents in each facility shall be:
(i) updated each calendar quarter; and

(ii) used to adjust the direct care component that becomes effective on the second calendar quarter following the updated case mix index for Medicaid residents.

Beginning July 1, 2024, subsequent to the annual rebase, the direct care component of the Medicaid rate shall be adjusted biannually to reflect changes in the provider's case mix index for Medicaid residents. If the facility has no Medicaid residents during a 6-month period, the facility's average case mix index for all residents shall be used in lieu of the case mix index for Medicaid residents. This adjustment shall be effective on January 1 after the effective date of the annual rebase.

(B) The case mix index for Medicaid residents in each facility shall be:

(i) updated every January 1; and

(ii) used to adjust the direct care component that becomes effective on the 6-month period following the updated case mix index for Medicaid residents.

In addition, each facility's total quality score shall be redetermined bi-annually based on the criteria in the Quality Program Manual.

(7) All rate-setting parameters and components used to calculate the annual rebase, except for the case mix index for Medicaid residents in that facility and the total quality score, shall apply to the calculation of any change in Medicaid rate that is authorized under subdivision (6).

(8) Rates effective until June 30, 2024, retroactive payment or repayment shall be required when an audit verifies an underpayment or overpayment due to intentional misrepresentation, billing or payment errors, or misstatement of historical financial or historical statistical data, or resident assessment data which caused a lower or higher rate than would have been allowed had the data been true and accurate. Upon discovery that a provider has received overpayment of a Medicaid claim from the office, the provider shall complete the appropriate Medicaid billing adjustment form prescribed by the office and reimburse the office for the amount of the overpayment, or the office shall make a retroactive payment adjustment, as appropriate.

(9) Providers shall pay interest on all overpayments, consistent with IC 12-15-13-4. The interest charge shall not exceed the percentage set out in IC 6-8.1-10-1(c). The interest shall:

(A) accrue from the date of the overpayment to the provider; and

(B) apply to the net outstanding overpayment during the periods in which such overpayment exists.

(10) Until January 31, 2024, when the number of nursing facility beds licensed by IDOH is changed after the cost reporting period, the provider may request in writing before the effective date of their next annual rebase an additional rebase effective on the first day of the calendar quarter on or following the date of the change in licensed beds. This additional rebase shall be determined using all rate-setting parameters in effect at the provider's latest annual rebase, except that the number of beds and associated bed days available for the calculation of the rate-setting limitations shall be based on the newly licensed beds.

Beginning February 1, 2024, when the number of nursing facility beds licensed by IDOH is changed, the provider may notify the office of these changes. For the July 1 rebase, the notification of the licensed bed change shall be in writing and submitted prior to January 31 preceding the July 1 rebase. For the January 1 bi-annual update, the notification of the licensed bed change shall be in writing and submitted prior to July 31 preceding the January 1 bi-annual update. For notifications received by the due date, the annual rebase at July 1 and bi-annual rate at January 1 shall be calculated utilizing the new number of nursing facility licensed beds.

405 IAC 1-14.7-7 Additional Reimbursement

Sec. 7. (a)The Special Facility Qualification report (Schedule Z) shall be completed by any provider requesting reimbursement for an SCU and/or Ventilator Program.

(1) Nursing facilities who have previously qualified as an SCU and/or Ventilator facility shall annually recertify that the facility is still in compliance with the requirements to continue to receive reimbursement. For annual recertifications, Schedule Z shall be completed based on the calendar year (January 1 through December 31) reporting period and submitted to the office not later than March 31 following the end of each calendar year.
(2) Nursing facilities who have developed an SCU and/or Ventilator program between October 1 and March 31 shall submit Schedule Z not later than March 31 to determine qualification and eligibility for reimbursement at the following July 1 rate effective date.
(3) Nursing facilities who have developed an SCU and/or Ventilator program between April 1 and September 30 shall submit Schedule Z not later than September 30 to determine qualification and eligibility for reimbursement at the following January 1 rate effective date.
(4) Nursing facilities who have discontinued an SCU and/or Ventilator program shall notify the office and indicate the date in which the program was discontinued.

(5) Nursing facilities who have developed an SCU and/or Ventilator program before December 31, 2023 may submit Schedule Z to determine qualification and eligibility for reimbursement beginning the effective date of the submission assuming that all applicable criteria were met.

(b) The office shall increase Medicaid reimbursement to nursing facilities with a qualifying ventilator program. Additional Medicaid reimbursement shall be made to the facilities at a rate of eighty dollars ($80.00) per eligible Medicaid resident day. The additional reimbursement shall:

(1) begin with the later of the effective date of the program or the first day for residents deemed ventilator dependent in accordance with the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (RAI Manual) or its successor published by CMS; and

(2) remain in effect until the earlier of the first day the resident is no longer deemed ventilator dependent in the RAI Manual or the program terminates.

(c) The office shall increase Medicaid reimbursement to nursing facilities with a qualifying special care unit program. The additional Medicaid reimbursement shall be made to the facilities at a rate of twelve dollars ($12) per eligible Medicaid Alzheimer's and dementia resident day in their SCU. The additional reimbursement shall:

(1) begin with the later of the effective date of the program or the first day for residents diagnosed with Alzheimer's or dementia; and

(2) remain in effect until the earlier of the first day the resident no longer has a diagnosis of Alzheimer's or dementia or the program terminates.

(d) The office shall increase Medicaid reimbursement to all nursing facilities for NEMT through an add-on in the amount of $1.21 per Medicaid resident day.

405 IAC 1-14.7-8 Minimum Data Set

Sec. 8. (a) Nursing facilities are required to electronically transmit MDS resident assessments in a complete, accurate, and timely manner as prescribed in the MDS and Case Mix Index Supportive Documentation Manual. An extension of the electronic MDS assessment due date may be granted by the office to a new operation attempting to submit MDS assessments for the first time if the:

(1) new operation is not currently enrolled or submitting MDS assessments under the Medicare program; and

(2) provider can substantiate to the office circumstances that preclude timely electronic transmission.

(b) If the office determines that a nursing facility has a delinquent MDS resident assessment, the assessment shall be assigned the delinquent classification as prescribed in the MDS and Case Mix Index Supportive Documentation Manual.

(c) The office shall adjust or revise MDS data items that an MDS review determines are unsupported to reflect the resident's highest functioning level that is supported according to the MDS and Case Mix Index Supportive Documentation Manual. Incorporation of any adjustments or revisions may result in a reclassification of the resident pursuant to the resident classification system.

(d) For rates effective prior to June 30, 2024, upon conclusion of an MDS review, the office shall recalculate the facility's CMI. If the recalculated CMI results in a change to the established Medicaid rate:

(1) the rate shall be recalculated; and

(2) any payment adjustment shall be made.

(e) For rates effective beginning July 1, 2024 and after, the result of an MDS review shall be applied in accordance with Section 12. Any CMI change as a result of the MDS review shall not be incorporated into either the Legacy System or Prospective System rate calculations in Section 6.

(f) CMIs are determined as prescribed in the MDS and Case Mix Index Supportive Documentation Manual for each resident to calculate the facility-average CMI for all residents and the facility-average CMI for Medicaid residents.

(g) The office shall provide each nursing facility with the following:

(1) A preliminary CMI report; and

(2) A final CMI report that shall be utilized to establish the facility-average CMI and the facility-average CMI for Medicaid residents utilized in establishing the nursing facility's Medicaid rate.

(h) In order to determine the normalized allowable direct care costs from each facility's cost report, the office shall determine each facility's CMI for all residents that corresponds to the cost reporting period in accordance with the MDS and Case Mix Index Supportive Documentation Manual.

405 IAC 1-14.7-9 Change of Ownership or Structure

Sec. 9. (a) The office shall be notified within thirty (30) days of any transaction affecting the following:

(1) ownership (operational license),

(2) property ownership,

(3) lessor/lessee,

(4) any management company, or

(5) any change in control or structure (including mergers, exchange of stock, etc.).
The provider shall submit a completed Checklist of Management Representations Concerning Change in Ownership to the office within thirty (30) days following the date requested by the office. The completed checklist shall include all supporting documentation to fully explain the transaction. For providers with an outstanding Checklist of Management Representations Concerning Change in Ownership, a field audit or desk review shall not be performed on any affected cost reports nor shall the affected cost report be used to establish reimbursement rates. Refer to section 12 for imposition of related penalties.

(b) For transactions prior to July 1, 2023, a cost report shall be filed for the first fiscal year end after the transaction date in which the provider has a minimum of six (6) full calendar months of actual historical data. The provider shall submit the cost report by the date identified on the Change of Ownership Letter.

(c) For transactions beginning July 1, 2023, the following shall apply:
(1) The office shall determine the nature of the transaction:
(2) If the nature of the transaction is determined to be one of the following, the fiscal period shall be determined in accordance with subdivision (3).
(A) any change in/to/from related party management company, or
(B) any change in a privately owned or operated nursing facility's ownership (operational license) except for when the seller (or their related entity) becomes the management company.
(3) The fiscal period shall be:
(A) from the start of the provider's required fiscal year through the day immediately preceding the transaction date; or
(B) from the transaction date through December 31.
(4) For any fiscal period identified in subdivision (3), a cost report shall be filed for the fiscal period that has a minimum of six (6) full calendar months of actual historical data. The cost report is due not later than the last day of the fifth calendar month after the fiscal period or thirty (30) days following notification by the office that the cost report shall be filed.

405 IAC 1-14.7-10 Related Parties

Sec. 10. (a) Common ownership exists when an individual, individuals, or any legal entity possesses ownership or equity of at least five percent (5%) in the provider as well as the institution or organization serving the provider. An individual is considered to own the interest of

immediate family for the determination of percentage of ownership. The following persons are considered immediate family:

(1) Spousal relationship.

(2) Natural parent, child, and sibling.

(3) Adopted child and adoptive parent.

(4) Stepparent, stepchild, stepsister, and stepbrother.

(5) Father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law, daughter-in-law, stepson-in-law, and stepdaughter-in-law.

(6) Grandparent and grandchild.

(7) Anyone who has been previously considered immediate family.

(b) Control exists where an individual or an organization has the power, directly or indirectly, to influence or direct the actions or policies of an organization or institution, whether or not actually exercised. A general partner is considered to control an entity.

(c) Transactions between related parties are not considered to have arisen through arm's-length negotiations. Costs applicable to services, facilities, and supplies furnished to a provider by related parties shall not exceed the lower of the cost to the related party, or the price of comparable services, facilities, or supplies purchased as an arm's-length transaction in an open competitive market. An exception to this subsection may be granted by the office if requested in writing by the provider before the annual rebase effective date to which the exception is to apply. The provider's request shall include a comprehensive representation that every condition in subsection (d) has been met. This representation shall include, but not be limited to, the percentage of business the provider transacts with related and nonrelated parties based upon revenue. When requested by the office, the provider shall submit documentation, such as invoices, standard charge master listings, and remittances, to substantiate the provider's charges for services, facilities, or supplies to related and nonrelated parties.

(d) The office may grant an exception when a related organization meets all of the following conditions:

(1) The supplying organization is a bona fide separate organization whose services, facilities, and supplies are made available to the public in an open competitive market.

(2) A sufficient part of the supplying organization's business activity is transacted with other than the provider and organizations related to the supplier in common ownership or control, and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization. Transactions with residents of nursing facilities that are owned, operated, or managed by the provider or organizations related to the provider or any former provider or related entity that currently serves as the management

company or entity in a similar decision making capacity for a NSGO provider shall not be considered an arm's-length business activity transacted in an open competitive market.
(3) The services, supplies, or facilities are those that commonly are obtained by institutions, such as the provider, from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions.
(4) For facilities other than NSGO nursing facilities, the organization actually furnishes such services, facilities, or supplies to other nonrelated party organizations. The charge to the provider shall be:

(A) in line with the charge for such services, facilities, or supplies in the open market; and
(B) not more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

(5) For NSGO nursing facilities, the organization actually furnishes such services, facilities or supplies to organizations that are not related to the NSGO provider or any former provider or related entity that currently serves as the management company or entity in a similar decision making capacity for the NSGO provider. The charge to the provider shall be:

(A) in line with the charge for such services, facilities, or supplies in the open market; and
(B) not more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

(e) The related-party exception shall be granted for any period of time, up to the maximum period of two (2) years.

(f) If a provider rents, leases, or purchases facilities or equipment from a related party property company, the historical cost to the related party, not to exceed fair market value, shall be utilized in computing the average historical cost of property of the median bed except as described in this section for the sale of facilities between family members.

(g) If a sale of facilities between family members meets the following conditions, the cost basis of the facility shall be recognized for the purpose of computing the average historical cost of property of the median bed in accordance with this rule as a bona fide sale arising from an arm's-length transaction, subject to the limitations of subsection (h):
(1) There is no current or previous spousal relationship between parties.
(2) The following persons are considered family members:

(A) Natural parent, child, and sibling.
(B) Adopted child and adoptive parent.
(C) Stepparent, stepchild, stepsister, and stepbrother.

(D) Father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law, and daughter-in-law.
(E) Grandparent and grandchild.
(F) Anyone who has been previously considered family members.

(3) The transfer is recognized and reported by all parties as a sale for federal income tax purposes.
(4) The seller is not associated with the facility in any way after the sale other than as a passive creditor.
(5) The buyer is actively engaged in the operation of the facility after the sale with earnings from the facility accruing to at least one (1) principal buyer primarily as salaries or self-employment income and not as leases, rents, or other passive income.
(6) This family sale exception has not been utilized during the previous eight (8) years on this facility.
(7) None of the entities involved is a publicly held corporation as defined by the Securities and Exchange Commission.
(8) If any of the entities involved are corporations, they shall be family owned corporations, where members of the same family control the corporations through ownership of fifty percent (50%) or more of the voting stock.

(h) In order to establish a historical cost basis in the sale of facilities between family members, the buyer shall obtain a Member Appraiser Institute (MAI) appraisal. The MAI appraisal is subject to the approval of the office. The appraisal shall be done within ninety (90) days of the date of the sale. The historical cost basis for purposes of determining the average historical cost of property of the median bed shall be the lower of the historical cost basis of the buyer or the MAI appraisal of facilities and equipment.

(i) If a lease of facilities between family members under subsection (g) qualifies as a capitalized lease under the Statement of Financial Accountant Standards Number 13 as issued by the Financial Accounting Standards Board, the transaction shall be treated as a sale of facilities between family members for purposes of determining the average historical cost of property of the median bed.

405 IAC 1-14.7-11 Quality Assessment Fee

Sec. 11. For nursing facilities certified for participation in the Medicaid program under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.), the quality assessment shall be an allowable cost for cost reporting and auditing purposes. The quality assessment shall be included in Medicaid reimbursement as an add-on to the Medicaid rate. The add-on is

determined by dividing the product of the assessment rate times total non-Medicare patient days by total patient days from the most recently completed desk reviewed cost report.

405 IAC 1-14.7-12 Penalties and Settlements

Sec. 12. (a) Penalties shall be assessed on a per nursing facility basis.

(b) Reimbursement lost because of any imposed penalty cannot be recovered by the provider.

(c) Penalties may be addressed through a retroactive reprocessing of claims or settlement process.

(d) Beginning April 1, 2024, penalties shall be calculated and assessed in accordance with the following:

	Event	Event Due Date	Penalty Amount	Penalty Assessment Begin Date	Penalty Assessment End Date
(1)	Cost Report Submission for Annual Rebase	End of the fifth month after the fiscal period	$15,000	16th day after event due date and every 15 days thereafter	Day of complete submission or one year from penalty assessment begin date whichever is earlier.
(2)	Cost Report Submission Following a Change in Ownership	Due date identified on the Change of Ownership Letter	$15,000	16th day after event due date and every 15 days thereafter	Day of complete submission or one year from penalty assessment begin date whichever is earlier.
(3)	Change in Ownership Checklist Submission	30 calendar days from checklist request	$15,000	16th day after event due date and every 15 days thereafter	Day of complete submission or one year from penalty assessment begin date whichever is earlier.
(4)	Prefield Information Request	Due date identified on Audit Notification Letter	$15,000	Day 1 after event due date	[redacted]
			$2,000	Each day, days 1 - 30.	Day of complete submission or day 31 whichever is earlier.

(5)	Field Work – Follow-Up Letter (exception noted in subsection (e)	Due date identified on Follow-Up Letter	$15,000	Day 1 after event due date	
			$2,000	Each day, days 1 - 30.	Day of complete submission or day 31 whichever is earlier.

(e) If the nursing facility cannot locate requested information in the Field Work – Follow-up letter as noted in subdivision 4 above, they shall supply a signed declaration, prescribed by the office, that they are unable to produce the requested documentation. This declaration shall be submitted at least one (1) day prior to the due date on the Field Work – Follow-up letter to avoid penalty.

(f) Until March 31, 2024, penalties shall be assessed as follows:
(1) Failure to submit a complete cost report as described in section 3 within the time limit required shall result in the following actions:
(A) When a complete cost report is more than one (1) calendar month past due, the following shall apply:
(i) the rate in effect effective immediately preceding the due date shall be reduced by ten percent (10%), effective on the first day of the seventh month following the provider's fiscal year end,
(ii) the reduced rate shall remain in effect until the first day of the month after the delinquent complete cost report is received by the office,
(iii) no rate adjustments shall be allowed until the first day of the calendar quarter following receipt of the delinquent complete cost report, and
(iv) no desk review or field audit shall be performed on incomplete submissions.
(B) If the Medicare filing deadline for submitting the Medicare cost report is delayed by the Medicare fiscal intermediary and the provider fails to submit its Medicare cost report to the office on or before the due date as extended by the Medicare fiscal intermediary, the following shall apply;
(i) the rate in effect immediately preceding the due date shall be reduced by ten percent (10%), effective on the first day of the month following the due date as extended by the Medicare fiscal intermediary,
(ii) the reduced rate shall remain in effect until the first day of the month after the delinquent Medicare cost report is received by the office,
(iii) no rate adjustments shall be allowed until the first day of the calendar quarter following receipt of the delinquent complete cost report, and

(iv) no desk review or field audit shall be performed on incomplete submissions

(2) Failure to submit a completed Checklist of Management Representations Concerning Change in Ownership to the office within ninety (90) days following the date the Checklist of Management Representations request is sent to the provider shall result in the following actions:

(A) The rate in effect immediately preceding the due date shall be reduced by ten percent (10%), effective on the first day of the month following the end of the ninety (90) day period,

(B) The reduced rate shall remain in effect until the first day of the month after the completed Checklist of Management Representations is received by the office, and

(C) No desk review or field audit shall be performed until the completed Checklist of Management Representations is received and reviewed.

(3) In the event the required prefield information has not been submitted by the due date indicated in the audit notification letter, the following actions shall be taken:

(A) The rate in effect immediately preceding the due date shall be reduced by ten percent (10%), effective on the first day following the date the response was due,

(B) The reduced rate shall remain in effect until:

(i) the first day following the office's receipt of a complete response, or

(ii) one (1) year after the effective date of the ten percent (10%) rate reduction.

(C) No rate adjustments shall be allowed until the first day of the calendar quarter following:

(i) the receipt of information requested in the written notice, or

(ii) one (1) year after the effective date of the ten percent (10%) rate reduction.

(4) In the event the required field work information has not been submitted by the due date indicated in the Field Work – Follow-Up Letter, the following actions shall be taken:

(A) The rate in effect immediately preceding the due date shall be reduced by ten percent (10%), effective on the first day following the date the response was due.

(B) The reduced rate shall remain in effect until:

(i) the first day following the office's receipt of a complete response, or

(ii) one (1) year after the effective date of the ten percent (10%) rate reduction.

(C) No rate adjustments shall be allowed until the first day of the calendar quarter following:

(i) the receipt of information requested in the written notice, or
(ii) one (1) year after the effective date of the ten percent (10%) rate reduction.

(5) In the event that the documentation submitted for the field audit is inadequate or incomplete or the 10% reduction has expired, the following additional actions shall be taken:

(A) Appropriate adjustments to the applicable cost report shall be made,
(B) The office shall document such adjustments in a finalized exception report, and
(C) The office shall incorporate such adjustments in the prospective rate calculations.

(g) If the office determines due to an MDS review that a nursing facility has unsupported MDS resident assessments, then the following procedures shall be followed in applying any penalty:

(1) The office shall:

(A) review a sample of MDS resident assessments; and
(B) determine the percent of assessments in the sample that are unsupported.

(2) If the percent of assessments in the initial sample that are unsupported is:

(A) greater than twenty percent (20%), the office shall expand to a larger sample of residents assessments; or
(B) equal to or less than twenty percent (20%), the office shall conclude the field portion of the MDS review.

(3) For rates effective beginning July 1, 2024 and after, a penalty for unsupported MDS resident assessments shall be calculated as follows:

(A) if the percentage of unsupported assessments for the initial and expanded sample of all assessments reviewed is greater than twenty percent (20%) a penalty shall be applied. The penalty shall be calculated as the administrative component portion of the Legacy System Medicaid rate in effect for the current bi-annual period multiplied by the applicable percentage in the table below multiplied by Medicaid days for the bi-annual rate period.

MDS Field Review for Which Penalty Is Applied	**Penalty Percent**
First MDS Review	7.5%
Second consecutive MDS Review	10%
Third consecutive MDS Review	15%

Fourth or more consecutive MDS Review(s)	25%

(B) Upon conclusion of an MDS review, the office shall calculate and implement a penalty based on changes to the facility's biannual Medicaid CMI. If the recalculated biannual Medicaid CMI is a change from the Medicaid CMI used in the initial Legacy rate calculation before the MDS Review the penalty shall be calculated per the table below:

CMI Penalty Calculation		
A.	Legacy System rate calculated with original biannual Medicaid CMI	The Medicaid rate calculated under Section 6(e) using the CMI prior to the MDS Review.
B.	Legacy System rate calculated with revised biannual Medicaid CMI	The Medicaid rate calculated under Section 6(e) using the CMI after completion of the MDS Review.
C.	Rate Differential	A - B
D.	Medicaid Days	
E.	CMI Penalty	C * D

(4) For rates effective prior to June 30, 2024, if the percentage of unsupported assessments for the initial and expanded sample of all assessments reviewed is greater than twenty percent (20%), a penalty shall apply, which shall be calculated as follows:

MDS Field Review for Which Penalty Is Applied	Administrative Component Penalty Percent
First MDS Review	15%
Second consecutive MDS Review	20%
Third consecutive MDS Review	30%
Fourth or more consecutive MDS Review(s)	50%

(A) The administrative component portion of the Medicaid rate in effect for the calendar quarter following completion of the MDS review shall be reduced by the percentage as shown in the following table:

(B) In the event a penalty is imposed, for purposes of determining the average allowable cost of the median patient day for the administrative component, there shall be no adjustment made by the office to the provider's allowable administrative costs.

405 IAC 1-14.7-13 Administrative Reconsideration and Appeal Process

Sec. 13. (a) A reconsideration request shall be in writing and contain specific issues to be considered and the rationale for the provider's position. The provider shall timely request administrative reconsideration before filing an appeal. The events detailed below shall be communicated to nursing facilities via a formal letter either through USPS mail or via a secure web portal at which point the period for a timely request begins. The events are:

(1) Schedule of adjustments or a summary of findings resulting from a review performed under section 4;

(2) CMI quarterly or bi-annual updates or recalculation of CMIs due to an MDS review;

(3) All parameters used to calculate an issued rate other than the schedule of adjustments in subdivision 1 and CMIs in subdivision 2 above; and

(4) Penalties or remedies from section 12.

The request shall be signed by the provider or authorized representative of the provider and shall be received by the office not later than fifteen (15) days after the date of issuance. The office shall evaluate the reconsideration request and may affirm or amend the original decision. The office shall thereafter notify the provider of its final decision in writing not later than forty-five (45) days from the office's receipt of the request for reconsideration. In the event that a timely response is not made by the office to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies under subsection (c).

(b) In accordance with IC 4-21.5-3-2(e) any notification letter served through the United States mail, the fifteen (15) day reconsideration period shall begin three (3) days after the date of the notification letter.

(c) After completion of the reconsideration procedure under subsection (a) the provider may initiate an appeal under IC 4-21.5-3. The request for an appeal shall be signed by the nursing facility provider. Only issues raised by the provider through administrative reconsideration may be subsequently raised in an appeal.

(d) The office may take action to implement changes made in accordance with subsection (a) without awaiting the outcome of an appeal filed in accordance with subsection (c).

(e) The office may implement Medicaid rates and recover overpayments from previous rate reimbursements, either through deductions of future payments or otherwise, without awaiting the outcome of the administrative appeal process, in accordance with IC 12-15-13-4(e).

405 IAC 1-14.7-14 Supplemental Payment Calculation

Sec. 14. (a) In addition to the established Medicaid rates for nursing facilities, any non-state government owned or operated nursing facility (NSGO providers) that has entered into an agreement with the office to participate in the nursing facility supplemental payment program shall receive a Medicaid supplemental payment adjustment. Privately owned or operated nursing facilities (Private providers) and non-participating NSGO providers, may only participate in the quality supplemental payment pool as detailed in subsection (c) below. Supplemental payments shall not exceed the upper payment limit for the provider class pursuant to 42 CFR 447.272.

(b) The Medicaid supplemental payment shall be transitioned from the Legacy Supplemental Payment System methodology in subsection (d) to the Pooled Supplemental Payment System methodology in subsection (c). The Medicaid supplemental payment shall be calculated as the sum of the following:
(1) Pooled Supplemental Payment System payment calculated in accordance with subsection (c) multiplied by the percentage below; and
(2) Legacy Supplemental Payment System payment calculated in accordance with subsection (d) multiplied by the percentage below.

Supplemental Payment Periods	**Pooled Supplemental Payment System**	**Legacy Supplemental Payment System**
Prior to July 1, 2024	0%	100%
July 1, 2024 – June 30, 2025	10%	90%
July 1, 2025 – June 30, 2026	40%	60%
July 1, 2026 – June 30, 2027	70%	30%
July 1, 2027 and forward	100%	0%

(c) The Pooled Supplemental Payment System calculates the Medicaid Supplemental Payment on a state fiscal year (SFY) basis utilizing a quarterly (July 1, October 1, January 1, April 1) statewide supplemental payment pool methodology for participating providers. The established supplemental payment pool is distributed to nursing facilities on a quarterly basis utilizing the prescribed methodology detailed below. An interim supplemental payment pool and provider distribution shall be calculated for each quarter of the SFY with a final supplemental payment pool and provider distribution for each quarter occurring after conclusion of the SFY.

(1) The aggregate supplemental payment pool for each quarter of the SFY is established utilizing participating NSGO providers as follows:

(A) Establish the estimated Medicare payments. For each Medicaid resident that is in a nursing facility during an MDS reporting period, the MDS assessments in effect for that period are classified using the Medicare resident classification system. The Medicare rate shall be adjusted by the Medicare geographic wage index and to remove the statewide average impact of covered benefit differences between the Medicare and Medicaid programs. A day-weighted average Medicare rate is determined for each nursing facility by multiplying the estimated Medicare rate for each Medicaid resident assessment by the number of days in the MDS reporting period in which the assessment was active to create that assessment's Medicare rate weight. The sum of each nursing facility's MDS resident assessment Medicare rate weights for the applicable MDS reporting period are divided by the total number of Medicaid resident assessment days detailed on the final MDS resident roster for the applicable reporting period to derive the estimated average Medicare rate. The estimated average Medicare rate for each provider is multiplied by their Medicaid resident days (eligible for supplemental payment) for both fee-for-service and managed Medicaid populations to determine the estimated Medicare payments. Provider Medicare payments are summed to establish the total estimated Medicare payments for the supplemental payment period. The MDS reporting periods utilized to determine the interim and final supplemental payment periods are as follows:

Supplemental Payment Period	**Interim Supplemental Payment MDS Reporting Period**	**Final Supplemental Payment MDS Reporting Period**
July 1 – September 30	March 1 – May 31	June 1 – August 31
October 1 – December 31	June 1 – August 31	September 1 – November 30
January 1 – March 31	September 1 – November 30	December 1 – February 28 (Feb. 29 in leap year)
April 1 – June 30	December 1 – February 28 (Feb. 29 in leap year)	March 1 – May 31

(B) Establish the estimated Medicaid payments for each provider. For each provider, the most recently available Medicaid per diem rate, inclusive of the per diem impact of the Medicaid add-on payments determined in section 7, is

multiplied by their Medicaid resident days (eligible for supplemental payment) for both fee-for-service and managed Medicaid populations to establish Medicaid payments for each provider. Provider Medicaid payments are summed to establish the total estimated Medicaid payments for the supplemental payment period.

(C) Determine the supplemental payment period pool. For each participating provider the estimated Medicaid payment in clause (B) shall be subtracted from their estimated Medicare payments in clause (A) to determine their UPL gap. The sum of each provider's UPL gap shall be the total supplemental payment period pool.

(D) After conclusion of each state fiscal year, the interim payment pool is subject to a final supplemental payment process where the underlying MDS resident assessments, Medicaid days, Medicare rates, and Medicaid rate information are reconciled to the actual payment period to calculate the final supplemental payment pool for each quarter of the SFY. The established supplemental payment pools are utilized for calculation of the interim and final payment pool distribution in subdivision 2 below.

(2) The supplemental payment pool distribution is segregated into the Base supplemental payment pool and the Quality supplemental payment pool. Medicaid days and Medicaid rates specified in the tables below are calculated for interim and final supplemental payment periods as described above. Payment to each participating provider for each quarter of the SFY is established as follows:

Uniform Percentage Calculation		
A.	Total Supplemental Payment Pool	Total UPL Gap calculated above
B.	Percentage of Pool Reserved for Quality	See Percentage of Pool Reserved for Quality Table Below
C.	Total Quality Pool	A * B
D.	Total Supplemental Payment Pool Net of Quality	A – C
E.	Total NSGO Provider Medicaid Days	
F.	Average NSGO Supplemental Per Patient Day payment	D / E
G.	Weighted Average NSGO Medicaid Rate	(Sum of the products of each NSGO provider's Medicaid per diem rate * their Medicaid days) / E
H.	NSGO Uniform Percentage	F / G

Percentage of Base Rate Paid Per Quality Point Earned Calculation		
A.	Total Quality Pool	Value as determined in the Uniform Percentage Calculation table above (Letter C)
B.	Facility Total Quality Score Points	Value as determined in accordance with the Quality Program Manual
C.	Medicaid Days	[redacted]
D.	Medicaid Rate	
E.	Total Quality Weight	Sum of the products of B * C * D for each provider
F.	Percentage of Base Rate Paid Per Quality Point Earned	A / E

Quality Percentage Calculation		
A.	Facility Total Quality Score	Value as determined in accordance with the Quality Program Manual
B.	Percentage of Base Rate Paid Per Quality Point Earned	Value as determined in Percentage of Base Rate Paid Per Quality Point Earned Calculation table above (Letter F)
C.	Quality Percentage	A * B

Percentage of Pool Reserved for Quality Table		
A.	January 1, 2025	10%
B.	July 1, 2025	12%
C.	July 1, 2026	14%
D.	July 1, 2027	16%
E.	July 1, 2028	18%
F.	July 1, 2029	20%

Total Provider Medicaid Fee-For-Service (FFS) Supplemental Payment		
A.	NSGO Uniform Percentage	Value as determined in the Uniform Percentage Calculation table above (Letter H). Non-participating NSGO or Non-NSGO provider entity values shall be zero.
B.	Quality Percentage	Value as determined in the Quality Percentage table above (Letter C)
C.	Medicaid Rate	[redacted]
D.	Total Supplemental Payment Rate	(A + B) * C

E.	Total Medicaid FFS Days	Medicaid days for FFS population only. Utilizes the same data source as Total Medicaid days
F.	Total Medicaid Days	[redacted]
G.	Total Medicaid FFS Percentage	E / F
H.	Total Medicaid FFS Supplemental Payment	D * G

(A) After conclusion of each state fiscal year, each provider's interim supplemental payment is subject to a final supplemental payment process where the underlying MDS resident assessment information, Medicaid days, Medicare rate, and Medicaid rate information are reconciled to the actual payment period to calculate the final supplemental payment for each quarter using the methodology prescribed in the above table. Any differential between the final and interim supplement payment shall be paid to or recouped from each provider.

(d) The Legacy Supplemental Payment System calculates the Medicaid supplemental payment on a state fiscal year (SFY) basis utilizing a quarterly (July 1, October 1, January 1, April 1) provider specific UPL gap payment methodology for participating NSGO providers. The established supplemental payment pool is distributed to nursing facilities on a quarterly basis utilizing the prescribed methodology detailed below. An interim and final supplemental payment shall be calculated for each quarter:The supplemental payment for each quarter is established as follows:

(A) Establish the estimated Medicare payments. For each Medicaid resident that is in a nursing facility during an MDS reporting period, the MDS assessments in effect for that period are classified using the Medicare resident classification system. The Medicare rate shall be adjusted by the Medicare geographic wage index and to remove the statewide average impact of covered benefit differences between the Medicare and Medicaid programs. A day-weighted average Medicare rate is determined for each nursing facility by multiplying the estimated Medicare rate for each Medicaid resident assessment by the number of days in the MDS reporting period in which the assessment was active to create that assessment's Medicare rate weight. The sum of each nursing facility's MDS resident assessment Medicare rate weights for the applicable MDS reporting period are divided by the total number of Medicaid resident assessment days detailed on the final MDS resident roster for the applicable reporting period to derive the estimated average Medicare rate. The estimated average Medicare rate for each provider is multiplied by their Medicaid resident days (eligible for supplemental payment) for both fee-for-service and managed Medicaid populations to determine total

estimated Medicare payments. The MDS reporting periods utilized to determine the interim and final supplemental payment periods are as follows:

For Supplemental Payment Periods Before July 1, 2024		
Supplemental Payment Period	**Interim Supplemental Payment MDS Reporting Period**	**Final Supplemental Payment MDS Reporting Period**
July 1 – September 30	April 1 – June 30	July 1 – September 30
October 1 – December 31	July 1 – September 30	October 1 – December 31
January 1 – March 31	October 1 – December 31	January 1 – March 31
April 1 – June 30	January 1 – March 31	April 1 – June 30

For Supplemental Payment Periods Beginning July 1, 2024		
Supplemental Payment Period	**Interim Supplemental Payment MDS Reporting Period**	**Final Supplemental Payment MDS Reporting Period**
July 1 – September 30	March 1 – May 31	June 1 – August 31
October 1 – December 31	June 1 – August 31	September 1 – November 30
January 1 – March 31	September 1 – November 30	December 1 – February 28 (Feb. 29 in leap year)
April 1 – June 30	December 1 – February 28 (Feb. 29 in leap year)	March 1 – May 31

(B) Establish the estimated Medicaid payments for each provider. For each provider, the most recently available Medicaid per diem rate, inclusive of the per diem impact of the Medicaid add-on payments determined in section 7, is multiplied by their Medicaid resident days (eligible for supplemental payment) for both fee-for-service and managed Medicaid populations to establish total Medicaid payments for each provider.

(C) Determine the total UPL gap for each provider. For each provider the estimated total Medicaid payment in clause (B) shall be subtracted from their estimated total Medicare payments in clause (A) to determine their UPL gap. For interim payment periods, any provider with a negative UPL gap (Medicaid payments exceed their specific Medicare UPL limit) shall not receive a payment under the legacy method, nor be required refund the Medicaid program at that

time. Any required refund to the Medicaid program shall occur only during the final supplemental payment process as described in clause (F).

(D) Determine the Medicaid FFS percentage for each provider. Divide each provider's Medicaid FFS days by total Medicaid Days for the supplemental payment period to establish the Medicaid FFS percentage.

(E) Determine the total supplemental payment for each provider. For each provider multiply their UPL gap calculated in clause (C) by the Medicaid FFS percentage calculated in clause (D) to determine the total supplemental payment for the supplemental payment period.

(F) After conclusion of each state fiscal year, the interim SFY quarterly supplemental payments are subject to a final supplemental payment process where the underlying MDS resident assessments, Medicaid days, Medicare rates, and Medicaid rate information are reconciled to the actual payment period to calculate the final supplemental payment. Any differential between the final and interim supplement payment shall be paid to or recouped from each provider. Any provider with a negative UPL gap (Medicaid payments exceed their specific Medicare UPL limit), shall be required to refund the Medicaid program for the differential.

Reimbursement for Religious Non-Medical Health Care Institutions

(a) Care for residents in a Religious Non-Medical Health Care Institution approved by the office may be reimbursed pursuant to the case mix reimbursement methodology found at 405 IAC 1-14.6.23

(b) Religious Non-Medical Health Care Institutions are not required to electronically transmit MDS resident assessment information.

(c) Initial interim rates will be set at the sum of the average allowable cost of the median patient day for the direct care, therapy, indirect care, administrative, and eighty percent (80%) of the capital component. Prior to the provider's first annual rate review, the direct care component of the Medicaid initial interim rate will be adjusted to reflect a case mix level of Reduced Physical Function PD 1. Initial interim rates shall be effective on the certification date or the date that a service is established, whichever is later. In determining the initial rate, limitations and restrictions otherwise outlined in this rule shall apply.

(d) Normalized allowable cost shall be the facility's total allowable direct patient care costs divided by a case mix level of Reduced Physical Function PD 1.

(e) The case mix index for Medicaid residents used to adjust the direct care component that becomes effective on the second calendar quarter following the facility's fiscal year end shall be a case mix level of Reduced Physical Function PD 1. No adjustment to the direct care component to reflect changes in the facility's Medicaid casemix for the three calendar quarters following the effective date of the annual rate review shall be performed.

(f) Except as noted in this section all other sections of 405 IAC 1-14.6 shall apply.

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Rule 15. Nursing Facilities; Electronic Transmission of Minimum Data Set
405 IAC 1-15-1 Scope

Sec. 1. (a) Nursing facilities certified to provide nursing facility care to Medicaid members are required to electronically transmit minimum data set (MDS) information for all nursing facility residents to the office. The MDS data is used to establish and maintain a case mix system for Medicaid reimbursement to nursing facilities and other Medicaid program management purposes.

(b) Nursing facilities certified to provide nursing facility care to Medicaid members are required to electronically transmit the end of therapy date for physical, occupational and speech therapy services provided to a resident in a format specified by the Office.

405 IAC 1-15-2 Definitions

Sec. 2. (a) The definitions in this section apply throughout this rule.

(b) "Case mix reimbursement" means a system of paying nursing facilities according to the mix of residents in each facility as measured by resident characteristics and service needs. Its function is to provide payment for resources needed to serve different types of residents.

(c) “End of therapy date” means the date each therapy regimen ended for physical therapy, occupational therapy, or speech therapy, which is the last date the resident received therapy treatment.

(d) "Minimum data set" or "MDS" means a core set of screening and assessment elements, including common definitions and coding categories, that forms the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicaid. The items in the MDS standardize communication about resident problems, strengths, and conditions within the facilities, between facilities, and between facilities and outside agencies. The Indiana system shall employ the MDS 3.0 or subsequent revisions as approved by CMS.

(e) "Resident classification system" means the classification system used to classify residents into groups to determine reimbursement levels as supported by the MDS and Case Mix Index Supportive Documentation Manual.

405 IAC 1-15-4 MDS Supporting Documentation Requirements

Sec. 4. (a) Supporting documentation requirements for all MDS data elements that are utilized to classify nursing facility residents in accordance with the resident classification system are contained in the MDS and Case Mix Supportive Documentation Manual. Additional guidance may be published as a provider bulletin and may be updated by the office as needed. Any such updates shall be made effective no earlier than permitted under IC 12-15-13-6(a).

(b) Nursing facilities shall maintain supporting documentation in the resident's medical chart for all MDS data elements that are utilized to classify nursing facility residents in accordance with the resident classification system. Such supporting documentation shall be maintained by the nursing facility for all residents in a manner that is accessible and conducive to review.

405 IAC 1-15-5 MDS Review Requirements

Sec. 5. (a) The office shall periodically review the MDS assessments and supporting documentation data maintained by nursing facilities for all residents, regardless of payer type. The reviews shall be conducted as frequently as deemed necessary by the office, and each nursing facility shall be reviewed no less frequently than every thirty-six (36) months. Advance notification shall be provided by the office for all MDS reviews, except for follow-up reviews that are intended to ensure compliance with validation improvement plans.

(b) All MDS assessments data, regardless of payer type, are subject to an MDS review.

(c) When conducting the MDS reviews, the office shall consider all MDS supporting documentation data that is provided by the nursing facility and is available to the reviewers prior to the exit conference. MDS supporting documentation data that is provided by the nursing facility after the exit conference begins shall not be considered by the office.

(d) The nursing facility shall be required to produce, upon request by the office, a computer generated copy of the MDS assessment that is transmitted in accordance with section 1 that shall be the basis for the MDS review.

(e) Suspected intentional alteration of clinical documentation, or creation of documentation after MDS assessments data have been transmitted, shall be referred to the Indiana Medicaid Fraud Control Unit for investigation of possible fraud. Such an investigation could result in a felony or misdemeanor criminal conviction.

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405 IAC 1-14.5-27 Limitation to Medicaid rate increases for HIV nursing facilities

Sec. 27. Notwithstanding all other provisions of this rule, for the period January 1, 2006, through June 30, 2007, HIV nursing facility rates that have been calculated under this rule shall be reduced by five dollars ($5) per resident per day.

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*There was no OBRA rate increase effective 4-1-93 however there has been an aggregate increase of .67 per-patient-day since 10-1-90 representing the conversion of cost recognition for the following listed OBRA '87 requirements.

COST RECOGNITION CATEGORIES

1. Resident's Rights-Transfer and Discharge Requirements 42 CFR 483.12(a)(5)(ii), consisting primarily of requirements to implement a resident appeal procedure associated with transfer and discharge of residents.

2. Other Staffing Requirements-Social Service Qualifications 42 CFR 483.15(g)(2)(ii) and 483.15(g)(4), requirement for and minimum qualification standards of a social worker for facilities with more than 120 beds.

3. Resident Assessment-42 CFR 483.20, requirement regarding frequency, timing and accuracy of resident assessments.

4. Plans For Care-42 CFR 483.20(d), requiring changes in timing and content of the resident care plan.

5. Resident Assessment Discharge Summary-42 CFR 483.20(e)(3), additional requirements to develop a discharge plan.

6. Nurse Staffing Requirements-42 CFR 483.30, requiring increase in nurse staffing resources in Indiana NFs with fewer than 40 beds to reach one full time equivalent RN.

7. Other Staffing Requirements-Dental Services 42 CFR 483.55, requiring increased responsibility placed on NFs to ensure resident's receipt of needed dental care.

8. Other-Inflation Applied Against 10-1-90 Cost Recognition

CATEGORY	COST RECOGNITION	PPD RATE INCREASE	PERCENT OF TOTAL INCREASE
1	$ 39,360	.0043	.6
2	$ 3,605,250	.3946	59.4
3	$ 402,588	.0440	6.6
4	$ 400,000	.0437	6.6
5	$ 234,000	.0256	3.9
6	$ 295,000	.0386	4.9
7	$ 636,000	.0696	10.5
8	$ 456,765	.0500	7.5
TOTALS	$ 6,068,963	.6704	100.0

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The OBRA rate increase of .04 ppd. represents the increase of cost recognition for the following listed OBRA '87 requirements. The prior .72 ppd. when added to this .04 increase represent a total increase of .76 ppd. since 10-1-90 for OBRA cost recognition.

COST RECOGNITION CATEGORIES

1. Resident's Rights-Transfer and Discharge Requirements 42 CFR 483.12(a)(5)(ii), consisting primarily of requirements to implement a resident appeal procedure associated with transfer and discharge of residents.

2. Other Staffing Requirements-Social Service Qualifications 42 CFR 483.15(g)(2)(ii) and 483.15(g)(4), requirement for and minimum qualification standards of a social worker for facilities with more than 120 beds.

3. Resident Assessment-42 CFR 483.20, requirement regarding frequency, timing and accuracy of resident assessments.

4. Plans For Care-42 CFR 483.20(d), requiring changes in timing and content of the resident care plan.

5. Resident Assessment Discharge Summary-42 CFR 483.20(e)(3), additional requirements to develop a discharge plan.

6. Nurse Staffing Requirements-42 CFR 483.30, requiring increase in nurse staffing resources in Indiana NFs with fewer than 40 beds to reach one full time equivalent RN.

7. Other Staffing Requirements-Dental Services 42 CFR 483.55, requiring increased responsibility placed on NFs to ensure resident's receipt of needed dental care.

8. Other-Inflation Applied Against 10-1-90 Cost Recognition

CATEGORY	COST RECOGNITION	PPD RATE INCREASE	PERCENT OF TOTAL INCREASE
1	$ 45,760	.0050	.7
2	$ 4,192,100	.4589	60.8
3	$ 468,104	.0512	6.8
4	$ 465,122	.0509	6.8
5	$ 272,091	.0298	3.9
6	$ 343,036	.0449	5.0
7	$ 739,515	.0809	10.7
8	$ 365,413	.0400	5.3
TOTALS	$ 6,891,141	.7616	100.0

The Office of Medicaid Policy & Planning, State of Indiana has submitted Medicaid state plan amendment TN 94-007 (reimbursement reform for large private ICFs/MR and small private group homes--CRFs/DD) and state plan amendment TN 94-019 (reimbursement changes resulting from a provider assessment program and rate rebasing for large private ICFs/MR and small private group homes--CRFs/DD). These amendments, in addition to making changes to the reimbursement criteria for the provider types mentioned, segregates the entire rate setting criteria for large and small private ICFs/MR from the criteria for nursing facilities. Upon approval by HCFA of those amendments, which carry an effective date of 7-1-94, the Indiana Medicaid state plan will no longer have rate setting criteria embodied in one amendment that contains rate setting criteria for all types of long term care facilities.

Upon approval of the above-mentioned amendments, and until such time as new amendments can be submitted and approved with exclusive language for "nursing facilities" and for "state operated ICFs/MR":

EFFECTIVE 7-1-94, THE REIMBURSEMENT CRITERIA CONTAINED AT PAGES 1 THROUGH 68-A OF ATTACHMENT 4.19D OF THE CURRENT EDITION OF THE MEDICAID STATE PLAN IS NULL AND VOID AS IT RELATES TO RATE SETTING FOR:

1. LARGE PRIVATE ICFs/MR, and

2. SMALL PRIVATE ICFs/MR (GROUP HOMES)

OBRA '87 AND '90 MEDICAID NF COST RECOGNITION & RATE INCREASE
FOR FEDERAL FISCAL YEAR 1995 EFFECTIVE 10-1-94

The Indiana Office of Medicaid Policy & Planning annually computes facility specific rates for Medicaid enrolled nursing facilities using a prospective methodology that requires NFs to submit annual reports of historical costs for a projected rate year.

Based on information contained in the Office's Long Term Care Information System gathered from all Medicaid enrolled nursing facility provider's historical cost reports as of June 1994, the following information is provided indicating the OBRA rate increase for federal fiscal year 1995. Because the effective date for this amendment will be 10-1-94, the actual statewide average Medicaid rate effective 9-30-94 is used to provide the base rate for the increase information. The rate is broken down into two components, the rate with OBRA costs included prior to 10-1-94, the OBRA increase on 10-1-94 and the final nursing facility single statewide average rate with OBRA cost increases on 10-1-94. Adjustments are required by Section 4211(b) of OBRA 1987 and 4801(e) of OBRA 1990.

The rate information specific to OBRA is determined as follows. Medicaid NF rates are calculated in conformity with the provisions outlined in this plan at pages 1 through 68 B of attachment 4.19D. These pages are incorporated by reference to provide the basic rate setting methodology including prior OBRA increases. In addition to these provisions, to segregate and arrive at OBRA specific cost increases allowable for rate recognition, Medicaid has compared NF costs for historical years prior to and after 10-1-93, documented and categorized the cost increases, reduced the cost increases by the GNP/IPD and HCFA/SNF inflators for the period in order to reduce cost increases to true operation increases, identified those costs that are attributable to OBRA requirements that necessitated additional expenditures by NFs after 10-1-90, and converted those costs to a per-patient-day increase as reflected by the following rate information.

THE EFFECTIVE DATE FOR INFORMATION ON THIS CHART IS 10-1-94

OBRA RATE YEAR	SINGLE STATEWIDE AVERAGE NF RATE EFFECTIVE 10-01-94 WITH PRIOR OBRA INCREASES INCLUDED	10-1-94 OBRA INCREASE	SINGLE STATEWIDE AVERAGE NF RATE WITH OBRA INCREASE 10-1-94
1994/95	$71.69	.03 ppd	$71.72 +(.0004)

The OBRA rate increase of .03 ppd. represents the increase of cost recognition for the following listed OBRA '87 requirements. The prior .76 ppd. when added to this .03 increase represent a total increase of .79 ppd. since 10-1-90 for OBRA cost recognition.

COST RECOGNITION CATEGORIES

1. Resident's Rights-Transfer and Discharge Requirements 42 CFR 483.12(a)(5)(ii), consisting primarily of requirements to implement a resident appeal procedure associated with transfer and discharge of residents.

2. Other Staffing Requirements-Social Service Qualifications 42 CFR 483.15(g)(2)(ii) and 483.15(g)(4), requirement for and minimum qualification standards of a social worker for facilities with more than 120 beds.

3. Resident Assessment-42 CFR 483.20, requirement regarding frequency, timing and accuracy of resident assessments.

4. Plans For Care-42 CFR 483.20(d), requiring changes in timing and content of the resident care plan.

5. Resident Assessment Discharge Summary-42 CFR 483.20(e)(3), additional requirements to develop a discharge plan.

6. Nurse Staffing Requirements-42 CFR 483.30, requiring increase in nurse staffing resources in Indiana NFs with fewer than 40 beds to reach one full time equivalent RN.

7. Other Staffing Requirements-Dental Services 42 CFR 483.55, requiring increased responsibility placed on NFs to ensure resident's receipt of needed dental care.

8. Other-Inflation Applied Against 10-1-90 Cost Recognition

CATEGORY	COST RECOGNITION	PPD RATE INCREASE	PERCENT OF TOTAL INCREASE
1	$ 48,318	.0053	.7
2	$ 4,426,695	.4846	62.0
3	$ 494,414	.0541	6.9
4	$ 491,066	.0537	6.9
5	$ 287,438	.0315	4.0
6	$ 362,403	.0475	5.0
7	$ 780,807	.0855	10.9
8	$ 248,081	.0272	3.5
TOTALS	$ 7,139,222	.7894	99.9

Rule 12. Rate-Setting Criteria for Nonstate-Owned Intermediate Care Facilities for Individuals with Developmental Disabilities and Community Residential Facilities for the Developmental Disabled

405 IAC 1-12-1 Policy; scope

Sec. 1. (a) This rule sets forth procedures for payment for services rendered to Medicaid **members** by duly certified nonstate-operated **ICFs/IID**, nonstate-operated CRMNFs, and nonstate-operated CRFs/DD. All payments referred to within this rule for the provider groups and levels of care are contingent upon the following:

(1) Proper and current certification.

(2) Compliance with applicable state and federal statutes and regulations.

(b) The system of payment outlined in this rule is a prospective system. Cost limitations are contained in this rule which establish parameters regarding the allowability of **ordinary patient or member related** costs and define reasonable allowable costs.

(c) Retroactive repayment will be required by providers when an audit verifies overpayment due to discounting, intentional misrepresentation, billing or payment errors, or misstatement of historical financial or historical statistical data which caused a higher rate than would have been allowed had the data been true and accurate. Upon discovery that a provider has received overpayment of a Medicaid claim from the office, the provider must complete the appropriate Medicaid billing adjustment form **as prescribed by the office** and reimburse the office for the amount of the overpayment, or the office shall make a retroactive payment adjustment, as appropriate.

(d) The office may implement Medicaid rates and recover overpayments from previous rate reimbursements, either through deductions of future payments or otherwise, without awaiting the outcome of the administrative appeal process, in accordance with IC 12-15-13-4(e).

(e) Providers must pay interest on overpayments, consistent with IC 12-15-13-4. The interest charge shall not exceed the percentage set out in IC 6-8.1-10-1(c). The interest shall accrue from the date of the overpayment to the provider and shall apply to the net outstanding overpayment during the periods in which such overpayment exists.

405 IAC 1-12-2 Definitions

Sec. 2. (a) The definitions in this section apply throughout this rule.

(b) "All-inclusive rate" means a per diem rate that, at a minimum, reimburses for all nursing or resident:
(1) care;
(2) room and board;
(3) supplies; and
(4) ancillary services;
within a single, comprehensive amount.

(c) "Allowable cost" means a computation performed by the **office** to determine the per patient day cost based on a review of an annual financial report and supporting information by applying this rule.

(d) "Allowable per patient or per resident day cost" means a ratio between total allowable costs and patient or resident days.

(e) "Annualized" means restating an amount to an annual value. This computation is performed by multiplying an amount applicable to a period of less or greater than three hundred sixty-five (365) days, by a ratio determined by dividing the number of days in the reporting period by three hundred sixty-five (365) days, except in leap years, in which case the divisor shall be three hundred sixty-six (366) days.

(f) "Annual or historical financial report" refers to a presentation of financial data, including appropriate supplemental data and accompanying notes derived from accounting records and intended to communicate the provider's economic resources or obligations at a point in time, or changes therein for a period of time in compliance with the reporting requirements of this rule, which shall constitute a comprehensive basis of accounting.

(g) "Average historical cost of property of the median bed" means the allowable resident-related property per bed for facilities that are not acquired through an operating lease arrangement, when ranked in numerical order based on the allowable resident-related historical property cost per bed that shall be updated each calendar quarter. Property shall be considered allowable if it satisfies the conditions of section 16(a) of this rule.

(h) "Average inflated allowable cost of the median patient day" means the inflated allowable per patient day cost of the median patient day from all providers when ranked in numerical order based on average inflated allowable cost. The average inflated allowable cost shall be maintained by the office and revised four (4) times per year effective April 1, July 1, October 1, and January 1 and shall be computed on a statewide basis for like levels of care, with the exceptions noted in this subsection, as follows:

(1) If there are fewer than six (6) homes with rates established that are licensed as developmental training homes, the average inflated allowable cost for developmental training homes shall be computed on a statewide basis utilizing all basic developmental homes with eight and one-half (8 1/2) or fewer hours per patient day of actual staffing.
(2) If there are fewer than six (6) homes with rates established that are licensed as small behavior management residences for children, the average inflated allowable cost for small behavior management residences for children shall be the average inflated allowable cost for child rearing residences with specialized programs increased by two hundred forty percent (240%) of the average staffing cost per hour for child rearing residences with specialized programs.
(3) If there are fewer than six (6) homes with rates established that are licensed as small extensive medical needs residences for adults, the average inflated allowable cost of the median patient day for small extensive medical needs residences for adults shall be the average inflated allowable cost of the median patient day for basic developmental homes multiplied by one hundred fifty-nine percent (159%).
(4) If there are fewer than six (6) homes with rates established that are licensed as extensive support needs residences, the average inflated allowable cost of the median patient day for extensive support needs residences for adults shall be the average inflated allowable cost of the median patient day for small extensive medical needs residences multiplied by one hundred fifty-two percent (152%).

(i) "Change of provider status" means a bona fide sale, lease, or termination of an existing lease that for reimbursement purposes is recognized as creating a new provider status that permits the establishment of an initial interim rate. Except as provided under section 17(f) of this rule, the term includes only those transactions negotiated at arm's length between unrelated parties.

(j) "Cost center" means a cost category delineated by cost reporting forms prescribed by the office.

(k) "DDRS" means the Indiana division of disability and rehabilitative services.

(l) "Debt" means the lesser of the original loan balance at the time of acquisition and original balances of other allowable loans or eighty percent (80%) of the allowable historical cost of facilities and equipment.

(m) "Department head" means an individual(s) responsible for the supervision and management of an ICF/IID or CRF/DD department. Home Office personnel responsible for the supervision and oversight of facility department heads qualify as general line personnel.

(n) "Desk review" means a review and application of these regulations to a provider submitted financial report including accompanying notes and supplemental information.

(o) "Equity" means allowable historical costs of facilities and equipment, less the unpaid balance of allowable debt at the provider's reporting year-end.

(p) "Fair rental value allowance" means a methodology for reimbursing extensive support needs residences for adults for the use of allowable facilities and equipment, based on establishing a rental rate, and a rental valuation on a per bed basis of the facilities and equipment.

(q) "Field audit" means a formal official verification and methodical examination and review, including the final written report of the examination of original books of accounts by auditors.

(r) "Forms prescribed by the office" means:
(1) forms provided by the office; or
(2) substitute forms that have received prior written approval by the office.

(s) "General line personnel" means management personnel above the department head level who perform a policymaking or supervisory function impacting directly on the operation of the facility.

(t) "Generally accepted accounting principles" or "GAAP" means those accounting principles as established by the designated authority that governs the preparation of financial statements based on whether an entity is government or nongovernment owned, or whether it is governed by the requirements of the state board of accounts.

(u) "Like levels of care" means care:
(1) within the same level of licensure provided in a CRF/DD;
(2) provided in a nonstate-operated ICF/IID; or
(3) provided in a nonstate-operated ICF/IID licensed as a CRMNF.

(v) "Non-rebasing year" means the year during which nonstate operated ICFs/IID and CRFs/DD annual Medicaid rate is not established based on a review of their annual financial report covering their most recently completed historical period. The annual Medicaid rate effective during a non-rebasing year shall be determined by adjusting the Medicaid rate from the previous year by an inflation adjustment. The following years shall be non-rebasing years:
October 1, 2019, through September 30, 2020
October 1, 2020, through September 30, 2021
October 1, 2021, through September 30, 2022
October 1, 2023, through September 30, 2024
October 1, 2025, through September 30, 2026
And every second year thereafter.

(w) "Ordinary patient or member-related costs" means costs of services and supplies that are necessary in delivery of patient or resident care by similar providers within the state.

(x) "Patient or resident/member care" means those Medicaid program services delivered to a Medicaid enrolled member by a provider.

(y) "Profit add-on" means an additional payment to providers in addition to allowable costs as an incentive for efficient and economical operation.

(z) "Reasonable allowable costs" means the price a prudent, cost conscious buyer would pay a willing seller for goods or services in an arm's length transaction, not to exceed the limitations set out in this rule.

(aa) "Rebasing year" means the year during which nonstate operated ICFs/IID and CRFs/DD Medicaid rate is based on a review of their annual financial report covering their most recently completed historical period. The following years shall be rebasing years:

October 1, 2018, through September 30, 2019
October 1, 2022, through September 30, 2023
October 1, 2024, through September 30, 2025

And every second year thereafter.

(bb) "Related party/organization" means that the provider:

(1) is associated or affiliated with; or
(2) has the ability to control or be controlled by;

the organization furnishing the service, facilities, or supplies.

(cc) "Routine medical and nonmedical supplies and equipment" includes those items generally required to assure adequate medical care and personal hygiene of patients or residents by providers of like levels of care.

(dd) "Unit of service" means all patient or resident care at the appropriate level of care included in the established per diem rate required for the care of a patient or resident for one (1) day (twenty-four (24) hours).

(ee) "Use fee" means the reimbursement provided to fully amortize both principal and interest of allowable debt under the terms and conditions specified in this rule, for all providers, except for providers of extensive support needs residences for adults.

405 IAC 1-12-3 Accounting records; retention schedule; audit trail; accrual basis; segregation of accounts by nature of business and by location

Sec. 3. (a) The basis of accounting used under this rule is a comprehensive basis of accounting other than **GAAP. All cost and charges reported on the provider's cost report must also be recorded on the provider's financial statements.** Costs **and charges** must be reported **on** the cost report in accordance with the following authorities, in the hierarchical order listed:

(1) Costs must be reported in accordance with the specific provisions as set forth in this rule, any financial report instructions, provider bulletins, and any other policy communications.

(2) Costs must be reported in conformance with cost finding principles published in the Medicare Provider Reimbursement Manual, CMS 15-1.

(3) Costs must be reported in conformance with **GAAP.**

(b) Each provider must maintain financial records for a **minimum** period of three (3) years after the date of submission of financial reports to the office. **Copies of any financial records or supporting documentation must be provided to the office upon request.** The accrual basis of accounting shall be used in all data submitted to the office except for government operated providers that are otherwise required by law to use a cash system. The provider's accounting records must establish an audit trail from those records to the financial reports submitted to the office.

(c) **The auditor shall schedule the field audit visit with the provider. If the auditor and provider are unable to reach an agreement on a scheduled field audit date, the auditor will assign a date for the field audit to begin no earlier than sixty (60) days after the date that the provider was initially contacted to schedule the field visit.**

(1) The auditor will confirm the field audit date by providing a written notice identifying the date of the scheduled field audit and all information the provider is required to submit in advance of the field audit date. The notice will be provided at least sixty (60) days prior to the commencement of field work, and will allow the provider a minimum of thirty (30) days to submit the required information, which shall be due to the auditor no less than thirty (30) days prior to the date of the scheduled field audit.

2) After assignment of a field audit date, a provider may submit a one-time request that the scheduled field audit be postponed to a later date.

(A) The office shall approve or deny the request in writing within fifteen (15) days of receiving the request.

(B) Any delay of the scheduled field audit date does not extend the due date of the required information.

(3) Failure to submit the required information by the due date in the written notice shall result in the following actions being taken:

(A) The rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the month following the date the response was due.

(B) The ten percent (10%) rate reduction shall remain in place until the first day of the month following the earlier of the receipt of information requested in the written notice or one (1) year after the effective date of the ten percent (10%) rate reduction.
(C) No rate increases will be allowed until the first day of the month following the earlier of the receipt of information requested in the written notice, or one (1) year after the effective date of the ten percent (10%) rate reduction.
(D) No reimbursement for the difference between the rate that would have otherwise been in effect and the reduced rate is recoverable by the provider.

(**d**) When a field audit indicates that the provider's records are inadequate to support data submitted to the office or the additional requested documentation is not provided pursuant to the auditor's request, and the auditor is unable to complete the audit, the following actions shall be taken:

(1) The auditor shall give a written notice listing all of the deficiencies in documentation.
(2) The provider will be allowed thirty (30) days from the date of the notice to provide the documentation and correct the deficiencies.
(3) Not later than thirty (30) days from the date of the notice described in subdivision (1), the provider may seek one (1) thirty (30) day extension to respond to the notice and shall describe the reason(s) the extension is necessary.

(**e**) In the event that the deficiencies in documentation are not corrected within the time limit specified in subsection (c), the following actions shall be taken:

(1) The rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the month following the date the response was due.
(2) The ten percent (10%) reduction shall remain in place until the first day of the month following the receipt of a complete response.
(3) If no response described in subdivision (2) is received, this reduction expires one (1) year after the effective date specified in subdivision (1).
(4) No rate increases will be allowed until the first day of the month following the receipt of the response and requested documentation, or the expiration of the reduction.
(5) No reimbursement for the difference between the rate that would have otherwise been in place and the reduced rate is recoverable by the provider.

(f) In the event that the documentation submitted is inadequate or incomplete, the following additional actions shall be taken:

(1) Appropriate adjustments to the applicable cost reports of the provider resulting from inadequate records shall be made.

(2) The **office** shall document such adjustments in a finalized exception report.

(3) The **office** shall incorporate such adjustments in the prospective rate calculations under section 1(d) of this rule.

(g) If a provider has business enterprises other than those reimbursed by Medicaid under this rule, the revenues, expenses, and statistical and financial records for such enterprises shall be clearly identifiable from the records of the operations reimbursed by Medicaid. If a field audit establishes that records are not maintained so as to clearly identify Medicaid information, none of the commingled costs shall be recognized as Medicaid allowable costs and the provider's rate shall be adjusted to reflect the disallowance effective as of the date of the most recent rate change.

(h) When multiple facilities or operations are owned by a single entity with a central office, the central office records shall be maintained as a separate set of records with costs and revenues separately identified and appropriately allocated to individual facilities. Each central office entity shall file an annual or historical financial report coincidental with the time period for any type of rate review for any individual facility that receives any central office allocation. Allocation of central office costs shall be reasonable, conform to GAAP, and be consistent between years. Any change of central office allocation bases must be approved by the office prior to the changes being implemented. Proposed changes in allocation methods must be submitted to the office at least ninety (90) days prior to the reporting period to which the change applies. Such costs are allowable only to the extent that the central office is providing services related to patient or resident care and the provider can demonstrate that the central office costs improved efficiency, economy, and quality of **member** care.

(i) The burden of substantiating that costs are patient or resident related lies with the provider.

405 IAC 1-12-4 Financial report to office; annual schedule; prescribed form; extensions; penalty for untimely filing

Sec. 4. (a) Each provider shall submit an annual financial report to the office not later than ninety (90) days after the close of the provider's reporting year. The annual financial report shall coincide with the fiscal year used by the provider to report federal income taxes for the operation unless the provider requests in writing that a different reporting period be used. Such a request shall be submitted within sixty (60) days after the initial **enrollment** of a provider. This option may be exercised only one (1) time by a provider. If a reporting period other than the tax year is established, audit trails between the periods are required, including reconciliation statements between the provider's records and the annual financial report.

(b) The provider's annual financial report shall be submitted using forms prescribed by the office. All data elements and required attachments shall be completed so as to provide full financial disclosure and shall include the following as a minimum:

(1) Patient or resident census data.
(2) Statistical data.
(3) Ownership and related party information.
(4) Statement of all expenses and all income.
(5) Detail of fixed assets and patient or resident related interest bearing debt.
(6) Complete balance sheet data.
(7) Schedule of Medicaid and private pay charges in effect on the last day of the reporting period and on the rate effective date as defined by this rule. Private pay charges shall be the lowest usual and **customary** charge.
(8) Certification statement signed by the provider that:
    (A) the data are true, accurate, related to patient or resident care; and
    (B) expenses not related to patient or resident care have been clearly identified.
(9) Certification statement signed by the preparer, if different from the provider, that the data were compiled from all information provided to the preparer by the provider, and as such are true and accurate to the best of the preparer's knowledge.

(c) Extension of the ninety (90) day filing period shall not be granted unless the provider substantiates to the **office** circumstances that preclude a timely filing. Requests for extensions shall be submitted to the **office** prior to the date due, with full and complete explanation of the reasons an extension is necessary. The **office** shall review **timely** requests for extension and notify the provider of approval or disapproval within ten (10) days of receipt. If the request for extension is disapproved, the report shall be due twenty (20) days from the date of receipt of the disapproval from the **office. Untimely requests for an extension will not result in a change to the original due date, nor will it alleviate the provider from the penalty provision in subsection (d).**

(d) Failure to submit an annual financial report within the time limit required shall result in the following actions:

(1) No rate review requests shall be accepted or acted upon by the office until the delinquent report is received, and the effective date of the Medicaid rate calculated utilizing the delinquent annual financial report shall be the first day of the month after the delinquent annual financial report is received by the office. All limitations in effect at the time of the original effective date of the annual rate review shall apply.
(2) When an annual financial report is thirty (30) days past due and an extension has not been granted, the rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the month following the thirtieth day the annual financial report is past due and shall so remain until the first day of the month after the delinquent annual financial report is received by the office. Reimbursement lost as a result of this penalty cannot be recovered by the provider.

405 IAC 1-12-5 New provider; initial financial report to office; criteria for establishing initial interim rates; supplemental report; base rate setting; **penalty for untimely filing of Checklist of Management Representations**

Sec. 5. (a) Rate requests to establish initial interim rates for a new operation, a new type of certified service, a new type of licensure for an existing group home, or a change of provider status shall be filed by submitting an initial rate request to the office on or before thirty (30) days after notification of the **enrollment** date or establishment of a new service or type of licensure. Initial interim rates will be set at the greater of:

(1) the prior provider's then current rate, including any changes due to a field audit, if applicable; or
(2) the fiftieth percentile rates as computed in this subsection.

Initial interim rates shall be effective upon the later of the **enrollment** date, the effective date of a licensure change, or the date that a service is established. The fiftieth percentile rates shall be computed on a statewide basis for like levels of care, except as provided in subsection (b), using current rates of all CRF/DD and **ICF/IID** providers. The fiftieth percentile rates shall be maintained by the office, and a revision shall be made to these rates four (4) times per year effective on April 1, July 1, October 1, and January 1.

(b) Until the identified threshold number of homes is obtained, the fiftieth percentile rates shall be determined as follows:

(1) If there are fewer than six (6) homes with rates established that are licensed as developmental training homes, the fiftieth percentile rates for developmental training homes shall be computed on a statewide basis using current rates of all basic developmental homes with eight and one-half (8½) or fewer hours per patient day of actual staffing.
(2) If there are fewer than six (6) homes with rates established that are licensed as small behavior management residences for children, the fiftieth percentile rate for small behavior management residences for children shall be the fiftieth percentile rate for child rearing residences with specialized programs increased by two hundred forty percent (240%) of the average staffing cost per hour for child rearing residences with specialized programs.
(3) If there are fewer than six (6) homes with rates established that are licensed as small extensive medical needs residences for adults, the fiftieth percentile rate for small extensive medical needs residences for adults shall be the fiftieth percentile rate for basic developmental homes multiplied by one hundred fifty-nine percent (159%).

(c) The provider shall file a nine (9) month historical financial report within sixty (60) days following the end of the first nine (9) months of operation. The nine (9) months of historical financial data shall be used to determine the provider's base rate. The base rate shall be effective from the first day of the tenth month of certified operation until the next regularly schedule annual review. An annual financial report need not be submitted until

(4) If there are fewer than six (6) homes with rates established that are licensed as extensive support needs residences for adults, the fiftieth percentile rate for extensive support needs residences for adults shall be the fiftieth percentile rate for small extensive medical needs residences multiplied by one hundred fifty-two percent (152%).

(c) The provider shall file a nine (9) month historical financial report within sixty (60) days following the end of the first nine (9) months of operation. The nine (9) months of historical financial data shall be used to determine the provider's base rate. The base rate shall be effective from the first day of the tenth month of **enrolled** operation until the next regularly scheduled annual review. An annual financial report need not be submitted until the provider's first fiscal year-end that occurs after the rate effective date of a base rate. In determining the base rate, limitations and restrictions otherwise outlined in this rule, except the annual rate limitation, shall apply. For purposes of this subsection, in determining the nine (9) months of the historical financial report, if the first day of **enrollment** falls on or before the fifteenth day of a calendar month, then that calendar month shall be considered the provider's first month of operation. If the first day of **enrollment** falls after the fifteenth day of a calendar month, then the immediately succeeding calendar month shall be considered the provider's first month of operation.

(d) The provider's historical financial report shall be submitted using forms prescribed by the office. All data elements and required attachments shall be completed so as to provide full financial disclosure and shall include the following at a minimum:

(1) Patient or resident census data.
(2) Statistical data.
(3) Ownership and related party information.
(4) Statement of all expenses and all income.
(5) Detail of fixed assets and patient or resident-related interest bearing debt.
(6) Complete balance sheet data.
(7) Schedule of Medicaid and private pay charges in effect on the last day of the reporting period and on the rate effective date as defined in this rule; private pay charges shall be the lowest usual and **customary** charge.
(8) Certification by the provider that:
    (A) the data are true, accurate, and related to patient or resident care; and
    (B) expenses not related to patient or resident care have been clearly identified.
(9) Certification by the preparer, if different from the provider, that the data were compiled from all information provided to the preparer, by the provider, and as such are true and accurate to the best of the preparer's knowledge.

(e) Extension of the sixty (60) day filing period shall not be granted unless the provider substantiates to the office circumstances that preclude a timely filing. Requests for extensions shall be submitted to the office prior to the date due, with full and complete explanation of the reasons an extension is necessary. The office shall review the request and notify the provider of approval or disapproval within ten (10) days of receipt. If the extension is disapproved, the report shall be due twenty (20) days from the date of receipt of the disapproval from the office.

(f) If the provider fails to submit the nine (9) months of historical financial data within ninety (90) days following the end of the first nine (9) months of operation and an extension has not been granted, the initial interim rate shall be reduced by ten percent (10%), effective on the first day of the tenth month after certification and shall so remain until the first day of the month after the delinquent annual financial report is received by the office. Reimbursement lost because of the penalty cannot be recovered by the provider. The effective date of the base rate calculated utilizing the delinquent historical financial report shall be the first day of the month after the delinquent historical financial report is received by the office. All limitations in effect at the time of the original effective date of the base rate review shall apply.

(g) Except as provided in section 17(f) of this rule, neither an initial interim rate nor a base rate shall be established for a provider whose change of provider status was a related party transaction as established in this rule.

(h) In the event of a change in provider ownership, ownership structure (including mergers, exchange of stock, etc.), provider, operator, lessor/lessee, or any change in control, the new provider shall submit a completed Checklist of Management Representations Concerning Change in Ownership to the office within thirty (30) days following the date the Checklist of Management Representations request is sent to the provider. The completed checklist shall include all supporting documentation. No Medicaid rate adjustments for the facility shall be performed until the completed checklist is submitted to the office. If the completed Checklist of Management Representations has not been submitted within ninety (90) days following the date the Checklist of Management Representations request is sent to the provider, the Medicaid rate currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the month following the end of the ninety (90) day period. The penalty shall remain until the first day of the month after the completed Checklist of Management Representations is received by the office. Reimbursement lost because of the penalty cannot be recovered by the provider.

405 IAC 1-12-6 Active providers; rate review; annual request

Sec. 6. (a) The rate effective date of the annual rate review established during rebasing years and non-rebasing years shall be the first day of the fourth month following the provider's reporting year end, provided the annual financial report is submitted within ninety (90) days of the end of the provider's reporting period.

(b) The annual rate review that shall become effective during a rebasing year shall be established using the annual financial report as the basis of the review.

(c) The annual rate review that shall become effective during a non-rebasing year shall be established by applying an inflation adjustment to the previous year's annual or base Medicaid rate that excludes the rate reduction amount specified in section 24(b) of this rule. The inflation adjustment prescribed by this subsection shall be applied by using the CMS Nursing Home without Capital Market Basket index as published by DRI/WEFA. The inflation adjustment shall apply from the midpoint of the previous year's annual or base Medicaid rate period to the midpoint of the current year annual Medicaid rate period prescribed as follows:

Rate Effective Date	Midpoint Quarter
January 1, Year 1	July 1, Year 1
April 1, Year 1	October 1, Year 1
July 1, Year 1	January 1, Year 2
October 1, Year 1	April 1, Year 2

405 IAC 1-12-7 Request for rate review; effect of inflation; occupancy level assumptions

Sec. 7. (a) Rate setting during rebasing years shall be based on the provider's annual or historical financial report for the most recent completed year. In determining prospective allowable costs during rebasing years, each provider's costs from the most recent completed year will be adjusted for inflation by the office using the following methodology. All allowable costs of the provider, except for:

(1) mortgage interest on facilities and equipment;
(2) depreciation on facilities and equipment;
(3) rent or lease costs for facilities and equipment; and
(4) working capital interest;

shall be increased for inflation using the CMS Nursing Home without Capital Market Basket index as published by IHS. The inflation adjustment shall apply from the midpoint of the annual or historical financial report period to the midpoint of the expected rate period.

(b) For purposes of determining the average allowable cost of the median patient day as applicable during rebasing years, each provider's costs from their most recent completed, non-excluded year will be adjusted for inflation by the office using the following methodology. Providers whose most recently completed rate is an initial interim rate shall be excluded from the determination of the average allowable cost of the median patient day. Any annual financial report period that, partially or fully, overlaps the period of March 1, 2020 through December 31, 2020 shall be excluded from the determination of the average allowable cost of the median patient day. For determinations of the average allowable cost of the median patient day on and after October 1, 2022, any financial report that partially or fully precedes July 1, 2021 shall have their allowable per diem costs increased by a proration of the 10% direct care workforce add-on effective July 1, 2021 based on the days in the financial report period prior to July 1, 2021 compared to the days for the entire financial report period. All allowable costs of the provider, except for:

(1) mortgage interest on facilities and equipment;
(2) depreciation on facilities and equipment;
(3) rent or lease costs for facilities and equipment; and
(4) working capital interest;

shall be increased for inflation using the CMS Nursing Home without Capital Market Basket index as published by IHS. The inflation adjustment shall apply from the midpoint of the annual or historical financial report period to the midpoint prescribed as follows:

Median Effective Date	Midpoint Quarter
January 1, Year 1	July 1, Year 1
April 1, Year 1	October 1, Year 1
July 1, Year 1	January 1, Year 2
October 1, Year 1	April 1, Year 2

(c) For **ICFs/IID** and CRFs/DD, allowable costs per patient or resident day shall be determined based on an occupancy level equal to the greater of actual occupancy, or ninety-five percent (95%) for **ICFs/IID** and ninety percent (90%) for CRFs/DD, for certain fixed facility costs. The fixed costs subject to this minimum occupancy level standard include the following:

(1) Director of nursing wages.
(2) Administrator wages.
(3) All costs reported in the ownership cost center, except repairs and maintenance.
(4) The capital return factor determined in accordance with sections 12 through 17 of this rule for all providers, except for providers of extensive support needs residences for adults.
(5) The fair rental value allowance determined in accordance with section 20.5 of this rule for providers of extensive support needs residences for adults.

405 IAC 1-12-8 Limitations or qualifications to Medicaid reimbursement; advertising; vehicle basis

Sec. 8. (a) Advertising is not an allowable cost under this rule except for those advertising costs incurred in the recruitment of facility personnel necessary for compliance with facility certification requirements. Advertising costs are not allowable in connection with public relations or fundraising or to encourage patient or resident utilization.

(b) Each facility and distinct home office location shall be allowed:

(1) one (1) patient or resident care-related automobile; and

(2) one (1) vehicle that can be utilized for facility maintenance or patient or resident support or for both uses;

to be included in the vehicle basis for purposes of cost reimbursement under this rule. Vehicle basis means the purchase price of the vehicle used for facility or home office operations. If a portion of the use of the vehicle is for personal purposes or for purposes other than operation of the facility or home office, then such portion of the cost must not be included in the vehicle basis. The facility and home office location(s) are responsible for maintaining records to substantiate operational and personal use for all allowable vehicles. This limitation does not apply to vehicles with a gross vehicle weight of more than six thousand (6,000) pounds.

405 IAC 1-12-9 Criteria limiting rate adjustment granted by office

Sec. 9. During rebasing years and for base rate reviews, the Medicaid reimbursement system is based on recognition of the provider's allowable costs plus a potential profit add-on payment. The payment rate established during rebasing years and for base rate reviews is subject to the following limitations:

(1) In no instance shall the approved Medicaid rate be higher than the rate paid to that provider by the general public for the same type of services. For purposes of this rule, the rates paid by the general public shall not include rates paid by the DDRS.

(2) Should the rate calculations produce a rate higher than the reimbursement rate requested by the provider, the approved rate shall be the rate requested by the provider.

(3) Inflated allowable per patient or per resident day costs plus the allowed profit add-on payment as determined by the methodology in Table I.

(4) In no instance shall the approved Medicaid rate exceed the overall rate limit percent (Column A) in Table II, times the average inflated allowable cost of the median patient or resident day.

TABLE I			
Profit Add-On			
The profit add-on is equal to the percent (Column A) of the difference (if greater than zero (0)) between a provider's inflated allowable per patient or resident day cost, and the ceiling (Column B) times the average inflated allowable per patient or resident day cost of the median patient or resident day. Under no circumstances shall a provider's per patient or resident day profit add-on exceed the cap (Column C) times the average inflated allowable per patient or resident day cost of the median patient or resident day.			
Level of Care	(A) Percent	(B) Ceiling	(C) Cap
Sheltered living	40%	105%	10%
Intensive training	40%	120%	10%
Child rearing	40%	130%	12%
Nonstate-operated **ICF/IID**	40%	125%	12%
Developmental training	40%	110%	10%
Child rearing with a specialized program	40%	120%	12%
Small behavior management residences for children	40%	120%	12%
Basic developmental	40%	110%	10%
Small extensive medical needs residences for adults	40%	110%	10%
Extensive support needs residences for adults	40%	110%	10%

TABLE II	
Overall Rate Limit	
Level of Care	(A) Percent
Sheltered living	115%
Intensive training	120%
Child rearing	130%
Developmental training	120%
Child rearing with a specialized program	120%
Small behavior management residences for children	120%
Basic developmental	120%
Small extensive medical needs residences for adults	120%
Extensive support needs residences for adults	120%
Nonstate-operated **ICF/IID**	107%

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Affected: IC 12-13-7-3; IC 12-15

Sec. 10. (a) The per diem rate shall be an all-inclusive rate. The office shall not set a rate for more than one (1) level of care for each CRF/DD provider.

(b) Costs and revenues shall be reported as required on the financial report forms. Patient or resident care costs shall be clearly identified.

(c) The provider shall report as patient or resident care costs only costs that have been incurred in the providing of patient or resident care services. The provider shall certify on all financial reports that costs not related to patient or resident care have been separately identified on the financial report.

(d) In determining reasonableness of costs, the office may compare line items, cost centers, or total costs of providers with like levels of care throughout the state. The office may request satisfactory documentation from providers whose costs do not appear to be accurate and allowable.

FOOTNOTE TO SECTION 10(d) ABOVE BUT NOT PART OF THE PROMULGATED REIMBURSEMENT RULE: THIS SECTION AUTHORIZES THE STATE TO COMPARE LINE ITEM, COST CENTERS OR TOTAL COSTS OF PROVIDERS WITH LIKE LEVELS OF CARE THROUGHOUT THE STATE. SUCH COMPARISONS WILL OCCUR DURING THE NORMAL DESK REVIEW AND AUDIT PROCESSES. THIS ACTIVITY NATURALLY REQUIRES THE USE OF PROFESSIONAL JUDGMENT. COSTS THAT APPEAR TO BE OUT OF LINE WITH PROVIDERS WITH LIKE LEVELS OF CARE WILL BE QUESTIONED IN MUCH THE SAME WAY THAT COSTS ARE QUESTIONED UNDER THE CURRENT APPROVED PLAN. SPECIFYING THE PRECISE CONDITIONS WHEN THESE ACTIONS MUST OCCUR IS NOT FEASIBLE.

(e) Indiana state taxes, including local taxes, shall be considered an allowable cost. Federal income taxes are not considered allowable costs. ***(Office of the Secretary of Family and Social Services; 405 IAC 1-12-10)***

405 IAC 1-12-11 Allowable costs; services provided by parties related to provider

Sec. 11. (a) Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control must be included in the allowable cost in the unit of service of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased as an arm's-length transaction, in an open competitive market.

(b) Common ownership exists when an individual, individuals, or any legal entity possesses ownership or equity of at least five percent (5%) in the provider as well as the institution or organization serving the provider. An individual is considered to own the interest of immediate family for the determination of percentage of ownership. The following persons are considered immediate family:

(1) Husband and wife.
(2) Natural parent, child, and sibling.
(3) Adopted child and adoptive parent.
(4) Stepparent, stepchild, stepsister, and stepbrother.
(5) Father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law, daughter-in-law, stepson-in-law, and stepdaughter-in-law.
(6) Grandparent and grandchild.

(c) Control exists where an individual or an organization has the power, directly or indirectly, to influence or direct the actions or policies of an organization or institution, whether or not actually exercised.

(d) Transactions between related parties are not considered to have arisen through arm's-length negotiations. Costs applicable to services, facilities, and supplies furnished to a provider by related parties shall not exceed the lower of the cost to the related party or the price of comparable services, facilities, or supplies purchased as an arm's-length transaction, in an open competitive market. An exception to this subsection may be granted by the office if requested in writing by the provider before the rate effective date of the review to which the exception is to apply. The provider's request shall include a comprehensive representation that every condition in subsection (e) has been met. This representation shall include, but not be limited to, the percentage of business the provider transacts with related and nonrelated parties based upon revenue. When requested by the office, the provider shall submit documentation, such as invoices, standard charge master listings, and remittances to substantiate the provider's charges for services, facilities, or supplies to related and nonrelated parties.

(e) The office shall grant an exception when a related organization meets all of the following conditions:

(1) The supplying organization is a bona fide separate organization whose services, facilities, and supplies are made available to the public in an open competitive market.

(2) A sufficient part of the supplying organization's business activity is transacted with other than the provider and organizations related to the supplier in common ownership or control, and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization. Transactions with residents of facilities that are owned, operated, or managed by the provider or organizations related to the provider shall not be considered a business activity for purposes of meeting this requirement.

(3) The services, supplies, or facilities are those which commonly are obtained by institutions, such as the provider, from other organizations and are not a basic element of patient or resident care ordinarily furnished directly to patients or residents by such institutions.

(4) The organization actually furnishes such services, facilities, or supplies to other non-related party organizations, and the charge to the provider is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

(f) The related-party exception shall be granted for any period of time, up to the maximum period of two (2) years.

405 IAC 1-12-12 Allowable costs; capital return factor
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 12. (a) Providers, other than extensive support needs residences for adults, shall be reimbursed for the use of facilities and equipment, regardless of whether they are owned or leased, by means of a capital return factor. The capital return factor shall be composed of a use fee to cover the use of facilities, land and equipment, and a return on equity. Such reimbursement shall be in lieu of the costs of all depreciation, interest, lease, rent, or other consideration paid for the use of property. This includes all central office facilities and equipment whose patient or resident care-related depreciation, interest, or lease expense is allocated to the facility.

(b) The capital return factor portion of the established rate during rebasing years is the sum of the allowed use fee, return on equity, and rent payments.

(c) Allowable patient or resident care-related rent, lease payments, and fair rental value of property used through contractual arrangement shall be subjected to limitations of the capital return factor as described in this section.

405 IAC 1-12-13 Allowable costs; capital return factor; computation of use fee component; interest; allocation of loan to facilities and parties
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 13. (a) The use fee limitation is based on the following:
(1) The assumption that facilities and equipment are prudently acquired and financed.
(2) Providers will obtain independent financing in accordance with a sound financial plan.
(3) Owner capital will be used for the balance of capital requirements.

(b) The amortization period to be used in computing the use fee shall be the greater of twenty (20) years or the actual amortization period for the facility and for facilities and equipment where a single lending arrangement covers both. Where equipment is specifically financed by means of a separate lending arrangement, a minimum of seven (7) years shall be the amortization period. Provided, however, that a mortgage existing on April 1, 1983, has a fully amortizing life of less than twenty (20) years, the use fee will be calculated using the actual life of the lending arrangement, but not less than twelve (12) years. If the facility payments toward the principal loan amount are less than the amount derived from a standard loan amortization during the reporting period, the computation of the use fee shall be limited to the principal and interest amounts actually paid during the reporting period, unless the financing arrangement specifically requires that amortized payments to be made to a sinking fund, or its equivalent, for future principal payments and the provider can demonstrate that payments from the sinking fund are actually made.

(c) The use fee component of the capital return factor shall be limited by the lessor of:

(1) the original loan balance at the time of acquisition;

(2) eighty percent (80%) of historical cost of the facilities and equipment; or

(3) eighty percent (80%) of the maximum allowable property basis at the time of the acquisition plus one-half (1/2) of the difference between that amount and the maximum property basis per bed on the rate effective date.

(d) The maximum interest rate allowed in computing the use fee shall not exceed one and one-half percent (1.5%) above the United States Treasury bond, ten (10) year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (0.5%) or the actual interest rate, whichever is lower. For property financing with a fixed interest rate, the date that the financing commitment was signed by the lender and borrower shall be the date upon which the allowable rate shall be determined. For property financing with a variable interest rate, the allowable interest rate shall be determined each year at the provider's report year end.

(e) The use fee determined under this section shall be subject to the limitations under section 15(b) of this rule.

(f) Refinancing of mortgages shall be amortized over the amortization period of the refinancing; however, the amortization period for the refinanced mortgage shall not be less than twenty (20) years. Refinancing arrangements shall be recognized only when the interest rate is less than the original financing,

and the interest rate on the refinancing shall not be allowable in excess of the interest rate limit established on the date the refinancing commitment was signed and the interest rate fixed by the lender and borrower.

(g) Variable interest debt will be recognized for the purpose of calculation of the use fee if the variable rate is a function of an arrangement entered into and incorporated in the lending arrangement at the time of the acquisition of the facility or as part of an allowable refinancing arrangement under subsection (f).

(h) Interest costs on borrowed funds used to construct facilities or enlarge existing facilities which are incurred during the period of construction shall be capitalized as part of the cost of the facility or addition.

(i) Interest costs on operating loans each reporting period shall be limited to interest costs of principal amounts that do not exceed a value equal to two (2) months of actual revenues. Interest on such loans shall be recognized only if the provider can demonstrate that such loans were reasonable and necessary in providing patient or resident related services. Working capital interest must be reduced by investment income. Working capital interest is an operating cost and will not be included in calculating the use fee.

(j) Loans covering more than one (1) facility or asset shall apply to the several facilities or assets acquired in proportion to the cost that each item bears to the total cost. Accordingly, if any building or asset covered by the loan is used for purposes other than patient or resident care, the use fee applicable to such assets will be determined based upon its proportionate share of the total asset cost.

(k) Loans from a related party must be identified and reported separately on the annual or historical financial report. Such loans shall be allowable if they meet all other requirements, the interest does not exceed the rate available in the open market, and such loans are repaid in accordance with an established repayment schedule.

(l) Use fee for variable interest rate mortgages will be calculated as follows:

(1) Recalculate the use fee for the reporting year based upon the provider's average actual rate of interest paid.

(2) Compare the use fee allowed in the reporting year and the recalculated use fee and determine the variance (amount by which the amount allowed in the prior rate case exceeded or was less than the amount earned under the recalculation in subdivision (1)).

(3) Calculate the prospective use fee based upon the interest rate in effect at the end of the provider's reporting year.

(4) The use fee on the prospective rate is the amount determined in subdivision (3) plus or minus the variance in subdivision (2).

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-13)

405 IAC 1-12-14 Allowable costs; capital return factor; computation of return on equity component

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 14. (a) For a provider with an initial interim rate resulting from:

(1) a change of provider status; or

(2) a new operation;

before the effective date of this rule, the return on equity shall be computed on the higher of twenty percent (20%) of the allowable historical cost of facilities and equipment or actual equity in allowable facilities and equipment up to sixty percent (60%) of allowable historical cost of facilities and equipment. Allowable historical cost of facilities and equipment is the lesser of the provider's actual historical costs of facilities and equipment, or the maximum allowable property basis at the time of the acquisition plus one-half (1/2) of the difference between that amount and the maximum allowable property basis per bed on the rate effective date.

(b) For a provider with an initial interim rate resulting from:

(1) a change of provider status; or

(2) a new operation;

on or after the effective date of this rule, the return on equity shall be computed on the actual equity in allowable facilities and equipment up to a maximum of eighty percent (80%) of allowable historical cost of facilities and equipment.

(c) The return on equity factor shall be equal to the interest rate used in computing the use fee plus one percent (1%), or one percent (1%) below the United States Treasury bond, ten (10) year amortization, constant maturity rate on the last day of the reporting period, plus three percent (3%), whichever is higher.

(d) The return on equity determined under this section shall be subject to the limitations of section 15(b) of this rule.

405 IAC 1-12-15 Allowable costs; capital return factor; use fee; depreciable life; property basis

Sec. 15. (a) The following is a schedule of allowable use fee lives by property category:

Property Basis	Use Fee Life
Land	20 years
Land improvements	20 years
Buildings and building components	20 years
Building improvements	20 years
Movable equipment	7 years
Vehicles	7 years

The maximum property basis per bed at the time of acquisition, for all providers, except for providers of extensive support needs residences for adults, shall be in accordance with the following schedule:

Acquisition Maximum Property

Date	Basis Per Bed
7/1/76	$12,650
4/1/77	$13,255
10/1/77	$13,695
4/1/78	$14,080
10/1/78	$14,630
4/1/79	$15,290
10/1/79	$16,115
4/1/80	$16,610
10/1/80	$17,490
4/1/81	$18,370
10/1/81	$19,140
4/1/82	$19,690
9/1/82	$20,000
3/1/83	$20,100
9/1/83	$20,600
3/1/84	$20,600
9/1/84	$21,200
3/1/85	$21,200
9/1/85	$21,200
3/1/86	$21,400
9/1/86	$21,500

3/1/87	$21,900
9/1/87	$22,400
3/1/88	$22,600
9/1/88	$23,000
3/1/89	$23,100
9/1/89	$23,300
3/1/90	$23,600
9/1/90	$23,900
3/1/91	$24,500
9/1/91	$24,700
3/1/92	$24,900
9/1/92	$25,300
3/1/93	$25,400
9/1/93	$25,700

The schedule shall be updated semiannually effective on March 1 and September 1 by the office and rounded to the nearest one hundred dollars ($100) based on the change in the R.S. Means Construction Index.

(b) The capital return factor portion of a rate, for all providers, except for providers of extensive support needs residences for adults, that becomes effective after the acquisition date of an asset shall be limited to the maximum capital return factor, which shall be calculated as follows:

(1) The use fee portion of the maximum capital return factor is calculated based on the following:

(A) The maximum property basis per bed at the time of acquisition of each bed, plus one-half (½) of the difference between that amount and the maximum property basis per bed at the rate effective date.

(B) The term is determined per bed at the time of acquisition of each bed and is twenty (20) years for beds acquired on or after April 1, 1983, and twelve (12) years for beds acquired before April 1, 1983.

(C) The allowable interest rate is the United States Treasury bond, ten (10) year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (0.5%) plus one and one-half percent (1.5%) at the earlier of the acquisition date of the beds or the commitment date of the attendant permanent financing.

(2) The equity portion of the maximum capital return factor is calculated based on the following:

(A) The allowable equity as established under section 14 of this rule.

(B) The rate of return on equity is the greater of the United States Treasury bond, ten (10) year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (0.5%) on the last day of the reporting period minus one percent (1%), or the weighted average of the United States Treasury bond, ten (10) year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (0.5%) plus one percent (1%) at the earlier of the acquisition date of the beds or the commitment date of the attendant permanent financing.

(c) For facilities with a change of provider status, the allowable capital return factor of the buyer/lessee shall be not greater than the capital return factor that the seller/lessor would have received on the date of the transaction, increased by one-half (½) of the percentage increase (as measured from the date of acquisition/lease commitment date by the seller/lessor to the date of the change in provider status) in the Consumer Price Index for All Urban Consumers (CPI-U) (United States city average). Any additional allowed capital expenditures incurred by the buyer/lessee shall be treated in the same manner as if the seller/lessor had incurred the additional capital expenditures.

d) The following costs, which are attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) for which any payment has been previously made under **Medicaid**, shall not be recognized as an allowable cost:

(1) Legal fees.
(2) Accounting and administrative costs.
(3) Travel costs.
(4) The costs of feasibility studies.

405 IAC 1-12-16 Capital return factor; basis; historical cost; mandatory record keeping; valuation

Sec. 16. (a) The basis used in computing the capital return factor and the average historical cost of property of the median bed shall be the historical cost of all assets used to deliver patient or resident-related services, provided they are:

(1) in use;
(2) identifiable to patient or resident care;
(3) available for physical inspection; and
(4) recorded in provider records.

If an asset does not meet all of the requirements prescribed in this section, the cost and any associated property financing or financings or capital lease or leases shall not be included in computing the capital return factor or the average historical cost of property of the median bed.

(b) The provider shall maintain detailed property schedules to provide a permanent record of all historical costs and balances of facilities and equipment. Summaries of such schedules shall be submitted with each annual or historical financial report, and the complete schedule shall be submitted to the office upon request.

(c) Assets used in computing the capital return factor and the average historical cost of property of the median bed shall include only items currently used in providing services customarily provided to patients or residents.

(d) When an asset is acquired by trading one (1) asset for another, or a betterment or improvement is acquired, the cost of the newly acquired asset, betterment, or improvement

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is acquired, the cost of the newly acquired asset, betterment, or improvement shall be added to the appropriate property category. All of the historical cost of the traded asset or replaced betterment or improvement shall be removed from the property category in which it was included.

(e) If a single asset or collection of like assets acquired in quantity, including permanent betterment or improvements, has at the time of acquisition an estimated useful life of at least three (3) years and a historical cost of at least five hundred dollars ($500), the cost shall be included in the property basis for the approved useful life of the asset. Items that do not qualify under this subsection shall be expensed in the year acquired.

(f) The property basis of donated assets, except for donations between providers or related parties, shall be the fair market value defined as the price a prudent buyer would pay a seller in an arms-length sale, or if over two thousand dollars ($2,000), the appraised value, whichever is lower. An asset is considered donated when the provider acquires the asset without making any payment for it in the form of cash, property, or services. If the provider and the donor are related parties, the net book value of the asset to the donor shall be the basis, not to exceed fair market value. Cash donations shall be treated as revenue items and not as offsets to expense accounts. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-16)*

405 IAC 1-12-17 Capital return factor; basis; sale or capital lease of facility; valuation; sale or lease among family members

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 17. (a) If a facility is sold or leased within eight (8) years of the seller's or lessor's acquisition date and this transaction is recognized as a change of provider status, the buyer's or lessee's property basis in facilities and equipment shall be the seller's or lessor's historical cost basis plus one percent (1%) of the

difference between the purchase price, or appraised value if lower, and the seller's or lessor's historical cost basis, for each month the seller or lessor has owned or leased the property.

(b) Leases shall be subject to the following purchase equivalency test based on the maximum capital return factor. The provider shall supply sufficient information to the office so as to determine the terms and conditions of a purchase that would be equivalent to the lease agreement. Such information shall include the following:

(1) Property basis and fair market value on the initial lease effective date.

(2) Inception date of the initial agreement between lessee and lessor.

(3) Imputed or stated interest rate.

(4) Duration of payments.

(5) Renewal options.

Such purchase equivalency terms and conditions shall be utilized to calculate the capital return factor as if it were a purchase. The provisions of section 15(c) through 15(d) of this rule shall apply. The lease payments determined under this section shall be subject to the limitations under section 15(b) of this rule.

(c) Where the imputed or stated interest rate is a variable rate, it shall be recognized only if the rate is reasonable and only if such arrangement was incorporated into the lease agreement at the time of acquisition.

FOOTNOTE TO SECTION 17(c) ABOVE BUT NOT PART OF THE PROMULGATED REIMBURSEMENT RULE: REASONABLE INTEREST RATES ARE THOSE RATES THAT ARE COMPARABLE TO CURRENT MARKET RATES.

(d) All leases, rental agreements, and contracts involving the use of property shall be subject to the same limitations as owners of property. The use fee calculation for variable rate leases will be calculated in the same manner as that set forth in section 13(k) of this rule. In no event shall the capital return factor be greater than the actual lease payment.

(e) If a provider rents, leases, or purchases facilities or equipment from a related party, the historical cost to the related party, not to exceed fair market value, shall be utilized in computing the capital return factor except as described in this section for the sale of facilities between family members.

(f) The sale of facilities between family members shall be eligible for consideration as a change of provider status transaction if all of the following requirements are met:

(1) There is no spousal relationship between parties.

(2) The following persons are considered family members:

(A) Natural parents, child, and sibling.

(B) Adopted child and adoptive parent.

(C) Stepparent, stepchild, stepsister, and stepbrother.

(D) Father-in-law, mother-in-law, sister-in-law, brother-in-law, and daughter-in-law.

(E) Grandparent and grandchild.

(3) The provider can demonstrate to the satisfaction of the office that the primary business purpose for the sale is other than increasing the established rate.

FOOTNOTE TO SECTION 17(f)(3) ABOVE BUT NOT PART OF THE PROMULGATED REIMBURSEMENT RULE: A PROVIDER CAN DEMONSTRATE TO THE SATISFACTION OF THE OFFICE THAT THE PRIMARY PURPOSE OF THE SALE OF FACILITIES BETWEEN FAMILY MEMBERS IS FOR REASONS OTHER THAN INCREASING THE ESTABLISHED RATE BY POINTING OUT THAT THE RATE TREATMENT OFFERED THROUGH THIS PLAN AND THE RATE SETTING CRITERIA LIMITS THE RATE FOR A NEW PROVIDER IN A CHANGE OF PROVIDER STATUS TRANSACTION TO THE STATEWIDE MEDIAN RATE FOR LIKE TYPE PROVIDERS OR THE PREDECESSOR PROVIDER'S RATE, WHICHEVER IS GREATER. IN ANY CASE THERE IS LITTLE OR NO OPPORTUNITY FOR A PROVIDER TO USE A FAMILY SALE TRANSACTION AS A METHOD MEANT SOLELY TO INCREASE THE FACILITY'S RATE.

(4) The transfer is recognized and reported by all parties as a sale for federal income tax purposes.

(5) The seller and all parties with an ownership interest in the previous provider are not associated with the facility in any way after the sale other than as a passive creditor.

(6) The buyer is actively engaged in the operation of the facility after the sale with earnings from the facility accruing to at least one (1) principal buyer primarily as salaries or self-employment income and not as leases, rents, or other passive income.

(7) This family sale exception has not been utilized during the previous eight (8) years on this facility.

(8) None of the entities involved is a publicly held corporation as defined by the Securities and Exchange Commission.

(9) If any of the entities involved are corporations, they must be family owned corporations, where members of the same family control the corporations through ownership of fifty percent (50%) or more of the voting stock.

(g) In order to establish an historical cost basis in the sale of facilities between family members, the buyer shall obtain a Member Appraiser Institute (MAI) appraisal, which appraisal is subject to the approval of the office. The appraisal shall be done within ninety (90) days of the date of the sale. The historical cost basis shall be the lower of the historical cost basis of the buyer or ninety percent (90%) of the MAI appraisal of facilities and equipment.

(h) If the conditions of this section are met, the cost basis and financing arrangements of the facility shall be recognized for the purpose of computing the capital return factor in accordance with this rule for a bona fide sale arising from an arm's-length transaction.

(i) If a lease of facilities between family members under subsection (f)(2) qualifies as a capitalized lease under guidelines issued in November 1976 by the American Institute of Certified Public Accountants, the transaction shall be treated as a sale of facilities between family members, for purposes of determining the basis, cost, and valuation of the buyer's capital return factor component of the Medicaid rate.

405 IAC 1-12-18 Unallowable costs; cost adjustments; charity and courtesy allowances; discounts; rebates; refunds of expenses

Sec. 18. (a) Charity, courtesy allowances, discounts, refunds, rebates, and other similar items granted by a provider shall not be included in allowable costs. Bad debts incurred by a provider shall not be an allowable cost.

(b) Payments that must be reported on the annual or historical financial report form that are received by a provider, an owner, or other official of a provider in any form from a vendor shall be considered a reduction of the provider's costs for the goods or services from that vendor.

(c) The cost of goods or services sold to nonpatients or nonresidents shall be offset against the total cost of such service to determine the allowable patient or resident related expenses. If the provider has not determined the cost of such items, the revenue generated from such sales shall be used to offset the total cost of such services.

405 IAC 1-12-19 Allowable costs; wages; costs of employment; record keeping; owner or related party compensation

Sec. 19. (a) Reasonable compensation of individuals employed by a provider is an allowable cost, provided the:

(1) employees are engaged in patient or resident care-related functions; and

(2) compensation amounts are reasonable and allowable under this section and sections 20 through 22 of this rule.

(b) The provider shall report using forms prescribed by the office all patient and resident-related staff costs and hours incurred to perform the function for which the provider was certified. Both total compensation and total hours worked shall be reported. Staffing limitations to determine Medicaid allowable cost shall be based on hours worked by employees. If a service is performed through a contractual agreement, imputed hours for contracted services are only required when the services obviate the need for staffing of a major function or department that is normally staffed by in-house personnel. For all providers, except for providers of extensive support needs residences for adults:

(1) hours for laundry services in CRF/DD or **ICF/IID** facilities that are properly documented through appropriate time studies, whether paid in-house or contracted, shall not be included in calculating the staffing limitation for the facility; and

(2) hours associated with the provision of day services and other ancillary services, except as specified in subsection (d), shall be excluded from the staffing limitation.

(c) Payroll records shall be maintained by the provider to substantiate the staffing costs reported to the office. The records shall indicate each employee's classification, hours worked, rate of pay, and the department or functional area to which the employee was assigned and actually worked. If an employee performs duties in more than one (1) department or functional area, the payroll records shall indicate the time allocations to the various assignments.

(d) When an owner or related party work assignment is at or below a department head level, the hours and compensation shall be included in the staffing hours reported using the forms prescribed by the office. Such hours and compensation must be reported separately and so identified. Compensation paid to owners or related parties for performing such duties shall be subject to the total staffing limitations and allowed if the compensation paid to owners or related parties does not exceed the price paid in the open market to obtain such services by nonowners or nonrelated parties. Such compensation to owners or related parties is not subject to the limitation found in section 20 of this rule.

405 IAC 1-12-20 Allowable costs; calculation of allowable owner or related party compensation; wages; salaries; fees; fringe benefits

Sec. 20. (a) Compensation for owner, related party, management, **general line personnel, and** consultants who perform management functions, or any individual or entity rendering services above the department head level shall be subject to the annual limitations described in this section. All compensation received by the parties as described in this subsection shall be reported and separately identified on the financial report form even though such payment may exceed the limitations. This compensation is allowed to cover costs for all administrative, policy making, decision making, and other management functions above the department head level. This includes wages, salaries, and fees for owner, administrator, assistant administrator, individuals within management, contractors, and consultants who perform management functions, as well as any other individual or entity performing such tasks.

(b) The maximum amount of owner, related party, management compensation for the parties identified in subsection (a) shall be the lesser of the amount under subsection (d), as updated by the office on July 1 of each year by determining the average rate of change of the most recent twelve (12) quarters of the Gross National Product Implicit Price Deflator, or the amount of patient or resident related wages, salaries, or fees actually paid or withdrawn which were properly reported to the Internal Revenue Service as wages, salaries, fringe benefits, expenses, or fees. If liabilities are established, they shall be paid within seventy-five (75) days after the end of the accounting period or such costs shall be disallowed.

(c) In addition to wages, salaries, and fees paid to owners under subsection (b), the office will allow up to twelve percent (12%) of the appropriate schedule for fringe benefits, business expenses charged to an

operation, and other assets actually withdrawn that are patient or resident related. These expenses include fringe benefits that do not meet nondiscriminatory requirements of the Internal Revenue Code, entertainment, travel, or continuing education. Other assets actually withdrawn include only those items that were actually accrued and subsequently paid during the cost reporting period in which personal services were rendered and reported to the Internal Revenue Service as fringe benefits, expenses, or fees. If liabilities are established, they shall be paid within seventy-five (75) days after the end of the accounting period or such costs shall be disallowed.

(d) The owner, related party, and management compensation and expense limitation per operation shall be as follows:

SEE COMPLETE TABLE DISPLAYED ON PAGE 109 OF THIS DOCUMENT

BEDS	OWNER AND MANAGEMENT COMPENSATION ALLOWANCE	OWNER'S EXPENSE (12% x Bed Allowance)
10	$18,527	$2,223
20	$24,717	$2,966
30	$30,887	$3,706
40	$37,049	$4,446
50	$43,241	$5,189
60	$46,948	$5,634
70	$50,657	$6,079
80	$54,362	$6,523
90	$58,055	$6,967
100	$61,763	$7,412
110	$66,731	$8,007
120	$71,663	$8,600
130	$76,628	$9,195
140	$81,546	$9,786
150	$86,496	$10,380
160	$91,427	$10,971
170	$96,378	$11,565
180	$101,313	$12,157
190	$106,262	$12,751
200	$111,196	$13,343
200 and over	$111,196 plus	$13,343 plus
	$225 per bed over 200	$27 per bed over 200

This subsection applies to each provider of a certified Medicaid operation. The unused portions of the allowance for one (1) operation shall not be carried over to other operations.

405 IAC 1-12-20.5 Extensive support needs residences for adults; fair rental value allowance

Sec. 20.5. Providers of extensive support needs residences for adults shall be reimbursed for the use of facilities and equipment, regardless of whether they are owned or leased, by means of a fair rental value allowance. The fair rental value allowance shall be in lieu of the costs of all depreciation, interest, lease, rent, or other consideration paid for the use of property. This includes all central office facilities and equipment whose patient care-related depreciation, interest, or lease expense is allocated to the facility. The fair rental value allowance shall be calculated as follows:

(1) The fair rental value allowance for extensive support needs residences for adults is calculated during rebasing years and base rate reviews by determining, on a per bed basis, the historical cost of allowable patient-related property for facilities that are not acquired through an operating lease arrangement, including the following:

(A) Land.
(B) Building.
(C) Improvements.
(D) Vehicles.
(E) Equipment.

The original historical cost of allowable resident related land, buildings, and improvements as of the provider's date of initial Medicaid certification shall be adjusted for changes in valuation by inflating the reported allowable patient-related historical cost of property from the date of facility acquisition to the present based on the change in the R. S. Means Construction Index.

(2) The inflation-adjusted historical cost of property per bed as determined in subdivision (1) is arrayed to arrive at the average historical cost of property of the median bed.

(3) The average historical cost of property of the median bed as determined in subdivision (2) is extended times the number of beds for each facility to arrive at the fair rental value amount.

(4) The fair rental value amount is extended by a rental rate to arrive at the fair rental allowance. The rental rate shall be a simple average of the United States Treasury bond, ten (10) year amortization, constant maturity rate plus three percent (3%), in effect on the first day of the month that the index is published for each of the twelve (12) months immediately preceding the calendar quarter that includes the rate effective date. The rental rate shall be updated quarterly on January 1, April 1, July 1, and October 1.

(5) If there are fewer than six (6) nonleased homes with rates established that are licensed as extensive support needs residences for adults, then the historical cost of property per bed used in the fair rental value calculation shall be one hundred eighteen thousand seven hundred fifty dollars ($118,750).

405 IAC 1-12-21 Nonstate-operated intermediate care facilities for individuals with intellectual disabilities; allowable costs; compensation; per diem rate

Sec. 21. (a) The procedures described in this section are applicable to ICFs/IID with nine (9) or more beds only, notwithstanding the application of standards and procedures set forth in sections 1 through 20 of this rule.

(b) The per diem rate for ICFs/IID is an all-inclusive rate. The per diem rate includes all services provided to patients by the facility.

(c) Costs related to staffing shall be limited to seven (7) hours worked per patient day.

(d) Any ICFs/IID that is licensed as a CRMNF will be paid at a rate of seven hundred three dollars and ten cents ($703.10) per resident day. This per diem rate is available only upon certification as a Medicaid ICF/IID and licensure by DDRS. ICFs/IID that are licensed as CRMNFs are not subject to other rate adjustments identified in this rule and will not receive a base rate nor be subject to the base rate reporting requirements at section 5 of this rule.

405 IAC 1-12-22 Community residential facilities for the developmentally disabled; allowable costs; compensation; per diem rate

Sec. 22. (a) Notwithstanding the application of standards and procedures set forth in sections 1 through 20.5 of this rule, the procedures described in this section apply to **ICFs/IID** with eight (8) or fewer beds (**CRFs/DD**), except for **ICFs/IID** licensed as:

(1) small behavior management residences for children for which the procedures described in this section apply to facilities with six (6) or fewer beds;

(2) small extensive medical needs residences for adults for which the procedures described in this section apply to facilities with four (4) beds; and

(3) extensive support needs residences for adults for which the procedures described in this section apply to facilities with four (4) beds.

(b) Costs related to staffing shall be limited to the following:

Type of License	Staff Hours Per Resident Day
Sheltered living	4.5
Intensive training	6.0
Developmental training	8.0
Child rearing	8.0
Child rearing residences with specialized programs	10.0
Basic developmental	10.0
Small behavior management residences for children	12.0
Small extensive medical needs residences for adults	12.0
Extensive support needs residences for adults	24.0

(c) Any change in staffing that exceeds the current limitations of four and one-half (4.5) hours per resident day for adults and eight (8) hours per resident day for children will require approval on a case-by-case basis, upon application by the facility. This approval will be determined in the following manner:

(1) A new or current provider of service that seeks staffing above four and one-half (4.5) hours per resident day for adults or eight (8) hours per resident day for children must first obtain approval from the DDRS, based upon the DDRS assessment of the program needs of the residents. The DDRS will establish the maximum number of staff hours per resident day for each facility, which may be less than but may not be more than the ceiling for each type of license. If a change in type of license is required to permit the staffing limitation determined by the DDRS, then the DDRS will make its recommendation to the licensing authority and convey to the **office** the decision of the licensing authority. The office shall:

(A) conduct a complete and independent review of a request for increased staffing; and

(B) retain final authority to determine whether a rate change will be granted as a result of a change in licensure type.

(2) If a provider of services holds a current license that would permit staffing above the limitation of four and one-half (4.5) hours per resident day for adults and eight (8) hours per resident day for children, but the provider does not seek approval of staffing beyond those limitations, then the DDRS may investigate whether the provider holds the appropriate type of license.

(d) The per diem rate shall be an all-inclusive rate. The established rate includes all services provided to residents by a facility. The office shall not set a rate for more than one (1) level of care for each **CRF/DD** provider.

405 IAC 1-12-23 Medical or nonmedical supplies and equipment; personal care items

Sec. 23. (a) Routine and nonroutine medical supplies and equipment are included in the provider's approved per diem rate, and the provider shall not bill **Medicaid** for such items in addition to the established rate. Under no circumstances shall the routine and nonroutine medical supplies and equipment be billed through a pharmacy or other provider. Routine supplies and equipment include those items routinely required for the care of residents. Nonroutine medical supplies and equipment are those items for which the need must be demonstrated by the resident's particular condition and identifiable to that resident. The medical records of each resident must indicate, by specific written physician's orders, the order for the service or supply furnished and the dispensing of the service or supply to the resident.

(b) Personal care or comfort items include the following:

(1) Hairbrushes and combs.
(2) Dental adhesives and caps.
(3) Toothpaste.
(4) Shower caps.
(5) Nail files.
(6) Lemon glycerine swabs.
(7) Mouthwashes.
(8) Toothbrushes.
(9) Deodorants.
(10) Shampoos.
(11) Disposable tissues.
(12) Razor.
(13) Any other items or equipment covered by Medicaid and specifically requested by a resident and not routinely provided by the provider.

These items may be included in the approved room charge. Under no circumstances shall items included as personal care or comfort be billed through a pharmacy or other provider to **Medicaid.**

405 IAC 1-12-24 Assessment methodology

Sec. 24. (a) This subsection is intentionally left blank.

(b) The assessment on provider total annual revenue authorized by IC 12-15-32-11 shall be an allowable cost for cost reporting and audit purposes. Total annual revenue is determined as follows:

(1) For an annual rate review, from the provider's previous annual financial reporting period as set out in section 4(a) of this rule.

(2) For a base rate review, from the provider's previous base financial reporting period as set out in section 5(c) of this rule.

(3) For an initial interim rate review for a new provider that is not the result of a change of ownership, the fiftieth percentile provider's assessment for a like level of care shall be used as determined in section 5(a) of this rule. The fiftieth percentile provider's assessment is divided by their resident days to determine the assessment per resident day amount. The assessment per resident day amount is then multiplied by the annualized bed days available to determine the new provider's annualized assessment.

Providers will submit data to calculate the amount of provider assessment with their annual and base rate reviews as set out in sections 4(a) and 5(c) of this rule, using forms or in a format prescribed by the office. These forms are subject to audit by the office or its designee.

(c) This subsection is intentionally left blank.

(d) For an **ICF/IID** that is licensed as a CRMNF, the total annual revenue on which the assessment is based shall be determined as follows:

(1) For the initial interim rate review, available bed days times the projected occupancy rate of sixty-nine percent (69%) times the approved Medicaid rate issued to the provider.

(2) For annual rate reviews, from the provider's previous annual financial reporting period as set out in section 4(a) of this rule.

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405 IAC 1-12-25 Reimbursement for day services

Sec. 25. For **ICF/IID** and CRF/DD facilities, the all-inclusive per diem rate shall include reimbursement for all day habilitation services. Costs associated with day habilitation services shall be reported to the office on the annual or historical financial report form using forms prescribed by the office. Allowable day habilitation costs shall be included in determining a provider's allowable costs for rate setting purposes in accordance with all sections of this rule.

405 IAC 1-12-26 Administrative reconsideration; appeal

Sec. 26. (a) The **office** shall notify each provider of the provider's rate and allowable cost determinations after they have been computed. If the provider disagrees with the rate or allowable cost determinations, the provider may request an administrative reconsideration by the **office**. Such reconsideration request shall be in writing and shall contain specific issues to be reconsidered and the rationale for the provider's position. The provider must request administrative reconsideration before filing an appeal. Only issues raised by the provider during the administrative reconsideration may be subsequently raised in an appeal. The request shall be signed by the provider or the authorized representative of the provider and must be received by the **office** not later than forty-five (45) days after release of the rate or allowable cost determinations as computed by the **office**. Upon receipt of the request for reconsideration, the **office** shall evaluate the data. After review, the **office** may amend the rate, amend the challenged procedure or allowable cost determination, or affirm the original decision. The **office** shall thereafter notify the provider of its final decision in writing, not later than forty-five (45) days from the **office's** receipt of the request for reconsideration. In the event that a timely response is not made by the **office** to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies as set out in subsection (c).

(b) If the provider disagrees with the preliminary recalculated Medicaid rate or allowable cost redetermination resulting from a financial audit adjustment or reportable condition the provider may request an administrative reconsideration from the **office**. Such reconsideration request shall be in writing and shall contain specific issues to be considered and the rationale for the provider's position. The provider must request administrative reconsideration before filing an appeal. Only issues raised by the provider during the administrative reconsideration may be subsequently raised in an appeal. The request shall be signed by the provider or the authorized representative of the provider and must be received by the **office** not later than forty-five (45) days after release of the preliminary recalculated Medicaid rate or allowable cost determinations as computed by the **office**. Upon receipt of the request for reconsideration, the **office** shall evaluate the data. After review, the **office** may amend the audit adjustment or reportable condition or affirm the original adjustment or reportable condition. The **office** shall thereafter notify the provider of its final decision in writing not later than forty-five (45) days from the **office's** receipt of the request for reconsideration. In the event that a timely response is not made by the **office** to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies under subsection (c).

(c) After completion of the reconsideration procedure under subsection (a) or (b), the provider may initiate an appeal under IC 4-21.5-3. The request for an appeal must be signed by the provider.

(d) The office may take action to implement Medicaid rates without awaiting the outcome of the administrative process, in accordance with section 1(d) of this rule.

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Rate-Setting Criteria for State-Owned Nursing Facilities and Intermediate Care Facilities for the Mentally Retarded

Section 1 Policy; scope

Sec. 1. (a) This section of the State Plan sets forth procedures for payment for services rendered to Medicaid recipients by duly certified, state-owned intermediate care facilities for the mentally retarded (ICF/MR) and state-owned nursing facilities. All payments referred to within this section of the State Plan for the provider groups and levels of care are contingent upon the following:

(1) Proper and current certification.

(2) Compliance with applicable state and federal statutes and regulations.

(b) The procedures described in this section of the State Plan set forth methods of reimbursement that promote quality of care, efficiency, economy, and consistency. These procedures recognize level and quality of care, establish effective accountability over Medicaid expenditures, provide for a regular review mechanism for rate changes, compensate providers for reasonable, allowable costs incurred by a prudent businessperson, and allow incentives to encourage efficient and economic operations. The system of payment outlined in this section of the State Plan is a retrospective system using interim rates predicated on a reasonable, cost-related basis**,** in conjunction with a final settlement process. Cost limitations are contained in this section of the State Plan which establish parameters regarding the allowability of costs and define reasonable allowable costs.

(c) Retroactive repayment will be required by providers when an audit verifies overpayment due to intentional misrepresentation, billing or payment errors, or misstatement of historical financial or historical statistical data which caused a rate higher than would have been allowed had the data been true and accurate. Upon discovery that a provider has received overpayment of a Medicaid claim from the office, the provider must complete the appropriate Medicaid billing adjustment form and reimburse the office for the amount of the overpayment.

(d) The office may implement Medicaid rates prospectively without awaiting the outcome of the administrative appeal process. However, any action by the office to recover an overpayment from previous rate reimbursements, either through deductions of future payments or otherwise, shall await the completion of the provider's administrative appeal within the office, providing the provider avails itself of the opportunity to make such an appeal. Interest shall be assessed in accordance with IC 12-15-13-3

Section 2 Definitions

Sec. 2. (a) As used in this section of the State Plan , "all-inclusive rate" means a per diem rate which, at a minimum, reimburses for all nursing care, room and board, supplies, and ancillary therapy services within a single, comprehensive amount.

(b) As used in this section of the State Plan , "annual, historical, or budget financial report" refers to a presentation of financial data,

including accompanying notes, derived from accounting records and intended to communicate the provider's economic resources or obligations at a point in time, or the changes therein for a period of time in compliance with the reporting requirements of this section of the State Plan which shall constitute a comprehensive basis of accounting.

(c) As used in this section of the State Plan , "budgeted/forecasted data" means financial and statistical information that presents, to the best of the provider's knowledge and belief, the expected results of operation during the rate period.

(d) As used in this section of the State Plan , "cost center" means a cost category delineated by cost reporting forms prescribed by the office.

(e) As used in this section of the State Plan , "office" means the office of Medicaid policy and planning.

(f) As used in this section of the State Plan , "desk review" means a review and application of these regulations to a provider submitted annual financial report including accompanying notes and supplemental information .

(g) As used in this section of the State Plan , "field audit" means a formal official verification and methodical examination and review, including the final written report of the examination of original books of accounts by auditors.

(h) As used in this section of the State Plan , "forms prescribed by the office" means forms provided by the office or substitute forms which have received prior written approval by the office.

(i) As used in this section of the State Plan , "general line personnel" means management personnel above the department head level who perform a policy making or supervisory function impacting directly on the operation of the facility.

(j) As used in this section of the State Plan , "generally accepted accounting principles" means those accounting principles as established by the Governmental Accounting Standards Board (GASB).

(k) As used in this section of the State Plan , "ICF/MR" means intermediate care facilities for the mentally retarded.

(l) As used in this section of the State Plan , "like levels of care" means ICF/MR level of care provided in a state-owned ICF/MR, and nursing facility level of care provided in a state-owned nursing facility.

(m) As used in this section of the State Plan , "ordinary patient related costs" means costs of services and supplies that are necessary in the delivery of patient care by similar providers within the state.

(n) As used in this section of the State Plan , "patient/recipient care" means those Medicaid program services delivered to a Medicaid enrolled recipient by a certified Medicaid provider.

(o) As used in this section of the State Plan , "reasonable allowable costs" means the price a prudent, cost conscious buyer would pay a willing seller for goods or services in an arm’s-length transaction, not to exceed the limitations set out in this section of the State Plan .

(p) As used in this section of the State Plan , "unit of service" means all patient care included in the established per diem rate required for the care of an inpatient for one (1) day (twenty-four (24) hours).

Section 3 Accounting records; retention schedule; audit trail; cash basis; segregation of accounts by nature of business and by location

Sec. 3. (a) The basis of accounting used under this section of the State Plan is a comprehensive basis of accounting other than generally accepted accounting principles. However, generally accepted accounting principles as prescribed by the Governmental Accounting Standards Board pronouncement shall be followed in the preparation and presentation of all financial reports and all reports detailing proposed change of provider transactions unless otherwise prescribed by this section of the State Plan .

(b) Each provider must maintain financial records for a period of three (3) years after the date of submission of financial reports to the office. State accounting records are maintained on a cash basis, which shall be used in all data submitted to the office. The provider's accounting records must establish an audit trail from those records to the financial reports submitted to the office.

(c) In the event that a field audit visit indicates that the provider's records are inadequate to support data submitted to the office, and the auditor is unable to complete the audit and issue an opinion, the provider shall be given, in writing, a list of the deficiencies and allowed sixty (60) days from the date of receipt of this notice to correct the deficiencies. In the event the deficiencies are not corrected within the sixty (60) day period, the office shall not grant any rate increase to the provider until the cited deficiencies are corrected and certified to the office by the provider. However, the office may:

(1) make appropriate adjustments to the applicable cost reports of the provider resulting from inadequate records;

(2) document such adjustments in a finalized exception report; and

(3) incorporate such adjustments in prospective rate calculations under section 1(d) of this section of the State Plan .

(d) If a provider has business enterprises other than those reimbursed by Medicaid under this section of the State Plan , the revenues, expenses, and statistical and financial records for such enterprises shall be clearly identifiable from the records of the operations reimbursed by Medicaid. If a field audit establishes that records are not maintained so as to clearly identify Medicaid information, none of the commingled costs shall be recognized as Medicaid allowable costs and the provider's rate shall be adjusted to reflect the disallowance effective as of the date of the most recent rate change.

Section 4 Financial report to office; annual schedule; prescribed form; extensions

Sec. 4. (a) Each provider shall submit an annual financial report to the office not later than ninety (90) days after the close of the provider's reporting year. The annual financial report shall coincide with the fiscal year used by the provider to report federal income taxes for the operation unless the provider requests in writing that a different reporting period be used. Such a request shall be submitted within sixty (60) days after the initial certification of a provider. This option may be exercised only one (1) time by a provider. If a reporting period other than the tax year is established, audit trails between the periods are required, including reconciliation statements between the provider's records and the annual financial report.

(b) The provider's annual financial report shall be submitted using forms prescribed by the office. All data elements and required attachments shall be completed so as to provide full financial disclosure and shall include the following as a minimum:

(1) Patient census data.

(2) Statistical data.

(3) Ownership and related party information.

(4) Statement of all expenses and all income.

(5) Detail of fixed assets and patient related interest bearing debt.

(6) Schedule of Medicaid and private pay charges; private pay charges shall be lowest usual and ordinary charge on the last day of the reporting period.

(7) Certification by the provider that the data are true, accurate, related to patient care, and that expenses not related to patient care have been clearly identified.

(8) Certification by the preparer, if different from the provider, that the data were compiled from all information provided to the preparer by the provider and as such are true and accurate to the best of the preparer's knowledge.

(c) Extension of the ninety (90) day filing period shall not be granted unless the provider substantiates to the office circumstances that preclude a timely filing. Requests for extensions shall be submitted to the office, prior to the date due, with full and complete explanation of the reasons an extension is necessary. The office shall review the request for extension and notify the provider of approval or disapproval within ten (10) days of receipt. If the request for extension is disapproved, the report shall be due twenty (20) days from the date of receipt of the disapproval from the office.

Section 5 New provider; initial financial report to office; criteria for establishing initial rates; supplemental report

Sec. 5. (a) Rate requests to establish initial rates for a new operation or a new type of certified service shall be filed by completing the budget financial report form and submitting it to the office on or before thirty (30) days after notification of the certification date or establishment of a new service or new operation. The budget financial report shall reflect the forecasted data of operating for the first twelve (12) months and shall be subject to appropriate reasonableness tests. Initial rates shall be effective upon certification, or the date that a service is established, whichever is later.

(b) The methodology, set out in this section of the State Plan , used to compute rates for active providers shall be followed to compute initial rates for new providers, except that historical data are not available.

Section 6 Active providers; rate review; annual request; additional requests; requests due to change in law

Sec. 6. (a) As a normal practice, rates shall be reviewed once each year using the annual financial report as the basis of the review. The rate effective date shall be the first day of the month following the provider's reporting year end, provided the annual financial report is submitted within ninety (90) days of the end of the provider's reporting period. If the provider requests that the interim rate be reviewed, a budget financial report covering the twelve (12) month period immediately following the expected rate effective date shall be prepared by the provider and submitted with the annual financial report.

(b) A provider shall not be granted an additional interim rate review until the review indicated in subsection (a) has been completed. A provider may request no more than one (1) additional interim rate review during its budget reporting year when the provider can reasonably demonstrate the need for a change in rate based on more recent historical and forecasted data. This additional interim rate review shall be completed in the same manner as the annual interim rate review, using all other limitations in effect at the time the annual interim review took place.

(c) To request the additional interim review, the provider shall submit, on forms prescribed by the office, a minimum of six (6) months of historical data of which at least four (4) months must be subsequent to the fiscal year end of the annual financial report. In addition, a budget financial report covering the twelve (12) month period immediately following the expected rate effective date shall be submitted. Any new rate resulting from this additional interim review shall be effective on the first day of the month following the submission of data to the office.

(d) The office may consider changes in federal or state law or regulation during a calendar year to determine whether a significant rate increase is mandated. This review will be considered separately by the office and will not be considered as an additional interim rate review.

Section 7 Request for rate review; budget component; occupancy level assumptions; effect of inflation assumptions

Sec. 7. (a) Under this rate setting system, emphasis is placed on proper planning, budgeting, and cost control by the provider. To establish consistency in the submission and review of forecasted costs, the following apply:

(1) Each interim rate review request shall include a budget financial report. If a budget financial report is not submitted, the interim rate review will not result in an increase in Medicaid rates but may result in a rate decrease based on historical or annual financial reports submitted.

(2) All budget financial reports shall be submitted using forms prescribed by the office. All forecasted data and required attachments shall be completed to provide full financial disclosure and will include as a minimum the following:

(A) Patient census data.
(B) Statistical data

(C) Ownership and related party information.
(D) Statement of all expenses and all income.
(E) Detail of fixed assets and patient related interest bearing debt.
(F) Schedule of Medicaid and private pay charges; charges shall be the lowest usual and ordinary charge on the rate effective date of the rate review.
(G) Certification by the provider that forecasted data has been prepared in good faith, with appropriate care by qualified personnel, using appropriate accounting principles and assumptions, and that the process to develop the forecasted data uses the best information that is reasonably available and is consistent with the plans of the provider. The certification shall state that all expenses not related to patient care have been clearly identified or removed.
(H) Certification by the preparer, if the preparer is different from the provider, that the forecasted data were compiled from all information provided to the preparer and that the preparer has read the forecasted data with its summaries of significant assumptions and accounting policies and has considered them to be not obviously inappropriate.

(3) The provider shall adjust patient census data based on the highest of the following:

(A) Historical patient days for the most recent historical period unless the provider can justify the use of a lower figure for the patient days.

(B) Forecasted patient days for the twelve (12) month budget period.

(4) The provider and the office shall recognize and adjust forecasted data accordingly for the inflationary or deflationary effect on historical data for the period between the midpoint of the historical or annual financial report time period and the midpoint of the budget financial report. Forecasted data may be adjusted based upon reasonably anticipated rates of inflation.

Section 8 Limitations or qualifications to Medicaid reimbursement; advertising; vehicle basis

Sec. 8. Advertising is not an allowable cost under this section of the State Plan except for those advertising costs incurred in the recruitment of facility personnel necessary for compliance with facility certification requirements. Advertising costs are not allowable in connection with public relations, fundraising, or to encourage patient utilization.

Section 9 Criteria limiting rate adjustment granted by office

Sec. 9. The Medicaid reimbursement system is based on recognition of the provider's allowable costs. Providers reimbursed under this rule will be reimbursed with a retrospective payment system. The annual financial reports filed by the providers will be used to determine the actual cost per day for services. A retroactive settlement will be determined for the time period

covered by the annual financial report. The total allowable costs will be divided by the actual client days to determine the actual per diem rate. The variance between the actual per diem rate and the interim per diem rates based on the projected budget and paid during the report period will be multiplied by the paid client days to arrive at the annual settlement

Section 10 Computation of rate; allowable costs; review of cost reasonableness

Sec. 10. (a) The rate for a room with two (2) beds, which is the basic per diem room rate, shall be established as a ratio between total allowable costs and patient days, subject to all other limitations described in this section of the State Plan

(b) Costs and revenues shall be reported as required on the financial report forms. Patient care costs shall be clearly identified.

(c) The provider shall report as patient care costs only costs that have been incurred in the providing of patient care services. The provider shall certify on all financial reports that costs not related to patient care have been separately identified on the financial report.

(d) In determining reasonableness of costs, the office may compare line items, cost centers, or total costs of providers with like levels of care. The office may request satisfactory documentation from providers whose costs do not appear to be reasonable.

Section 11 Allowable costs; capital reimbursement; depreciable life

Sec. 11. (a) Providers shall be reimbursed for the use of facilities and equipment, regardless of whether they are owned or leased. Such reimbursement shall include all depreciation, interest, lease, rent, or other consideration paid for the use of property. This includes all central office facilities and equipment whose patient care-related depreciation, interest, or lease expense is allocated to the facility.

(b) The straight line method will be used to calculate the allowance for depreciation. For depreciation purposes, the following will be used:

Property	Depreciable Life
Land improvements	20 years
Buildings and building components	40 years
Building improvements	20 years
Movable equipment	10 years
Vehicles	4 years
Software	3 years

Section 12 Capital reimbursement; basis; historical cost; mandatory record keeping; valuation

Sec. 12. (a) The basis used in computing the capital reimbursement shall be the historical cost of all assets used to deliver patient related services, provided the following:

(1) They are in use.
(2) They are identifiable to patient care.
(3) They are available for physical inspection.
(4) They are recorded in provider records.

If an asset does not meet all of the requirements prescribed in this section, the cost shall not be included in computing the reimbursement.

(b) The provider shall maintain detailed property schedules to provide a permanent record of all historical costs and balances of facilities and equipment. Summaries of such schedules shall be submitted with each annual financial report, and the complete schedule shall be submitted to the office upon request.

(c) Assets used in computing capital reimbursement shall include only items currently used in providing services customarily provided to patients.

(d) When an asset is acquired by trading one (1) asset for another, or a betterment or improvement is acquired, the cost of the newly acquired asset, betterment, or improvement shall be added to the appropriate property category. All of the historical cost of the traded asset or replaced betterment or improvement shall be removed from the property category in which it was included.

(e) If a single asset or collection of like assets acquired in quantity, including permanent betterment or improvements, has at the time of acquisition an estimated useful life of at least three (3) years and a historical cost of at least five hundred dollars ($500), the cost shall be included in the property basis for the approved useful life of the asset. Items that do not qualify under this subsection shall be expensed in the year acquired.

(f) The property basis of donated assets, except for donations between providers or related parties, shall be the fair market value defined as the price a prudent buyer would pay a seller in an arm's-length sale, or if over two thousand dollars ($2,000), the appraised value, whichever is lower. An asset is considered donated when the provider acquires

the asset without making any payment for it in the form of cash, property, or services. If the provider and the donated asset are related parties, the net book value of the donor shall be the basis, not to exceed fair market value. Cash donations shall be treated as revenue items and not as offsets to expense accounts.

Section 13 Unallowable costs; cost adjustments; charity and courtesy allowances; discounts; rebates; efunds of expenses

Sec. 13. (a) Charity, courtesy allowances, discounts, refunds, rebates, and other similar items granted by a provider shall not be included in allowable costs. Bad debts incurred by a provider shall not be an allowable cost.

(b) Payments that must be reported on the annual financial report form that are received by a provider, an owner, or other official of a provider in any form from a vendor shall be considered a reduction of the provider's costs for the goods or services from that vendor.

(c) The cost of goods or services sold to nonpatients shall be offset against the total cost of such service to determine the allowable patient related expenses. If the provider has not determined the cost of such items, the revenue generated from such sales shall be used to offset the total cost of such services.

Section 14 Allowable costs; wages; costs of employment; record keeping; owner or related party compensation

Sec. 14. (a) Reasonable compensation of individuals employed or to be employed by a provider is an allowable cost, provided such employees are engaged in, or will be engaged in, patient care-related functions and that forecasted compensation amounts are reasonable in light of historical data under this section and section 15 of this section of the State Plan .

(b) The provider shall report on the financial report form in the manner prescribed, using the forms prescribed by the office, all patient related staff costs and hours incurred, and forecasted to be incurred, to perform the function for which the provider was certified. Both total compensation and total hours worked, and forecasted to be worked, shall be reported. If a service is performed through a contractual agreement, imputed hours for contracted services shall be reported.

(c) Payroll records shall be maintained by the provider to substantiate the staffing costs reported to the office. Said records shall indicate each employee's classification, hours worked, rate of pay, and the department or functional area to which the employee was assigned and actually worked. If an employee performs duties in more than one (1) department or functional area, the payroll records shall indicate the time allocations to the various assignments.

Section 15 Allowable costs; calculation of allowable owner or related party compensation; wages; salaries; fees; fringe benefits

Sec. 15. (a) Compensation for management, consultant, or any individual or entity rendering services above the department head level shall be subject to the annual limitations described in this section. All compensation received by the parties as described in this subsection shall be reported and separately identified on the financial report form even though such payment may exceed the limitations. This compensation is allowed to cover costs for all administrative, policy making, decision making, and other management and consultant functions above the department head level. This includes wages, salaries, and fees for owner, administrator, assistant administrator, management, contractor, and consultant as well as any other individual or entity performing such tasks.

(b) The maximum amount of management compensation for the parties identified in subsection (a) shall be the lesser of the amount under subsection (d), as updated by the office on July 1 of each year by determining the average rate of change of the most recent twelve (12) quarters of the Gross National Product Implicit Price Deflator, or the amount of patient related wages, salaries, or fees actually paid or withdrawn which were properly reported to the federal Internal Revenue Service as wages, salaries, fringe benefits, expenses, or fees. If liabilities are established, they shall be paid within seventy-five (75) days after the end of the accounting period or such costs shall be disallowed.

(c) In addition to wages, salaries, and fees paid to owners under subsection (b), the office will allow up to twelve percent (12%) of the appropriate schedule for fringe benefits, business expenses charged to an operation, and other assets actually withdrawn that are patient related. These expenses include fringe benefits that do not meet nondiscriminatory requirements of the Internal Revenue Code, entertainment, travel, or continuing education. Other assets actually withdrawn include only those items that were actually accrued and subsequently paid during the cost reporting period in which personal services were rendered and reported to the federal Internal Revenue Service as fringe benefits, expenses, or fees. If liabilities are established, they shall be paid within seventy-five (75) days after the end of the accounting period or such costs shall be disallowed.

(d) The management compensation and expense limitation per operation effective July 1, 1995, shall be as follows:

Owner and ManagementCompensation		Owner's Expenses
Beds	Allowance	(12% x bed allowance)
10	$21,542	$2,585
20	$28,741	$3,449
30	$35,915	$4,310
40	$43,081	$5,170
50	$50,281	$6,034
60	$54,590	$6,551
70	$58,904	$7,068
80	$63,211	$7,585
90	$67,507	$8,101
100	$71,818	$8,618
110	$77,594	$9,311
120	$83,330	$10,000

130	$89,103	$10,692
140	$94,822	$11,379
150	$100,578	$12,069
160	$106,311	$12,757
170	$112,068	$13,448
180	$117,807	$14,137
190	$123,562	$14,827
200	$129,298	$15,516
200 & over	$129,298+$262/bed over 200	$15,516+$31/bed over 200

This subsection applies to each provider of a certified Medicaid operation. The unused portions of the allowance for one (1) operation shall not be carried over to other operations.

Section 16 Allocation of costs

Sec. 16. (a) The detailed basis for allocation of expense between different levels of care in a facility shall remain a prerogative of the provider as long as the basis is reasonable and consistent between accounting periods.

(b) However, the following relationships shall be followed:

(1) Reported expenses and patient census information must be for the same reporting period.

(2) Nursing salary allocations must be on the basis of nursing hours worked and must be for the reporting period except when specific identification is used based on the actual salaries paid for the reporting period.

(3) Any change in the allocations must be approved by the office prior to the changes being implemented. Proposed changes in allocation methods must be submitted to the office for approval at least ninety (90) days prior to the provider's reporting year end.

Section 17 State-owned facilities per diem rate

Sec. 17. (a) The per diem rate for providers reimbursed under this rule is an all-inclusive rate. The per diem rate includes all services provided to recipients by the facility.

(b) Resources from health insurance plans available to the resident shall apply first to defraying the costs of medical services before Medicaid. Such resources shall include, but not be limited to, Medicare, Civilian Health and Medical Plan for Uniform Services, Veteran’s Administration, and other health insurances. Services reimbursed through other sources shall be segregated and not claimed on the facility’s cost report.

Section 18 Administrative reconsideration; appeal

Sec. 18. (a) The Medicaid rate setting contractor shall notify each provider of the provider's rate after such rate has been computed. If the provider disagrees with the rate determination, the provider must request an administrative reconsideration by the Medicaid rate setting contractor. Such reconsideration request shall be in writing and shall contain specific issues to be reconsidered and the rationale for the provider's position. The request shall be signed by the provider or the authorized representative of the provider and must be received by the contractor within forty-five (45) days after release of the rate computed by the Medicaid rate setting contractor. Upon receipt of the request for reconsideration, the Medicaid rate setting contractor shall evaluate the data. After review, the Medicaid rate setting contractor may amend the rate, amend the challenged procedure or determination, or affirm the original decision. The Medicaid rate setting contractor shall thereafter notify the provider of its final decision in writing, within forty-five (45) days of the Medicaid rate setting contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the rate setting contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies as set out in subsection (c).

(b) If the provider disagrees with a rate redetermination resulting from an audit adjustment, the provider must request an administrative reconsideration from the Medicaid audit contractor. Such reconsideration request shall be in writing and shall contain specific issues to be considered and the rationale for the provider's position. The request shall be signed by the provider and must be received by the Medicaid audit contractor within forty-five (45) days after release of the rate computed by the Medicaid rate setting contractor. Upon receipt of the request for reconsideration, the Medicaid audit contractor shall evaluate the data. After review, the Medicaid audit contractor may amend the audit adjustment or affirm the original adjustment. The Medicaid audit contractor shall thereafter notify the provider of its final decision in writing within forty-five (45) days of the Medicaid audit contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the audit contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies under subsection (c).

(c) After completion of the reconsideration procedure under subsection (a) or (b), the provider may initiate an appeal under 405 IAC 1-1.5.

(d) The office may take action to prospectively implement Medicaid rates without awaiting the outcome of the administrative process.

State: Indiana

Adds 405 IAC 1-19 and 405 IAC 1-20 concerning provisions affecting notification requirements and change of ownership for all providers in the Medicaid program, and defines how funds will be allocated (paid and recouped) to long term care providers when a change of ownership occurs.

Rule 19 Ownership and Control Disclosures

405 IAC 1-19-1 Information to be disclosed

Sec. 1. (a) In accordance with and in addition to 42 CFR 455, Subpart B and 42 CFR 1002, Subpart A, as amended, the following disclosure requirements apply to all providers of Medicaid services and shall be disclosed in accordance with this rule:

(1) The name and address of each person with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of five percent (5%) or more.

(2) Whether any of the persons named, in compliance with subdivision (1), is related to another as spouse, parent, child, or sibling.

(3) The name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest. This requirement applies to the extent that the disclosing entity can obtain this information by requesting it in writing from the person. The disclosing entity must:
(A) keep copies of all these requests and the responses to them;
(B) make them available to the office upon request; and
(C) advise the office when there is no response to a request.

(4) The name, address, and Social Security number of any agent or managing employee.

(b) Any document or agreement, stipulating ownership interests or rights, duties, and liabilities of the entity or its members, required to be filed with the secretary of state, whether it be a single filing or a periodic filing, shall also be filed with the office or its fiscal agent. In the case of a partnership, the partnership agreement, if any, and any amendments thereto, shall be filed with the office immediately upon creation or alteration of the partnership.

(c) A long term care facility provider shall comply with notification requirements set forth in 405 IAC 1-20 for change of ownership.

(d) The office may suspend payment to an existing provider or reject a prospective provider's application for participation if the provider fails to disclose ownership or control information as required by this rule and 405 IAC 1-14.6-5.

405 IAC 1-19-2 Time and manner of disclosure

Sec. 2. (a) Any disclosing entity that is a long term care facility must supply the information specified in this rule to the Indiana state department of health at the time it is surveyed.

(b) Any disclosing entity that is not a long term care facility must supply the information specified in this rule to the office or its fiscal agent at any time there is a change in ownership or control.

(c) Any new provider must supply the information specified in this rule at the time of filing a complete application.

(d) Providers are required to notify the office upon such time as the information specified in this rule changes within forty-five (45) days of the effective date of change in such form as the office shall prescribe. Long term care providers involved in a change of ownership shall provide notification in accordance with 405 IAC 1-20. New nursing facility providers are required to notify the office in accordance with this rule and 405 IAC 1-14.6-5.

Rule 20. Change of Ownership for a Long Term Care Facility

405 IAC 1-20-1 General

Sec.1. (a) As used in 405 IAC 1-19 and this rule, "long term care facility" means any of the following:

(1) A nursing facility.

(2) A community residential facility for the developmentally disabled.

(3) An intermediate care facility for the mentally retarded.

(b) For Medicaid provider agreement purposes, the provider is the party directly or ultimately responsible for operating the business enterprise. This party is legally responsible for decisions and liabilities in a business management sense. The same party also bears the final responsibility for operational decisions made in the capacity of a governing body and for the consequences of those decisions.

(c) Whether the owner of the provider enterprise (provider) owns the premises or rents or leases the premises from a landlord or lessor is immaterial. However, if the provider enters into an agreement, which allows the landlord to make or participate in decisions about the ongoing operation of the provider enterprise, this indicates that the provider has entered into either a partnership agreement or a management agency agreement instead of a property lease. A new partnership agreement constitutes a change of ownership.

405 IAC 1-20-2 Notification requirements

Sec. 2. (a) When a change of ownership in a long term care facility is contemplated, the transferor provider shall notify the office, or its fiscal agent, no less than forty-five (45) days prior to the effective date of sale or lease agreement that a change of ownership may take place.

(b) Notification shall be in writing and include the following:

(1) A copy of the agreement of sale or transfer.

(2) The expected date of transfer.

(3) If applicable, the name of any individual who has an ownership or control interest, is a managing employee, or an agent of the transferor, who will also hold an ownership or control interest, be a managing employee, or be an agent of the transferee.

(c) The transferee shall make application to the office for an amendment to the transferor's provider agreement no less than forty-five (45) days prior to the expected date of transfer in accordance with this rule and 405 IAC 1-14.6-5(c).

(d) If notification requirements from both the transferor and the transferee have not been met on or before the forty-fifth day before the effective date of the change of ownership, all Medicaid payments due to the transferor will be held until such time as the information is received, reviewed, and approved for completeness. Payments will be held until such time as the transferee has fulfilled enrollment requirements in the Medicaid program as set forth in the provider manual and provider enrollment packet.

(e) The effective date of the change of ownership will be determined by the Indiana state department of health's certification and transmittal and amended by the Indiana state department of health, if necessary, to correspond with the transferor/transferee agreement of sale or transfer.

405 IAC 1-20-3 Change of ownership types

Sec. 3. A change of ownership in an existing long-term care facility occurs under, but is not limited to, any of the following circumstances:

(1) For a sole proprietorship, if a provider of services is an entity owned by a single individual, a transfer of title and property to the enterprise to another person or firm, whether or not including a transfer of title to the real estate or if the former sole proprietor becomes one of the members of a business entity succeeding him or her as the new owner.

(2) For a partnership, a new partnership, or the removal, addition, or substitution of an individual partner in an existing partnership, in the absence of an express statement to the contrary in the partnership agreement, that dissolves the old partnership and creates a new partnership.

(3) For a corporation, a new corporation, the merger of the applicant or provider corporation into another corporation, or the consolidation of two (2) or more corporations, or any other change resulting in the creation of a new corporation. In an incorporated provider entity, the corporation is the owner. The governing body of the corporation is the group having direct legal responsibility under state law for operation of the corporation's entity, whether that body is:

(A) a board of trustees;

(B) a board of directors;

(C) the entire membership of the corporation; or

(D) known by some other name.

405 IAC 1-20-4 Change of ownership effect

Sec. 4. When there is a change of ownership of a long term care facility, the office will transfer the provider agreement to the transferee subject to the terms and conditions under which it was originally issued and subject to any existing plan of correction and pending audit findings as follows:

(1) The transferor and transferee shall reach an agreement between themselves concerning Medicaid reimbursements, underpayments, overpayments, and civil monetary penalties.

(2) From the effective date of change of ownership and if all requirements are met, all reimbursements will be made to the transferee, regardless of whether the reimbursement was incurred by a current owner or previous owner.

(3) From the effective date of change of ownership, the transferee shall assume liability for repayment to the office of any amount due the office, regardless of whether liability was incurred by a current owner or operator or by a previous owner or operator.
(4) Liability of current and previous providers to the office shall be joint and several.
(5) A current or previous owner or lessee may request from the office a list of all known outstanding liabilities due the office by the facility and of any known pending office actions against a facility that may result in further liability.
(6) For purposes of this section, examples of reimbursements, overpayments, and penalties shall include, but not be limited to, the following:
(A) Outstanding claims.
(B) Any retro rate adjustment that results in an underpayment or overpayment based upon the transferor's cost report.
(C) Amounts identified during past, present, or future audits that pertain to an audit period prior to a change in ownership.
(D) Pending or completed surveillance utilization review (SUR) audit.
(E) Imposition of penalties due to failure of the provider to be in substantial compliance with applicable federal requirements for nursing facilities participation in the Medicare or Medicaid program.
(F) Civil monetary penalties.
(G) Amounts established by final administrative decisions.

405 IAC 1-20-5 Record retention

Sec. 5. The transferee shall take possession of the Medicaid records of the transferor and safeguard them for no less than three (3) years from the date of the last claim reimbursed by the office or until any pending administrative or judicial appeal is closed, whichever is longer.

SECTION 3. Upon the effective date of 405 IAC 1-19-2, all disclosing entities have sixty (60) days to comply.

Timely Claims Payment - Definition of Claim

Inpatient/Outpatient Hospital, Nursing Facility and Home Health (UB92) - A claim is a paper document or an electronic record requesting payment for services provided during a date range for which there are one or more accommodation revenue codes, HCPCS and/or ancillary codes.

Pharmacy - A claim is each detail line item of a paper document or an electronic record requesting payment for pharmacy services (indicated by NDC codes) provided to a recipient by the billing provider. However, compound drugs are billed on a separate claim form and each of these compound drug claim forms represents a separate claim, the line items on which are the components of a compound drug.

All other claim types - A claim is an individual line item on a paper document or electronic record requesting payment for services furnished to a recipient by the billing provider. Services provided are represented on the claim by HCPCS or other approved billing codes.

Crossover claims are defined as set out above, depending on the claim type submitted.

Provider Reimbursement Appeal Procedures

405 IAC 1-1.5-1 Scope
Authority: IC 12-15-21
Affected: IC 4-21.5-3

Sec. 1. (a) This rule governs the procedures for appeals to the office of Medicaid policy and planning (office) involving actions or determinations of reimbursement for all Medicaid providers.

(b) This rule governs the procedures for appeals to the office from the following actions or determinations:

(1) Setting rates of reimbursement.
(2) Any action based upon a final audit.
(3) Determination of change of provider status for purposes of setting a rate of reimbursement.
(4) Determination by the office that an overpayment to a provider has been made due to a year-end cost settlement.
(5) Any other determination by the office that a provider has been paid more than it was entitled to receive under any federal or state statute or regulation.
(6) The office's refusal to enter into a provider agreement.
(7) The office's suspension, termination, or refusal to renew an existing provider agreement.

(c) Notwithstanding subsections (a) and (b), this rule does not govern determinations by the office or its contractor with respect to the authorization or approval of Medicaid services requested by a provider on behalf of a recipient.

405 IAC 1-1.5-2 Appeal requests
Authority: IC 12-15-21
Affected: IC 4-21.5-3-7, IC 12-15-13-3

Sec. 2. (a) Appeals governed by this rule will be held in accordance with IC 4-21.5-3, except as specifically set out in this rule. The ultimate authority for purposes of this section is the secretary of family and social services administration, in accordance with IC 12-8-6-6.

(b) A request for an appeal must be filed within the following time limits:
(1) A request for an appeal of a determination that an overpayment has occurred must be filed within the time limits set out in IC 12-15-13-3.
(2) A hospital's request for an appeal of an action described in IC 4-21.5-3-6(a)(3) and (a)(4) must be filed within 180 days.

(3) All other appeal requests governed by this rule must be filed with the ultimate authority within fifteen (15) calendar days of receipt of the determination by the office of Medicaid policy and planning (office), in accordance with IC 4-21.5-3-7. However, any provider subject to administrative review or reconsideration under 405 IAC 1 must seek administrative review or reconsideration prior to filing an appeal request.

(c) An appeal request must state facts demonstrating that:

(1) the petitioner is a person to whom the order is specifically directed;

(2) the petitioner is aggrieved or adversely affected by the order; or

(3) the petitioner is entitled to review under any law.

Failure of the provider to file the appeal request within the time limits listed in subsection (b) will result in the waiver of any right to appeal from the office's determination.

(d) The provider must file with the office a statement of issues:

(1) within forty-five (45) calendar days after the provider receives notice of the determination of the office; or

(2) at the time the provider files a timely request for appeal; whichever is later.

(d) The statement of issues shall set out in detail:

(1) the specific findings, action, or determinations of the office from which the provider is appealing;

(2) with respect to each finding, action, or determination, why the provider believes that the office's determination was in error; and

(3) with respect to each finding, action, or determination, all statutes or rules supporting the provider's contentions of error.

(f) A hospital appealing an action described in IC 4-21.5-3-6 (a)(3) and (a)(4) must include its statement of issues in its petition for review.

(g) The statement of issues shall govern the scope of the issues to be adjudicated in the appeal under this rule. The provider will not be permitted to expand the appeal beyond the statement of issues with respect to:

(1) the specific findings, action, or determination of the office; or

(2) the reason or rationale supporting the provider's appeal.

(h) The provider may supplement or modify its statement of issues for good cause shown, up to sixty (60) calendar days after the appeal request is mailed to the office. The administrative law judge assigned to hear the appeal will determine good cause.

(i) Within thirty days after filing a petition for review, and upon a finding of good cause by the administrative law judge, a hospital appealing an action described in IC 4-21.5-3-6 (a)(3) and (a)(4) may amend the statement of issues contained in a petition for review to add one (1) or more additional issues.

(j) Failure of the provider to timely file a statement of issues within forty-five (45) calendar days from the date the provider files the appeal request will result in automatic certification to the secretary for summary review, in accordance with section 3 of this rule.

(k) Notwithstanding (d) and (e) of this section, a hospital provider that files an appeal after a determination regarding year-end cost settlement may preserve any Medicaid issues that are affected by any Medicare appeal issues, by indicating in its statement of issues that Medicare issues timely filed before the fiscal intermediary are also preserved in its Medicaid statement of issues.

405 IAC 1-1.5-3 Summary review
Authority: IC 12-15-21
Affected: IC 4-21.5-3

Sec. 3. (a) The office of Medicaid policy and planning (office) will provide a summary review by the secretary of family and social services administration (secretary) of certain issues set out in the provider's statement of issues. Issues in the provider's statement of issues that challenge the propriety of:

(1) all or part of the general methodology or criteria utilized by the office for setting rates;

(2) all or part of the general methodology or criteria utilized by the office with respect to any audits;

(3) all or part of the general methodology or criteria utilized by the office for making determinations with respect to change of provider status; and

(4) all or part of any other general methodology or criteria utilized by the office for making any determination set out in section 1(b) of this rule;

will be certified for summary review by the secretary.

(b) The office shall not certify for summary review any issue in which the provider challenges the application of the office's methodology or criteria in the provider's particular circumstances. Issues involving application of the office's methodology or criteria will be set for an evidentiary hearing under IC 4-21.5-3. The administrative law judge shall exclude any:

(1) evidence or argumentation on issues certified to the secretary, or

(2) issues not specifically enumerated in the provider's statement or amended statement of issues.

(c) For appeals filed before the effective date of this rule, the office may certify issues determined under subsection (a) to the secretary or the secretary's designee, according to the issues set out in the provider's appeal letter.

(d) There shall be no appeal from a determination by the office certifying any issues for summary review by the secretary.

405 IAC 1-1.5-4 Decision on summary review
Authority: IC 12-15-21
Affected: IC 4-21.5-3-28

Sec. 4. (a) Upon a determination of the office of Medicaid policy and planning (office) that any or all of the issues in the provider's statement of issues concern issues in section 3(a) of this rule, the office will certify to the secretary of family and social services administration (secretary) those issues for summary review by the secretary or the secretary's designee. With respect to each issue certified by the office, the secretary or the secretary's designee will issue a decision:

(1) affirming the determination of the office;

(2) dissolving the determination of the office; or

(3) remanding the determination of the office for an evidentiary hearing before an administrative law judge.

(b) The decision of the secretary or the secretary's designee on summary review shall be rendered within forty-five (45) calendar days after certification by the office to the secretary.

(c) The secretary shall send a notice of the decision on summary review to the provider. The decision on summary review of the secretary or the secretary's designee is interlocutory unless it adjudicates all the issues in the provider's appeal. It is not a final order until all issues in the provider's statement of issues are adjudicated by the secretary or the secretary's designee under IC 4-21.5-3-28. A provider may not seek judicial review of an adverse determination of the secretary on summary review until such time as a final order on all the issues in the provider's statement of issues is rendered.

405 IAC 1-1.5-5 Repayment of overpayment to Office
Authority: IC 12-15-21
Affected: IC 4-21.5-3; IC 24-4.6-1-101

Sec. 5. (a) The office of Medicaid policy and planning (office) may require the repayment of any amount determined by the office to have been paid to the provider in error, prior to an evidentiary hearing or summary review, unless an appeal is pending and the provider has elected not to repay an alleged overpayment pursuant to 405 IAC 1-1-5(d)(3). The office may, in its discretion, recoup any overpayment to the provider by the following means:

(1) Offset the amount of the overpayment against current Medicaid payments to a provider.

(2) In the case of an institutional provider, offset the amount of the overpayment to any or all of the Medicaid facilities owned by the provider, until the overpayment has been satisfied.

(3) Require that the provider satisfy the overpayment by refunding the entire amount of the overpayment to the office directly.

(4) Enter into an agreement with the provider in accordance with 405 IAC 1-1-5.

(b) Interest from the date of the overpayment will be assessed even if the provider repays the overpayment to the office within thirty (30) days after receipt of the notice of the overpayment. This subsection applies to any of the methods of recoupment set out in this section. Interest on overpayments shall not exceed the percentage set out in IC 12-15-13-3(f)(1).

(c) Notwithstanding any other rule in this article, for hospitals who receive a notice that the provider has been underpaid by the Office as a result of the cost settlement process, the Office will pay interest to the hospital on the amount of the underpayment. Such interest will accrue from the date of the underpayment at the rate of interest set out in IC 12-15-13-3 (f)(2).

Requirements for Third Party Liability -
Identifying Liable Resources

A. State Wage and Income Collection Agencies (SWICA) - 42 CFR 433.138(d)(1)

County department caseworkers enter recipient/applicant information directly into the Indiana Client Eligibility System (ICES) which in turn sends the necessary data to the Indiana Department of Employment and Training (IDETS) once a month (more often if indicated). The resultant data match giving wage information is returned to ICES and kept on file for the record.

When there is a "hit" (data found by IDETS for a recipient), an alert is sent to the caseworker who has the responsibility for verification follow up*. Once TPL is verified, the information is entered in ICES within 30 days and then sent to the IMMIS via daily electronic data exchange to be entered in the TPL data base.

A separate data match with IDETS is created by the IV-D agency to uncover employment information about absent parents.

B. SSA Wage and Earnings File - 42 CFR 433.138(d)(1)

Once a month the electronic State Beneficiary Data File (BENDATA) is created on tape and sent to SSA for the Beneficiary and Earnings Data Exchange/ Beneficiary Earnings Exchange Record (BENDEX/BEER) data exchange. When the BENDEX/BEER tapes are received in return, the data is processed by ICES and placed on line for reference. An alert is sent to the county caseworker responsible for verification and follow up when information is received on BEER for an active recipient. Additionally, Social Security income

* "Follow Up" for the verification of TPL information gathered from data exchanges includes, but is not limited to, sending employment and benefits verification letters to employers and or insurance companies, phone calls and letters to attorneys and/or those suspected to be liable for accident related claims, letters and/or phone calls to medical providers.

information from the BENDEX is used to automatically update the Medicaid and Food Stamp budgets of matched recipients in ICES. The BENDEX is then sent to the Medicaid contractor to electronically update the MMIS TPL file with Medicare information to cost avoid for the future and to seek recovery of claims already paid.

C. Worker's Compensation - 42 CFR 433.138(d)(4)(i)

The data match is conducted with Worker's Compensation annually. A tape is created by the Indiana Industrial Board of all those who have filed a worker's compensation suit in the previous year. The contractor has the responsibility to do verification follow-up and then to establish Medicaid's interest in settlement proceedings arising from the accident.

D. State Motor Vehicle Accident Report Files (42 CFR 433.138(d)(ii)

The Medicaid contractor conducts data matches with the State Motor Vehicle Accident Report Files annually. A tape is created by the State Police of all vehicular accidents during the previous year. The contractor has the responsibility to do verification follow-up and then to establish Medicaid's interest in settlement proceedings arising from an accident when appropriate.

E. Patient Compensation Board

The Medicaid contractor conducts data matches with the State Patient Compensation Board monthly. A tape is created by the Indiana Patient Compensation Board of all those who have filed a malpractice suit against a health care provider in the previous month. The contractor has the responsibility to do verification follow-up and then to establish Medicaid's interest in settlement proceedings arising from the suit.

F. Black Lung

The Medicaid contractor conducts data matches with the Department Of Labor, Division of Coal Miners annually. A data exchange tape is created from the MMIS Medicaid Eligibility files and in turn a tape is received of all those who are

qualified for Black Lung benefits. The contractor has the responsibility to do verification follow-up and then to bill the Board for reimbursement of claims already paid by Medicaid.

G. Defense Eligibility and Enrollment Reporting System (DEERS)

The Medicaid contractor conducts data matches with DEERS annually. A data exchange tape is created from the IV-D and Medicaid Eligibility files. In turn, a tape is received from DEERS of all those who qualify for Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) benefits. The contractor has the responsibility to do verification follow-up, add the information to the TPL data base for future cost avoidance, and then bill CHAMPUS for reimbursement of claims already paid by Medicaid.

H. Diagnosis and Trauma Code Edits (See 42 CFR 433.138(e).)

The Medicaid contractor conducts diagnosis and trauma code edits for all ICD diagnostic codes that identify an accident or injury.

All claims in the IMMIS weekly processing cycle are edited for trauma codes. Claims with these trauma codes are reported to the contractor's TPL unit via the MARS reporting system for potential recovery. Recipients who have claims with these edits are contacted by the contractor to determine the potential for recovery. If potential exists, the contractor opens a casualty case and tracks the proceedings. The time frames for follow-up depend on the particulars of the case.

Information regarding the potential recovery of trauma related expenditures is maintained in the contractor's third party recovery unit and includes all parties involved in the case as well as Medicaid expenditure information related to the injury. Since liability is not finally established for such cases until settlement, casualty liability information is not coded on the IMMIS. Therefore, recovery of casualty related expenditures is performed on a post-payment basis. However, if liability is established for future medical expenses, the information is then coded on the TPL file.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Indiana

STATE LAWS REQUIRING THIRD PARTIES TO PROVIDE
COVERAGE ELIGIBILITY AND CLAIMS DATA

1902(a)(25)(I) The State has in effect laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility and claims data, of 1902(a)(25)(I) of the Social Security Act.

Requirements for Third Party Liability - Payment of Claims

1) The Indiana Medicaid Third Party Liability (TPL) program establishes coordination of benefit rules designed to ensure that Medicaid is the payer of last resort, unless otherwise required. The claims payment system will apply edits that facilitate appropriate cost avoidance/coordination of benefit activities.

   When a third party payor fails to respond within 90 days of the date of the provider's attempt to bill, one of the following attachments must accompany the Medicaid claim:

   a.) copies of unpaid bills sent to the third party (whether an individual or an insurance company);

   b.) written notification from the provider giving the date of attempts to bill and explaining that the third party failed to respond within 90 days from the billing date.

   c.) When the third party payor is an absent parent who has been billed at the address supplied by the recipient of local welfare office, but the billing is returned "address unknown" the returned envelope may be filed with the claim.

   Effective December 31st, 2021 system edits will be updated to require TPL resource validation prior to making payment determinations for claims that contain services for prenatal care including labor and delivery and postpartum care. Applicable claims will be cost avoided accordingly.

   Claims for services relating to pediatric preventative care are excluded from cost avoidance and will follow the pay and chase methodology, unless the state has made a determination related to cost-effectiveness and access to care that warrants cost avoidance for up to 90 days.

   When coordination of benefits decisions are the result of child support enforcement, claims will not be subject to cost avoidance for up to 100 days following the date the claim has been submitted in accordance with the flexibilities outlined in 1902(a)(25)(F).

2) Health recovery cases are established whenever Medicaid has paid claims in instances where:

   a.) the TPL unit learns of previously unidentified insurance benefits which were available for a period of at least two months prior to the date the benefits are coded on the recipient resource file, and/or

   b.) the TPL Unit is notified that a recipient has insurance coverage for a service for which a paid claim appears on the Medicaid monthly Explanation of Benefits.

      The following threshold applies:

      There is no threshold.

3) Casualty or liability recovery cases are established whenever Medicaid has paid related claims in instances where:

   a.) The TPL Unit is notified that a recipient was a victim of a violent crime or was involved in an accident; and/or

b.) the TPL Unit is notified that a recipient is the plaintiff in a malpractice, product liability, or class action lawsuit involving injury or impairment.

The following threshold applies:

Recovery will be sought in all cases where total Medicaid expenditures exceed $500.00, if it appears it will be cost effective to pursue the case.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory Indiana

Citation	Condition or Requirement
1906 of the Act	State Methodology on Cost Effectiveness of Employer-Based Group Health Plans

Indiana's formula for determining the cost-effectiveness of an insurance plan compares the **purchase cost** of the available insurance coverage to the estimated **average annual Medicaid expenditures** for the recipient to be covered by the plan. The purchase cost is computed by totalling the dollar amounts of the annual **premium, deductible, coinsurance, administrative cost,** and **non-covered services.** [See definitions below for each of the highlighted factors.] The average annual Medicaid expenditure is estimated using State-developed tables of historical expenditure data per recipient type (based on demographics such as aid category, age, sex, institutional status, high cost diagnosis).

Since estimated annual Medicaid expenditures are based on averages and actual individuals' expenditures vary widely across the range from which the average is calculated, the State will ensure a higher probability of overall cost-effectiveness by paying the premium only when the estimated average annual expenditure is greater than or equal to twice the purchase cost*. For example:

purchase cost = $1500
estimated expenditures must be ≥ $3000

Definitions:

1. **Average Annual Medicaid Expenditure** - the average annual benefit dollars Medicaid expects to expend on behalf of the recipient (based on expenditures for similar individuals)

2. **Premium** - the fee Medicaid must pay to obtain the available insurance coverage for one year

* In cases where the individual is known to have a high cost diagnosis, the twice-the-cost criterion will not be applied.

3. **Deductible** - the annual policy-specific deductible amount

4. **Coinsurance** - the amount of any copayments/contributions the insured is required to pay (pro-rated based upon the number and types of services the insured is expected to receive in a year according to State-developed, policy-specific tables)

5. **Administrative Cost** - the annualized administrative cost of ongoing operation of the health insurance premium payment program on a per recipient basis

6. **Non-Covered Services** - the annual cost of services expected to be paid by Medicaid which are not covered by the available insurance policy or for which policy benefits are exhausted

7. **Purchase Cost** - the sum total of the dollar amounts for items 2. through 6. above

State/Territory: Indiana

Citation	Sanctions for Psychiatric Hospitals
1902(y)(1), 1902(y)(2)(A), and Section 1902(y)(3) of the Act (P.L. 101-508, Section 4755(a)(2))	(a) The State assures that the requirements of section 1902(y)(1), section 1902(y)(2)(A), and section 1902(y)(3) of the Act are met concerning sanctions for psychiatric hospitals that do not meet the requirements of participation when the hospital's deficiencies immediately jeopardize the health and safety of its patients or do not immediately jeopardize the health and safety of its patients.
1902(y)(1)(A) of the Act	(b) The State terminates the hospital's participation under the State plan when the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies immediately jeopardize the health and safety of its patients.
1902(y)(1)(B) of the Act	(c) When the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies do not immediately jeopardize the health and safety of its patients, the State may: 1. terminate the hospital's participation under the State plan; or 2. provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding; or 3. terminate the hospital's participation under the State plan and provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding.
1902(y)(2)(A) of the Act	(d) When the psychiatric hospital described in (c) above has not complied with the requirements for a psychiatric hospital within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period.

State: Indiana

Citation	Sanctions for MCOs and PCCMs
1932(e) 42 CFR 438.726	(a) The State will monitor for violations that involve the actions and failure to act specified in 42 CFR Part 438 Subpart I and to implement the provisions in 42 CFR 438 Subpart I, in manner specified below: Through routine monitoring, the State may identify contract non-compliance issues resulting from non-performance. If this occurs, the Assistant Secretary of the OMPP or his/her designee will notify the MCO in writing of the nature of the non-performance issue, the basis and nature of the sanction, and the required timeframe for correction. The State will establish a reasonable period of time, not less than ten business days, in which the MCO must provide a written response to the notification. If the noncompliance is not corrected within the specified time, the State may enforce any of the remedies listed below or as allowed under 42 CFR 438 Subpart I. (b) The State uses the definition below of the threshold that would be met before an MCO is considered to have repeatedly committed violations of section 1903(m) and thus subject to imposition of temporary management: (c) The State's contracts with MCOs provide that payments provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS under 42 CFR 438.730(e). ___ Not applicable; the State does not contract with MCOs, or the State does not choose to impose intermediate sanctions on PCCMs.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Indiana

INCOME AND ELIGIBILITY VERIFICATION SYSTEM PROCEDURES
REQUESTS TO OTHER STATE AGENCIES

In addition to IEVS data matches, the State of Indiana conducts the following non-IEVS data matches:

XRPT/DEBN – Verifies new SSN for clients referred by caseworker (SSA)

Numident/DENB – Verifies SSN provided by the client (SSA)

CSE/DECB – Child Support Enforcement; payment and/or absent parent information (CSB)

AIM – Medicaid match; auto updates eligibility screens AEFME, AEFMC and DEBN (OMPP)

40 Quarters of Coverage/DEQE – Verifies quarters of coverage for wages or self-employment income of legal aliens (SSA)

New Hire/DENH – shows newly hired recipients with in-state jobs (IDWD)

Credit Bureau/DECM – shows results of match with the Credit Bureau (XPERIAN)

Redbook/AERVH – shows the Redbook value of the vehicle that has been entered (BMV)

DRS – national match with Food and Nutrition Services, which identifies Food Stamp individuals who have been disqualified or who have a pending disqualification (FNS)

Federal & State Tax Intercept – identifies TANF and Food Stamp clients with a delinquent claim and who are eligible for a tax refund in order to allow for interception of their tax checks (IDR)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: INDIANA

METHOD FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS TO HOMELESS INDIVIDUALS

A homeless individual may arrange with the County Department of Welfare to obtain his Medicaid card in one of the following methods of his choice:

1) He may obtain the Medicaid card at the County Welfare Department.
2) The Medicaid card can be mailed to an address specified by the individual; for example, a friend or relative, social service agency, church, or shelter for the homeless.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Indiana

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE

The following is a written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives. If applicable States should include definitions of living will, durable power of attorney for health care, durable power of attorney, witness requirements, special State limitations on living will declarations, proxy designation, process information and State forms, and identify whether State law allows for a health care provider or agent ofthe provider to object to the implementation of advance directives on the basis of conscience.

There are four Indiana laws that pertain to advance directives: the Health Care Consent Act, the Living Will Act, the Powers of Attorney Act, and the Out of Hospital Do Not Resuscitate Declarations Act. These laws may be used singly or in combination. The following is a condensed version of each law:

Indiana Health Care Consent Act

Pursuant to IC 16-36-1, the Indiana Health Care Consent Act, a patient can (1) appoint a health care representative to make decisions regarding the patient's own medical treatments when the patient is no longer able; and (2) delegate authority to someone to consent to health care for another, such as a child. To appoint a health care representative for the patient's own health care, the patient must put the appointment in writing, sign it, and have the signature witnessed by another adult. The patient may specify terms and conditions on the authority delegated. To delegate the authority to consent to health care for another, the delegation must be in writing, signed by the delegate, and witnessed by an adult. The delegation may specify conditions on the authority delegated.

Indiana Living Will Act

Pursuant to IC 16-36-4, the Indiana Living Will Act, a patient may execute one of two kinds of legal documents for use in the event the patient has a terminal condition and becomes unable to give medical instructions. The first, the Living Will Declaration, is used if the patient wants to tell his/her doctor and family that certain life-prolonging medical treatments shouldnot be used, so that the patient can be allowed to die naturally from the terminal condition. The second of these documents, the Life-Prolonging Procedures Declaration, can be used if the patient wants all possible life-prolonging medical treatments used to extend the patient's life.

For either of these documents to be effective, the document must be in writing, voluntarily signed by the patient (or someone the patient directs to sign in the patient's presence), and witnessed by two adults. Both a Living Will Declaration and a Life-Prolonging Procedures Declaration can be revoked orally, in writing, or by the patient's act of physically canceling or destroying the declaration. The revocation is effective, however, only when the patient's doctor is informed.

Pursuant to IC 16-36-4-10, a copy of the Form of Declaration is included at Attachment 4.34-A, Pages 3 and 3a.

IC 16-36-4-13 allows a physician to refuse to use, withhold, or withdraw life-prolonging procedures if, after reasonable investigation, he/she finds no other physician willing to honor the patient's declaration.

Indiana Out of Hospital Do Not Resuscitate Declarations Act

Pursuant to IC 16-36-5, the Out of Hospital Do Not Resuscitate Declarations Act, a person with a terminal condition, outside of a hospital or health facility, may direct that cardiopulmonary resuscitation procedures be withheld or withdrawn, and the person permitted to die naturally.

In order to be effective, an out of hospital DNR declaration must be voluntary, in writing, signed by the person making the declaration (or by another person in his presence and at his express direction), dated, and signed in the presence of at least two competent witnesses. The declaration may be revoked orally, in writing, or by the person canceling or destroying the declaration. The revocation is effective, however, only when the person's doctor is informed.

Pursuant to IC 16-36-5-15, a copy of the Form of Declaration is included at Attachment 4.34-A, Pages 4 and 4a.

Indiana Powers of Attorney Act

IC 30-5, the Indiana Power of Attorney Act, defines how a patient can give someone the power to act for the patient in a myriad of situations, including health care. The person appointed by the patient does not have to be an attorney; however, the power of attorney must be in writing and signed in the presence of a notary public. The power of attorney must articulate who is the patient's attorney in fact, and state exactly what powers the patient wants and does not want to give the attorney in fact. Since the attorney in fact may choose not to act for the patient, the patient may wish to consult with the person before making the appointment.

16-36-4-10 Form of living will declaration

Sec. 10. The following is the living will declaration form:

LIVING WILL DECLARATION

Declaration made this ___ day of ___ (month, year). I, _____ , being at least eighteen (18) years of age and of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, and I declare:

If at any time my attending physician certifies in writing that: (1) I have an incurable injury, disease, or illness; (2) my death will occur within a short time; and (3) the use of life prolonging procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the performance or provision of any medical procedure or medication necessary to provide me with comfort care or to alleviate pain, and, if I have so indicated below, the provision of artificially supplied nutrition and hydration. (Indicate your choice by initialling or making your mark before signing this declaration):

_____ I wish to receive artificially supplied nutrition and hydration, even if the effort to sustain life is futile or excessively burdensome to me.

_____ I do not wish to receive artificially supplied nutrition and hydration, if the effort to sustain life is futile or excessively burdensome to me.

_____ I intentionally make no decision concerning artificially supplied nutrition and hydration, leaving the decision to my health care representative appointed under IC 16-36-1-7 or my attorney in fact with health care powers under IC 30-5-5.

In the absence of my ability to give directions regarding the use of life prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of the refusal.

I understand the full import of this declaration.

Signed _____

_____
City, County, and State of Residence

The declarant has been personally known to me, and I believe (him/her) to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not a parent, spouse, or child of the declarant. I am not entitled to any part of the declarant's estate or directly financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years of age.

Witness _____ Date _____

Witness _____ Date _____

As added by P.L.2-1993, SEC.19. Amended by P.L.99-1994, SEC.2.

16-36-4-11 Form of life-prolonging procedures will declaration

Sec. 11. The following is the life prolonging procedures will declaration form:

LIFE PROLONGING PROCEDURES DECLARATION

Declaration made this _____ day of _____ (month, year). I, _____, being at least eighteen (18) years of age and of sound mind, willfully and voluntarily make known my desire that if at any time I have an incurable injury, disease, or illness determined to be a terminal condition I request the use of life prolonging procedures that would extend my life. This includes appropriate nutrition and hydration, the administration of medication,

and the performance of all other medical procedures necessary to extend my life, to provide comfort care, or to alleviate pain.

In the absence of my ability to give directions regarding the use of life prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to request medical or surgical treatment and accept the consequences of the request.

I understand the full import of this declaration.

Signed _____

_____

City, County, and State of Residence

The declarant has been personally known to me, and I believe (him/her) to be of sound mind. I am competent and at least eighteen (18) years of age.

Witness _____ Date _____

Witness _____ Date _____

As added by P.L.2-1993, SEC.19.

16-36-4-12 Revocation of living will declaration or life-prolonging procedures will declaration

Sec. 12. (a) A living will declaration or a life prolonging procedures will declaration may be revoked at any time by the declarant by any of the following:

(1) A signed, dated writing.

(2) Physical cancellation or destruction of the declaration by the declarant or another in the declarant's presence and at the declarant's direction.

(3) An oral expression of intent to revoke.

(b) A revocation is effective when communicated to the attending physician.

(c) No civil or criminal liability is imposed upon a person for failure to act upon a revocation unless the person had actual knowledge of the revocation.

(d) The revocation of a life prolonging procedures will declaration is not evidence that the declarant desires to have life prolonging procedures withheld or withdrawn. *As added by P.L.2-1993, SEC.19.*

16-36-4-13 Certification of qualified patient; procedure where physician refuses to honor declaration

Sec. 13. (a) The attending physician shall immediately certify in writing that a person is a qualified patient if the following conditions are met:

(1) The attending physician has diagnosed the patient as having a terminal condition.

(2) The patient has executed a living will declaration or a life prolonging procedures will declaration in accordance with this chapter and was of sound mind at the time of the execution.

(b) The attending physician shall include a copy of the certificate in the patient's medical records.

(c) It is lawful for the attending physician to withhold or withdraw life prolonging procedures from a qualified patient if that patient properly executed a living will declaration under this chapter.

(d) A health care provider or an employee under the direction of a health care provider who:

(1) in good faith; and

(2) in accordance with reasonable medical standards;

participates in the withholding or withdrawal of life prolonging procedures from a qualified

(c) If the attending physician does not transfer a patient under subsection (a), the attending physician may attempt to ascertain the patient's intent and attempt to determine the validity of the declaration by consulting with any of the following individuals who are reasonably available, willing, and competent to act:

(1) A court appointed guardian of the patient, if one has been appointed. This subdivision does not require the appointment of a guardian so that a treatment decision may be made under this section.

(2) A person designated by the patient in writing to make a treatment decision.

(3) The patient's spouse.

(4) An adult child of the patient or a majority of any adult children of the patient who are reasonably available for consultation.

(5) An adult sibling of the patient or a majority of any adult siblings of the patient who are reasonably available for consultation.

(6) The patient's clergy.

(7) Another person who has firsthand knowledge of the patient's intent.

(d) The individuals described in subsection (c)(1) through (c)(7) shall act in the best interest of the patient and shall follow the patient's express or implied intent, if known.

(e) The attending physician acting under subsection (c) shall list the names of the individuals described in subsection (c) who were consulted and include the information received in the patient's medical file.

(f) If the attending physician determines from the information received under subsection (c) that the patient intended to execute a valid out of hospital DNR declaration, the attending physician may:

(1) issue an out of hospital DNR order, with the concurrence of at least one (1) physician documented in the patient's medical file; or

(2) request a court to appoint a guardian for the patient to make the consent decision on behalf of the patient.

(g) An out of hospital DNR order must be issued on the form specified in section 15 of this chapter. *As added by P.L.148-1999, SEC.12.*

16-36-5-14 Effect of declaration during pregnancy

Sec. 14. An out of hospital DNR declaration and order of a declarant known to be pregnant has no effect during the declarant's pregnancy. *As added by P.L.148-1999, SEC.12.*

16-36-5-15 Form

Sec. 15. An out of hospital DNR declaration and order must be in substantially the following form:

OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION AND ORDER

This declaration and order is effective on the date of execution and remains in effect until the death of the declarant or revocation.

OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION

Declaration made this _____ day of _____. I, _____, being of sound mind and at least eighteen (18) years of age, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below. I declare:

My attending physician has certified that I am a qualified person, meaning that I have a terminal condition or a medical condition such that, if I suffer cardiac or pulmonary failure, resuscitation would be unsuccessful or within a short period I would experience repeated

cardiac or pulmonary failure resulting in death.

I direct that, if I experience cardiac or pulmonary failure in a location other than an acute care hospital or a health facility, cardiopulmonary resuscitation procedures be withheld or withdrawn and that I be permitted to die naturally. My medical care may include any medical procedure necessary to provide me with comfort care or to alleviate pain.

I understand that I may revoke this out of hospital DNR declaration at any time by a signed and dated writing, by destroying or canceling this document, or by communicating to health care providers at the scene the desire to revoke this declaration.

I understand the full import of this declaration.

Signed_____

Printed name_____

_____

City and State of Residence_____

The declarant is personally known to me, and I believe the declarant to be of sound mind. I did not sign the declarant's signature above, for, or at the direction of, the declarant. I am not a parent, spouse, or child of the declarant. I am not entitled to any part of the declarant's estate or directly financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years of age.

Witness_____

Printed name_____ Date_____

Witness_____

Printed name_____ Date_____

OUT OF HOSPITAL DO NOT RESUSCITATE ORDER

I,_____, the attending physician of _____, have certified the declarant as a qualified person to make an out of hospital DNR declaration, and I order health care providers having actual notice of this out of hospital DNR declaration and order not to initiate or continue cardiopulmonary resuscitation procedures on behalf of the declarant, unless the out of hospital DNR declaration is revoked.

Signed_____ Date_____

Printed name_____

Medical license number_____

As added by P.L.148-1999, SEC.12.

16-36-5-16 Copies of declaration and order

Sec. 16. Copies of the out of hospital DNR declaration and order must be kept:

(1) by the declarant's attending physician in the declarant's medical file; and

(2) by the declarant or the declarant's representative.

As added by P.L.148-1999, SEC.12.

16-36-5-17 Identification devices

Sec. 17. (a) The emergency medical services commission shall develop an out of hospital DNR identification device that must be:

(1) a necklace or bracelet; and

(2) inscribed with:

(A) the declarant's name;

(B) the declarant's date of birth; and

(C) the words "Do Not Resuscitate".

(b) An out of hospital DNR identification device may be created for a declarant only after an out of hospital DNR declaration and order has been executed by a declarant and an attending physician.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Indiana

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

The State uses other factors described below to determine the seriousness of deficiencies in addition to those described at §488.404(b)(1):

N/A

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Termination of Provider Agreement: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Temporary Management: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

_X_ Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Denial of Payment for New Admissions: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy	___ Alternative Remedy
(Will use the criteria and notice requirements specified in the regulation.)	(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Civil Money Penalty: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy	___ Alternative Remedy
(Will use the criteria and notice requirements specified in the regulation.)	(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

State Monitoring: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy	___ Alternative Remedy
(Will use the criteria and notice requirements specified in the regulation.)	(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Indiana

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Transfer of residents; Transfer of residents with closure of facility: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

_X_ Specified Remedy	___ Alternative Remedy
(Will use the criteria and notice requirements specified in the regulation.)	(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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State/Territory: Indiana

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Additional Remedies: Describe the criteria (as required at §1919(h)(2)(A)) for applying the additional remedy. Include the enforcement category in which the remedy will be imposed (i.e., category 1, category 2, or category 3 as described at 42 CFR 488.408).

N/A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: INDIANA

DISCLOSURE OF ADDITIONAL REGISTRY INFORMATION

N/A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: INDIANA

COLLECTION OF ADDITIONAL REGISTRY INFORMATION

State Name and date of reciprocity from another state
Date of training completion
Date of testing
Name of person giving exam
Facility where training was given
Current employer by Medicare/Medicaid #
All QMA's are identified by coded registry number

* U.S. Government Printing Office : 1991 - 312-149/40413

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

DEFINITION OF SPECIALIZED SERVICES:

Specialized services are those services identified through the Level II Assessment that are required to address the identified needs related to the person's developmental disability and/or mental illness. These services are not typically provided within or by a nursing facility due to the duration and/or intensity of the services. Specialized services include, but are not limited to, short-term inpatient psychiatric care, long-term inpatient psychiatric care, supported employment, supported employment follow-along, sheltered work, vocational evaluation, work adjustment training, vocational skills training and job placement.

INDIANA'S DEFINITION OF DEVELOPMENTAL DISABILITY:

A person with a developmental disability has a severe, chronic disability attributable to mental retardation, cerebral palsy, epilepsy, autism, or a condition other than mental illness, closely related to mental retardation in that the impairment of general intellectual function or adaptive behavior is similar to that of mental retardation. The condition is manifested prior to age 22, is likely to continue indefinitely, and requires the person to have 24 hour supervision. As a result of the condition, the person has substantial functional limitations in three or more of the following major life areas: self care, understanding and use of language, learning, mobility, self direction and/or capacity for independent living.

INDIANA'S DEFINITION OF MENTAL ILLNESS:

An individual is considered to have a mental illness if he/she has a current primary or secondary diagnosis of a major mental disorder (as defined in the Diagnostic and Statistical Manual of Mental Disorders) limited to schizophrenic, schizoaffective disorders, psychotic disorder not otherwise specified (formerly atypical psychosis), delusional (formerly paranoid) disorder, and mood (formerly affective) disorders of the bipolar and major depressive type, and he/she does not have a diagnosis of senile or presenile dementia (including Alzheimer's disease of a related disorder).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Indiana

CATEGORICAL DETERMINATIONS

RESPITE SHORT-TERM (30-Day):

An individual may be admitted to a nursing facility from home for short-term respite care not to exceed thirty (30) calendar days per quarter, with a break of at least 30 days between stays of 15 or more consecutive days of respite care. Respite care is a temporary or periodic service provided to a functionally impaired individual for the purpose of relieving the regular caregiver.

At the time of admission, there must be an express intent of leaving the nursing facility by the expiration of the approved time period. NOTE: for persons with a Developmental Disability (DD) and Mental Illness (MI), the Preadmission Screening (PAS) Agency must contact the local DD Respite Care Agency or Community Mental Health Center (CMHC) prior to authorization. Nursing facility (NF) placement is to be the placement of last resort.

ADULT PROTECTIVE SERVICES (7-Day):

An endangered adult who is referred to Adult Protective Services (APS) may be admitted from home for a period not to exceed seven (7) days while a determination is made and/or alternative arrangements for longer term care are made. The individual must be in need of intensive emergency intervention; i.e., the individual is determined to be in imminent danger, as certified by the signature of the APS investigator. NOTE: for DD and MI persons, the PAS Agency must immediately notify the local DD Integrated Field Services Agency or CMHC. NF placement is to be the placement of last resort.

CONTINUING CARE RETIREMENT COMMUNITY (5-Day):

A resident of a continuing care retirement community (CCRC) who becomes seriously ill may be temporarily admitted to the nursing facility of the same CCRC for a period not to exceed five (5) days without being subject to PASRR review. The purpose of this advance categorical determination is to allow medical treatment for a physical illness and/or to determine if hospitalization is necessary for that illness. This temporary admission may not be used for the purpose of assessment or treatment of a psychiatric disorder.

At the time of admission, there must be an express intent of leaving the nursing facility by the expiration of the approved time period. If the stay is to exceed the time period, the facility must refer the individual for a PASRR review no later than the fifth day following the admission. For purposes of PASRR, such referrals shall be considered preadmission screenings.

Revision: HCFA-PM-92-3 (HSQB)
APRIL 1992

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: INDIANA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Survey and Certification Education Program

The State has in effect the following survey and certification periodic educational program for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies.

As a State Agency we have offered programs to the Provider community to educate them on correct regulations and changes in procedures and policies. We offered eight (8) programs throughout the state on the OBRA '87 regulations and survey process and eight (8) programs on the Resident Assessment Instrument. In addition, the Bureau Director, Division Director and training staff honor requests for speaking engagements to organizations within the provider community addressing a variety of issues relevant to the survey and certification process.

A quarterly newsletter is also mailed to the provider community. The contents address issues and concerns about the survey and certification process in an attempt to maintain an open line of communication.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: INDIANA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for the Investigation of Allegations of Resident Neglect and Abuse and Misappropriation of Resident Property

The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facility or by another individual used by the facility in providing services to such a resident.

Investigation of Complaints

All investigations for complaints will be completed according to guidelines.

Complaints will be surveyed within two (2) days of receipt.

The supervisor assigns a complaint to the surveyor to be conducted within the time frame.

The surveyor does not announce the complaint survey.

e surveyor explains to facility administration the general nature of the complaint and avoids the impression that a predetermination has been made as to the validity of the allegation.

The surveyor does not divulge nor confirm complainant's identity.

A partial survey, to include a quick tour of the facility prior to focusing on the specific regulatory requirements related to the allegation is conducted.

Appropriate samples of residents, rooms, records, services, etc.... are reviewed.

Supervisor will advise the surveyor or team of unusual specific information to obtain, copies to make, and items to review within the facility.

During an investigation of a complaint, the surveyor may suspect or learn of information which may suggest that a much more serious or life threatening condition exists. The surveyor immediately notifies the supervisor by telephone of the concern and receives any special instructions which may ensue. If necessary, the special instructions may include a full survey.

When the surveyor is investigating a complaint, special assistance may be needed in the investigation. The assistance may be special investigation instructions, repeat visits, and/or manpower from the Office of Legal Affairs (OLA) Special Investigator, Attorney General, Adult Protective Services (APS) or Medical Director. The coordination of surveyors with additional personnel and scheduling of related meetings will be accomplished by the supervisor.

A form is used to document observations made, conditions observed, and investigative procedures followed. Additional findings are also summarized.

An exit conference is conducted to discuss with the facility representative the cited deficiencies. During the exit the confidentiality of the complainant and individuals contained within the complaint are maintained.

Findings which identify serious neglect or abuse of a resident, which were not previously referred to Office of Legal Affairs will be referred for further investigation and/or for a recommendation of a citation. The Office of Legal Affairs investigator will investigate further upon the discretion of the Director, Office of Legal Affairs.

'ngs which identify substantial non-compliance may result in remedial action. If no findings are cited, there is no action

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APRIL 1992

Attachment 4.40-C
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: INDIANA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Procedures for Scheduling and Conduct of Standard Surveys

The State has in effect the following procedures for the scheduling and conduct of standard surveys to assure that it has taken all reasonable steps to avoid giving notice.

Survey scheduling occurs approximately six months in advance based on the facility's TLA to assure the visit occurs in the 90-120 day timeframe. All schedules are maintained as specified in Policy and Procedure number 123.000. The STate Fire Marshal's office is given a date on or after which they may conduct the life safety code survey. The long term care survey date is not released. Survey protocol follow federal guidelines defined in the State Operations Manual Appendix P "SURVEY PROTOCOL FOR LONG TERM CARE FACILITIES".

All facility visits are confidential and are not announced prior to the facility visit.

To protect the actual date of a pending facility visit, route sheets are kept under lock and key when office is closed. Only designated staff has direct access to route sheets and quarterly schedules.

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State/Territory: INDIANA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Programs to Measure and Reduce Inconsistency

The State has in effect the following programs to measure and reduce inconsistency in the application of survey results among surveyors.

The Training Department, within the Bureau of Quality Assurance has a variety of programs which attempt to minimize the inconsistencies among surveyors. For new surveyors we provide two (2) weeks in-house training. During this two week period we review all aspects of the survey process, emphasizing the protocols developed by both the State and Federal agencies. The third week new surveyors are involved in a "mock" survey at a long-term care facility with a training officer, using the knowledge they have learned in-house.

For older surveyors we provide bi-monthly staff meetings. These provide inservice training on documentation, policies and procedures, interpretation of new regulations plus education on pharmacy issues, dental services, and mental health issues to name just a few. In addition, surveyors receive any appropriate directives or updated information through their weekly mail.

The training department also chairs a Quality Assurance Committee monthly. Randomly selected survey reports from each area are reviewed. Each survey is critiqued using the guidelines provided by HCFA in "Principles of Documentation". The comments generated from this meeting are then shared with the Area Supervisors and individual surveyors.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: INDIANA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for Investigations of Complaints and Monitoring

The State has in effect the following process for investigating complaints of violations of requirements by nursing facilities and monitors onsite on a regular, as needed basis, a nursing facility's compliance with the requirements of subsection (b), (c), and (d) for the following reasons:

(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

(ii) the facility was previously found not to be in compliance with such requirements and has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

(iii) the State has reason to question the compliance of the facility with such requirements.

Post Certification Reviews (PCR) Visit/Validation Visits/(i.e. follow ups) are scheduled for facilities with Level A's/Conditions (MR/DD) and/or Level B's/standards (MR/DD) out of compliance at time of survey.

PCR's are scheduled within 45 days from the last day of the survey by the surveyor. Communication between surveyor and supervisor will take place prior to that scheduled visit.

The follow up visit verifies the facility's progress in correcting the certification deficiencies cited during the last survey.

The surveyor checks all citings.

The past two (2) weeks schedule of work is to be reviewed to determine licensed nurse coverage and overall nursing coverage at each PCR/Validation visit even though it was not cited on the survey.

On completion of the report, an exit interview conference is held with the administrator's selected staff.

The justification for new Level B's/standards (MR/DD) out of compliance, how to write a plan of correction letter, and justification letters are signed and left with the administrator.

When all deficiencies/findings are corrected and there are no new findings, a form is completed stating "All Deficiencies Corrected-No New Findings".

Quality Assurance and R.N. waiver visits will be made to facilities with recent licensure and certification problems to determine compliance with state rules and federal regulations.

For all state walk-thru visits, the following must be done:

*Complete a tour of the facility, noting significant problems which could indicate non-compliance with state rules, or federal regulations

*Review the previous two (2) weeks of posted nursing hours, as worked.

*Observe a meal.

When the visit is for the purpose of monitoring a facility's compliance with the terms of an R.N. waiver eight (8) areas are reviewed.

If no care problems are noted and the facility is operating within the terms of their waiver, no findings need be cited.

If the facility is operating without R.N. coverage beyond the scope of the waiver, a finding is made.

If it is determined that the facility has not complied with the terms of the waiver, the office is notified so a determination can be made concerning revocation of the waiver.

If problems are observed in the facility which may warrant a full survey, the supervisor responsible for the area of the state in which the facility is located is contacted. The supervisor in conjunction with the Director of Field Operations will decide on the merit of conducting a full survey.

Monitors shall be approved and shall have duties in accordance with the following procedure.

*Shall be licensed.

*Shall be available to serve as a monitor the required number of hours as determined necessary.

*Shall not currently be employed as an administrator of any other health facility.

*Shall have at least two (2) years experience as a health facility administrator in the State of Indiana.

*Monitors shall enter into a written contract with the facility. The contract shall state the number of hours to be worked, the fee to be paid by the facility, and shall be approved by the Bureau Director.

*Shall take necessary steps to protect residents of a facility if necessary.

*Shall serve as a consultant to the facility administrator and Bureau Director concerning the operation of the health facility. The Monitor shall be available if necessary, for meetings with the Bureau Director or Division Director.

*Shall submit weekly written reports to the Bureau Director on the operation of the facility and the status and condition of the patients.

Shall observe the operation and provision of services cited as problem areas during the normal workday, with additional time allocated to the observation of continuity of services on the evening and night shifts.

The weekly report shall address each of the findings and problems noted on the survey or complaint investigation which led to the adverse licensure action and to the placement of a monitor.

Employee Education About False Claims Recoveries

1a. The Indiana Office of Medicaid Policy and Planning (OMPP) or its contractors will conduct reviews annually of selected entities defined under 4.42(a)(1)(A). These reviews will include examination of the entities' policies and procedures regarding the education of employees, management, officers, contractors or agents of the entity regarding the False Claims Act, specifically on the entities' methods for detecting and preventing fraud, waste, and abuse in Federal health care programs, discussion of the laws described in the policies, whistleblower protection rights, and other provisions named in section 1902(a)(68) of the Social Security Act.

1b. Upon request by OMPP or its contractors, entities will provide a copy of the policies and procedures to OMPP or the OMPP contractor who conducts the review.

2a. During the review, the Indiana Office of Medicaid Policy and Planning (OMPP) or its contractors will further examine the entities' employee policy handbook, if one exists, for a detailed discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers, and a specific discussion of the entities' policies and procedures for detecting and preventing fraud, waste, and abuse in Federal health care programs.

2b. Upon request by OMPP or its contractors, entities will provide a copy of the employee handbook, if one exists, to OMPP or the OMPP contractor who conducts the review.

3a. Entities are required to submit to OMPP a corrective action plan within sixty days (60) if an entity is found not to be in compliance with any part of the requirements noted above regarding the False Claims Act and section 1902(a)(68) of the Social Security Act.

3b. The corrective action plan will describe the actions and methods the entity will follow to ensure that the entity comes into compliance. The corrective action plan will designate a contact person within the entity responsible for communicating with OMPP on implementation of the plan.

4. The State will incorporate into the provider agreement and affected contracts the requirements of this law within the third calendar quarter of 2007.

5. The State will provide information to entities through publication of a notice regarding the requirements to meet compliance with section 1902(a)(68). This publication will include information that the providers will be susceptible to audit beginning fourth quarter of 2007.

Description of Methods of Administration to Assure Compliance with the Requirements of Title VI of the Civil Rights Act of 1964

Office of Medicaid Policy and Planning Obligations

- Provide each program applicant with a written statement of rights via pamphlet or on the application form.

- Inform providers that civil rights violations may lead to decertification via a statement in the provider agreement.

- Advise all contractors of obligation to ensure non-discriminatory practices via a clause in the contract.

- Advise all employees of their civil rights and complaint procedures via posters, bulletins and handbooks distributed by Family & Social Services Administration Human Resources.

- Make available for public review this description of the agency's methods of administration to assure compliance with Section 504 requirements.

- Ensure investigation of complaints against providers by either the Indiana Civil Rights Commission or the United States Department of Health and Human Services, Office for Civil Rights.

- Provide, via the PAS Coordinator, a summary of patient rights and complaint procedures at the time of Pre-Admission Screening (PAS).

- Inform Long Term Care Facility patients and applicants that intake, admission, patient evaluation and treatment must be non-discriminatory via statements contained in application forms and in materials distributed/posted by Pre-Admission Screening Coordinators and LTC providers.

- Notify Medicaid recipients of their rights and complaint procedures annually.

Medicaid MMIS Contractor Obligations

- Distribute Medicaid Provider Manuals containing an explanation of providers' obligations to ensure non-discriminatory delivery of Medicaid-covered services.

- Notify service providers, via periodic bulletins, of their obligation to assure non-discriminatory provision of Medicaid services to individuals with AIDS or HIV.

- When distributing Medicaid Provider Manuals, supply providers with copies of pamphlets and fact sheets provided by the U.S. Office for Civil Rights.

State Department of Health Obligations

- Each time a nursing facility certification survey is conducted, the surveyor will:

  Ask the facility administrator to complete and sign Civil Rights Form #28348 ("Nursing Home On-site Review Report")

  Review the completed form and check for the proper posting of the open admissions policy

  During the course of the survey, observe the residents and staff to assure non-discriminatory policies are followed

  Include the Civil Rights Survey Form with the facility's certification and transmittal packet.

Long Term Care Provider Obligations

- Notify the Office of Medicaid Policy and Planning of civil rights complaints or lawsuits filed against the provider.

- Cooperate with inspections or investigations of civil rights violations.

- Sign a Medicaid Provider agreement indicating that civil rights violations may result in revocation of provider status.

- Complete Civil Rights Survey Form #28348 as required by surveyor conducting certification survey.

- Include open admissions policy on marketing materials; maintain written policies regarding the protection of patients' civil rights; and display the Office for Civil Rights' "Fact Sheet" supplied by the Medicaid agency.

Medicaid Administration

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

State Plan Administration Designation and Authority	A1

42 CFR 431.10

Designation and Authority

State Name: Indiana

As a condition for receipt of Federal funds under title XIX of the Social Security Act, the single state agency named below submits the following state plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this state plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

Name of single state agency: Office of the Secretary of the Family and Social Services Administration

Type of Agency:

- ○ Title IV-A Agency
- ○ Health
- ○ Human Resources
- ◉ Other

Type of Agency: Human Services

The above named agency is the single state agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named as the single state agency.)

The state statutory citation for the legal authority under which the single state agency administers the state plan is:

IC 12-8-1.5-10.5

The single state agency supervises the administration of the state plan by local political subdivisions.

○ Yes ◉ No

☑ The certification signed by the state Attorney General identifying the single state agency and citing the legal authority under which it administers or supervises administration of the program has been provided.

An attachment is submitted.

The state plan may be administered solely by the single state agency, or some portions may be administered by other agencies.

The single state agency administers the entire state plan under title XIX (i.e., no other agency or organization administers any portion of it).

◉ Yes ○ No

Medicaid Administration

The entity or entities that have responsibility for determinations of eligibility for families, adults, and for individuals under 21 are:

- ☒ The Medicaid agency
- ☐ Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- ☐ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

The entity that has responsibility for determinations of eligibility for the aged, blind, and disabled are:

- ☐ The Medicaid agency
- ☐ Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- ☐ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ☒ The Federal agency administering the SSI program

  Indicate which agency determines eligibility for any groups whose eligibility is not determined by the Federal agency:

  - ☒ Medicaid agency
  - ☐ Title IV-A agency
  - ☐ An Exchange

The entity or entities that have responsibility for conducting fair hearings with respect to denials of eligibility based on the applicable modified adjusted gross income standard are:

- ☒ Medicaid agency
- ☐ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ☐ An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

The agency has established a review process whereby the agency reviews appeals decisions made by the Exchange or Exchange appeals entity or other state agency, but only with respect to conclusions of law, including interpretations of state or federal policies.

○ Yes ◉ No

State Plan Administration — Organization and Administration — A2

42 CFR 431.10
42 CFR 431.11

Organization and Administration

Provide a description of the organization and functions of the Medicaid agency.

In 1991, the Indiana General Assembly established the FSSA in order to consolidate and better integrate the delivery of human services to Indiana residents. The Secretary of FSSA, a cabinet-level position appointed by the Governor, oversees the agency and is the agency's highest-ranking official. Pursuant to P.L. 109-2014, §§ 15-19, the Office of the Secretary of FSSA is now the Medicaid agency. Within the FSSA and under its direction, FSSA's Office of Medicaid Policy and Planning (OMPP) is divided into four units which perform the following functions:

• Eligibility: OMPP's Eligibility Unit develops eligibility policy and programs and provides guidance and support to agency field offices related to eligibility policy, systems coordination, and customer service.

• Pharmacy: OMPP's Pharmacy Unit oversees contractors providing clinical services (including prior authorization), clinical analytics, drug class reviews, drug rebate administration, claims processing, and drug pricing. The Pharmacy Unit also monitors changes to federal and State law to evaluate potential impacts to pharmacy policy and drafts legislative and program policy changes to reflect such changes.

• Quality: OMPP's Quality Unit is responsible for monitoring quality performance within the state's medical assistance programs. The Quality Unit also researches policy requests from providers and recommends changes to coverage and benefits.

• Reimbursement: OMPP's Reimbursement Unit oversees the process of providing compensation to Indiana Medicaid providers that is in accordance with federal and State laws and the Indiana Medicaid State Plan.

In addition to its function as the Medicaid agency, the Office of the Secretary of FSSA oversees and directs several other divisions that have Medicaid responsibilities. These divisions include the following:

• FSSA's Division of Family Resources (DFR) is responsible for determining eligibility for Medicaid for all populations based on policy developed by the OMPP Eligibility Unit. DFR is also responsible for determining eligibility for and managing timely delivery of other programs, including Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF) benefits.

• FSSA's Operations Division includes the Office of Hearings and Appeals and the Medical Review Team (MRT). FSSA's Operations Division also oversees contractors providing services related to prior authorization, the Medicaid Management Information System (MMIS), and managed care. The Office of Hearings and Appeals has responsibility for all fair hearings of Indiana's Medicaid program. Any party complaining of an action made by Medicaid may file a request for an administrative hearing. The hearing is held before an administrative law judge (ALJ) within the Office of Hearings and Appeals. Any party who is not satisfied with the decision of the ALJ may request agency review of the decision. The secretary of the FSSA or the secretary's designee reviews the ALJ's decision to determine if there is evidence in the record to support the decision and the decision is in accordance with policies, rules, statutes, and regulations applicable to the issue.

• FSSA's Office of Compliance oversees the Medicaid Program Integrity Unit, which identifies, investigates and refers suspected fraud cases, and performs audit and investigation functions.

• FSSA's Division of Healthcare Strategies and Technology provides data analytics, project management, and application support for all divisions and units. Additionally, the division oversees HIPAA compliance and data security throughout FSSA.

• FSSA's Division of Aging (DA) establishes and monitors programs that serve the needs of Indiana seniors. DA focuses on home- and community-based services for the elderly and disabled, assists OMPP with nursing home reimbursement policy, and oversees the Residential Care Assistance Program and Money Follows the Person Program. DA also operates the Aged & Disabled Waiver and the Traumatic Brain Injury (TBI) Waiver.

• FSSA's Division of Disability and Rehabilitative Services (DDRS) sets care standards for the provision of needed services for children and adults with physical and cognitive disabilities and provides these individuals with continuous, lifelong support. DDRS also operates the Family Supports Waiver and the Community Integration and Habilitation Waiver.

• FSSA's Division of Mental Health and Addition (DMHA) sets care standards for the provision of mental health and addiction services. DMHA also certifies all community mental health centers and addiction treatment service providers. Additionally, DMHA operates the Psychiatric Residential Treatment Facility (PRTF) Transition Waiver and three 1915(i) programs, Behavioral & Primary Healthcare Coordination (BPHC), Adult Mental Health & Habilitation (AMHH), and Child Mental Health Wraparound (CMHW).

Upload an organizational chart of the Medicaid agency.

An attachment is submitted.

Medicaid Administration

Provide a description of the structure of the state's executive branch which includes how the Medicaid agency fits in with other health, human service and public assistance agencies.

In 1991, the Indiana General Assembly established the FSSA in order to consolidate and better integrate the delivery of human services to Indiana residents. The Secretary of FSSA, a cabinet-level position appointed by the Governor, oversees the agency and is the agency's highest-ranking official. Pursuant to P.L. 109-2014, §§ 15-19, the Office of the Secretary of FSSA is now the Medicaid agency. No other agencies outside the FSSA have responsibilities for administering Medicaid.

Entities that determine eligibility other than the Medicaid Agency (if entities are described under Designation and Authority)

Remove

Type of entity that determines eligibility:

- ○ Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- ○ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ◉ The Federal agency administering the SSI program

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

Pursuit to a 1634 agreement, the Social Security Administration determines eligibility for Supplemental Security Income recipients.

Add

Entities that conduct fair hearings other than the Medicaid Agency (if are described under Designation and Authority)

Remove

Type of entity that conducts fair hearings:

- ○ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ○ An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

Add

Supervision of state plan administration by local political subdivisions (if described under Designation and Authority)

Is the supervision of the administration done through a state-wide agency which uses local political subdivisions?

○ Yes ○ No

State Plan Administration Assurances A3

42 CFR 431.10
42 CFR 431.12
42 CFR 431.50

Assurances

- [x] The state plan is in operation on a statewide basis, in accordance with all the requirements of 42 CFR 431.50.
- [x] All requirements of 42 CFR 431.10 are met.
- [x] There is a Medical Care Advisory Committee to the agency director on health and medical services established in accordance with meeting all the requirements of 42 CFR 431.12.
- [x] The Medicaid agency does not delegate, to other than its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters.

Assurance for states that have delegated authority to determine eligibility:

- [■] There is a written agreement between the Medicaid agency and the Exchange or any other state or local agency that has been delegated authority to determine eligibility for Medicaid eligibility in compliance with 42 CFR 431.10(d).

Assurances for states that have delegated authority to conduct fair hearings:

- [ ] There is a written agreement between the Medicaid agency and the Exchange or Exchange appeals entity that has been delegated authority to conduct Medicaid fair hearings in compliance with 42 CFR 431.10(d).
- [ ] When authority is delegated to the Exchange or an Exchange appeals entity, individuals who have requested a fair hearing are given the option to have their fair hearing conducted instead by the Medicaid agency.

Assurance for states that have delegated authority to determine eligibility and/or to conduct fair hearings:

- [x] The Medicaid agency does not delegate authority to make eligibility determinations or to conduct fair hearings to entities other than government agencies which maintain personnel standards on a merit basis.

PRA Disclosure Statement

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State of Indiana

ATTORNEY GENERAL'S CERTIFICATION

Pursuant to the Social Security Act, 42 USC, Section 1396(a) (1965), I certify that the Office of Medicaid Policy and Planning is designated as the single state agency responsible for administering the State Plan under Title XIX of the Social Security Act, effective December 31, 1991 through March 24, 2014. I certify that the Office of the Secretary of the Family and Social Services Administration is designated as the single state agency responsible for administering the State Plan under Title XIX of the Social Security Act, effective March 25, 2014.

The legal authority under which the Office of Medicaid Policy and Planning administers the State Plan on a statewide basis through March 24, 2014 is Indiana Code § 12-8-6.5-3. Effective March 25, 2014, the legal authority under which the Office of the Secretary of the Family and Social Services Administration administers the State Plan on a statewide basis is Indiana Code § 12-8-1.5-10.5.

5/7/14
Date

[redacted]
Gregory F. Zoeller
Attorney General of Indiana

STATE OF INDIANA
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GREG ZOELLER
INDIANA ATTORNEY GENERAL

TELEPHONE: 317.232.6201
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DELEGATION OF AUTHORITY

According to IC 4-6-5-1 and pursuant to IC 1-1-4-1(5), I hereby delegate authority to **MATTHEW JAMES LIGHT**, Deputy Attorney General and Chief Counsel, Advisory Section, to sign on my behalf the following:

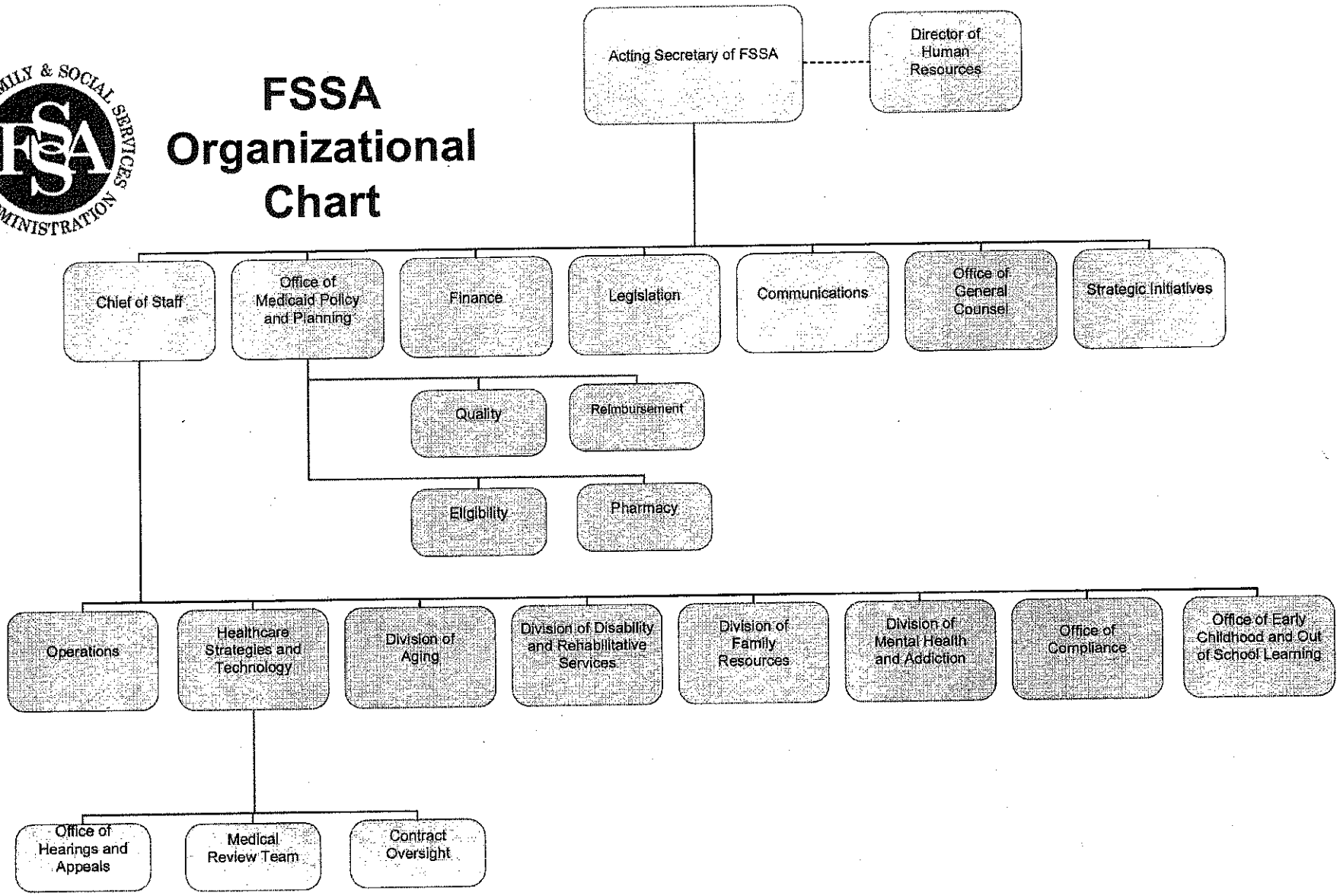
- any certifications or other documents required by any federal statute or regulation to be signed by the Attorney General of this State;
- any certifications or other documents required by any state statute, rule, or local ordinance to be signed by the Attorney General of this State;
- contract form approvals to be granted by the Attorney General of this State pursuant to IC 4-13-2-14.3(e);
- opinions of counsel when required to be issued by the Attorney General of this State in connection with financing transactions by bodies corporate and politic, the Indiana Finance Authority, or in connection with any other transaction requiring the Attorney General of this State to issue an opinion of counsel;
- to administer oaths of office to deputy attorneys general pursuant to IC 4-6-1-4 and IC 4-6-5-2;
- Voluntary Remediation Covenants not to Sue authorized by IC 13-25-5-18;
- contract form and legality to be signed by the Attorney General of this State pursuant to IC 4-13-2-14.3; and
- administrative rule approvals for form and legality to be signed by the Attorney General pursuant to IC 4-22-2-32.
- Memoranda of Understanding with state agencies or instrumentalities of the State regarding legal services to be provided by the Office of the Attorney General.

This delegation of authority shall be effective as of January 14, 2013, and shall be effective for only so long as I am the Attorney General of Indiana and Matthew James Light occupies his current position, or until such time as I may specifically revoke this delegation.

[redacted]

Gregory F. Zoeller
Attorney General of Indiana
Atty. No. 1958-98

FSSA Organizational Chart



Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

MAGI-Based Income Methodologies **S10**

1902(e)(14)
42 CFR 435.603

☑ The state will apply Modified Adjusted Gross Income (MAGI)-based methodologies as described below, and consistent with 42 CFR 435.603.

In the case of determining ongoing eligibility for beneficiaries determined eligible for Medicaid on or before December 31, 2013, MAGI-based income methodologies will not be applied until March 31, 2014, or the next regularly-scheduled renewal of eligibility, whichever is later, if application of such methods results in a determination of ineligibility prior to such date.

In determining family size for the eligibility determination of a pregnant woman, she is counted as herself plus each of the children she is expected to deliver.

In determining family size for the eligibility determination of the other individuals in a household that includes a pregnant woman:

- ◉ The pregnant woman is counted just as herself.
- ○ The pregnant woman is counted as herself, plus one.
- ○ The pregnant woman is counted as herself, plus the number of children she is expected to deliver.

Financial eligibility is determined consistent with the following provisions:

When determining eligibility for new applicants, financial eligibility is based on current monthly income and family size.

When determining eligibility for current beneficiaries, financial eligibility is based on:

- ◉ Current monthly household income and family size
- ○ Projected annual household income and family size for the remaining months of the current calendar year

In determining current monthly or projected annual household income, the state will use reasonable methods to:

- ☒ Include a prorated portion of a reasonably predictable increase in future income and/or family size.
- ☒ Account for a reasonably predictable decrease in future income and/or family size.

Except as provided at 42 CFR 435.603(d)(2) through (d)(4), household income is the sum of the MAGI-based income of every individual included in the individual's household.

In determining eligibility for Medicaid, an amount equivalent to 5 percentage points of the FPL for the applicable family size will be deducted from household income in accordance with 42 CFR 435.603(d).

Household income includes actually available cash support, exceeding nominal amounts, provided by the person claiming an individual described at §435.603(f)(2)(i) as a tax dependent.

○ Yes ◉ No

Medicaid Eligibility

☒ The age used for children with respect to 42 CFR 435.603(f)(3)(iv) is:

◉ Age 19

○ Age 19, or in the case of full-time students, age 21

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 40 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.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

AFDC Income Standards — S14

Enter the AFDC Standards below. All states must enter:

MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988 and
AFDC Payment Standard in Effect As of July 16, 1996

Entry of other standards is optional.

MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988

Income Standard Entry - Dollar Amount - Automatic Increase Option — S13a

The standard is as follows:

- (•) Statewide standard
- ( ) Standard varies by region
- ( ) Standard varies by living arrangement
- ( ) Standard varies in some other way

Enter the statewide standard

	Household size	Standard ($)	
+	1	152	X
+	2	247	X
+	3	310	X
+	4	373	X
+	5	435	X
+	6	498	X
+	7	561	X

Additional incremental amount

(•) Yes ( ) No

Increment amount $ 63

The dollar amounts increase automatically each year

( ) Yes (•) No

AFDC Payment Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option — S13a

The standard is as follows:

- (●) Statewide standard
- ( ) Standard varies by region
- ( ) Standard varies by living arrangement
- ( ) Standard varies in some other way

Enter the statewide standard

	Household size	Standard ($)	
+	1	139.5	X
+	2	229.5	X
+	3	288	X
+	4	346.5	X
+	5	405	X
+	6	463.5	X
+	7	522	X

Additional incremental amount

(●) Yes ( ) No

Increment amount $ 58.5

The dollar amounts increase automatically each year

( ) Yes (●) No

MAGI-equivalent AFDC Payment Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- (●) Statewide standard
- ( ) Standard varies by region
- ( ) Standard varies by living arrangement
- ( ) Standard varies in some other way

Enter the statewide standard

	Household size	Standard ($)	
+	1	152	X
+	2	247	X
+	3	310	X
+	4	373	X
+	5	435	X
+	6	498	X
+	7	561	X

Additional incremental amount

(●) Yes ( ) No

Increment amount $ 63

The dollar amounts increase automatically each year

( ) Yes (●) No

AFDC Need Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

( ) Statewide standard

( ) Standard varies by region

( ) Standard varies by living arrangement

( ) Standard varies in some other way

The dollar amounts increase automatically each year

( ) Yes ( ) No

AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date.

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

( ) Statewide standard

( ) Standard varies by region

○ Standard varies by living arrangement

○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ○ No

MAGI-equivalent AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

○ Statewide standard

○ Standard varies by region

○ Standard varies by living arrangement

○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ○ No

TANF payment standard

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

○ Statewide standard

○ Standard varies by region

○ Standard varies by living arrangement

○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ○ No

MAGI-equivalent TANF payment standard

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- ◯ Statewide standard
- ◯ Standard varies by region
- ◯ Standard varies by living arrangement
- ◯ Standard varies in some other way

The dollar amounts increase automatically each year

◯ Yes ◯ No

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 40 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.

Medicaid Eligibility

State Name: Indiana

OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0013

Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage
Parents and Other Caretaker Relatives **S25**

42 CFR 435.110
1902(a)(10)(A)(i)(I)
1931(b) and (d)

■ **Parents and Other Caretaker Relatives** - Parents and other caretaker relatives of dependent children with household income at or below a standard established by the state.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Individuals qualifying under this eligibility group must meet the following criteria:

■ Are parents or other caretaker relatives (defined at 42 CFR 435.4), including pregnant women, of dependent children (defined at 42 CFR 435.4) under age 18. Spouses of parents and other caretaker relatives are also included.

The state elects the following options:

☐ This eligibility group includes individuals who are parents or other caretakers of children who are 18 years old, provided the children are full-time students in a secondary school or the equivalent level of vocational or technical training.

☒ Options relating to the definition of caretaker relative (select any that apply):

☐ The definition of caretaker relative includes the domestic partner of the parent or other caretaker relative, even after the partnership is terminated.

Definition of domestic partner:

☒ The definition of caretaker relative includes other relatives of the child based on blood (including those of half-blood), adoption or marriage.

Description of other relatives: Any blood relative within the fifth degree of relationship, including, but not limited to, those of half blood, first cousins once removed, and individuals of preceding generations as denoted by prefixes of grand, great, great-great, or great-great-great (this group includes the sister, brother, aunt, and uncle of the child).

☐ The definition of caretaker relative includes any adult with whom the child is living and who assumes primary responsibility for the dependent child's care.

☒ Options relating to the definition of dependent child (select the one that applies):

- (●) The state elects to eliminate the requirement that a dependent child must be deprived of parental support or care by reason of the death, physical or mental incapacity, or absence from the home or unemployment of at least one parent.
- ( ) The child must be deprived of parental support or care, but a less restrictive standard is used to measure unemployment of the parent (select the one that applies):

[■] Have household income at or below the standard established by the state.

[■] MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

[■] Income standard used for this group

[■] Minimum income standard

The minimum income standard used for this group is the state's AFDC payment standard in effect as of May 1, 1988, converted to MAGI-equivalent amounts by household size. The standard is described in S14 AFDC Income Standards.

[☑] The state certifies that it has submitted and received approval for its converted May 1, 1988 AFDC payment standard.

An attachment is submitted.

[■] Maximum income standard

[☑] The state certifies that it has submitted and received approval for its converted income standard(s) for parents and other caretaker relatives to MAGI-equivalent standards and the determination of the maximum income standard to be used for parents and other caretaker relatives under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group is:

- (●) The state's effective income level for section 1931 families under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.
- ( ) The state's effective income level for section 1931 families under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.
- ( ) The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.
- ( ) The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:

- (●) A percentage of the federal poverty level: 113 %
- ( ) The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.
- ( ) The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.
- ( ) The state's TANF payment standard, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.
- ( ) Other dollar amount

[■] Income standard chosen:

Indicate the state's income standard used for this eligibility group:

- (●) The minimum income standard
- ( ) The maximum income standard
- ( ) The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date. The standard is described in S14 AFDC Income Standards.
- ( ) Another income standard in-between the minimum and maximum standards allowed

[■] There is no resource test for this eligibility group.

[■] Presumptive Eligibility

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

(●) Yes ( ) No

[■] The presumptive period begins on the date the determination is made.

[■] The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

[■] Periods of presumptive eligibility are limited as follows:

- ( ) No more than one period within a calendar year.
- ( ) No more than one period within two calendar years.
- (●) No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

○ Other reasonable limitation:

The state requires that a written application be signed by the applicant or representative.

◉ Yes ○ No

○ The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.

◉ The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

An attachment is submitted.

☑ The presumptive eligibility determination is based on the following factors:

☑ The individual must be a caretaker relative, as described at 42 CFR 435.110.

☑ Household income must not exceed the applicable income standard described at 42 CFR 435.110.

☒ State residency

☒ Citizenship, status as a national, or satisfactory immigration status

☑ The state uses qualified entities, as defined in section 1920A of the Act, to determine eligibility presumptively for this eligibility group.

List of Qualified Entities **S17**

A qualified entity is an entity that is determined by the agency to be capable of making presumptive eligibility determinations based on an individual's household income and other requirements, and that meets at least one of the following requirements. Select one or more of the following types of entities used to determine presumptive eligibility for this eligibility group:

☐ Furnishes health care items or services covered under the state's approved Medicaid state plan and is eligible to receive payments under the plan

☐ Is authorized to determine a child's eligibility to participate in a Head Start program under the Head Start Act

☐ Is authorized to determine a child's eligibility to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990

☐ Is authorized to determine a child's eligibility to receive assistance under the Special Supplemental Food Program for Women, Infants and Children (WIC) under section 17 of the Child Nutrition Act of 1966

☐ Is authorized to determine a child's eligibility under the Medicaid state plan or for child health assistance under the Children's Health Insurance Program (CHIP)

☐ Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801)

☐ Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs

☐ Is a state or Tribal child support enforcement agency under title IV-D of the Act

☐ Is an organization that provides emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act

Medicaid Eligibility

☐ Is a state or Tribal office or entity involved in enrollment in the program under Medicaid, CHIP, or title IV-A of the Act

☐ Is an organization that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 et seq.)

☐ Is a health facility operated by the Indian Health Service, a Tribe, or Tribal organization, or an Urban Indian Organization

☒ Other entity the agency determines is capable of making presumptive eligibility determinations:

	Name of entity	Description	
+	Qualified Provider	Provider types eligible to enroll as a presumptive eligibility Qualified Provider (PE QP) include: Acute Care Hospitals, Psychiatric Hospitals, community mental health centers (CMHCs), rural health clinics (RHCs), federally qualified health centers (FQHCs), and local health departments. To be eligible, an acute care hospital, psychiatric hospital, CMHC, RHC, local health department or FQHC must: • Participate as a provider under the Indiana State Plan or under a demonstration program under Section 1115 of the Social Security Act. Local county health departments are not required to participate as a Medicaid provider. • Notify the FSSA of the provider's intention to make presumptive eligibility determinations. • Agree to make presumptive eligibility determinations consistent with state policies and procedures. • Guide individuals in the process for completing and submitting the Indiana Application for Health Coverage paperwork to the FSSA. • Complete and submit PE QP eligibility attestations through the PE enrollment process on Web interChange. CMHCs, RHCs, FQHCs, and local health departments that wish to enroll as PE QPs are provided Web interChange training. During the Web interChange training session, the CMHC, RHC, FQHC, or local health department also receive a printed copy of the HPE/PE Process Guide.	X

☑ The state assures that it has communicated the requirements for qualified entities, at 1920A(b)(3) of the Act, and has provided adequate training to the entities and organizations involved. A copy of the training materials has been included.

Medicaid Eligibility

State Name: Indiana

OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0013

Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage
Pregnant Women **S28**

42 CFR 435.116
1902(a)(10)(A)(i)(III) and (IV)
1902(a)(10)(A)(ii)(I), (IV) and (IX)
1931(b) and (d)
1920

☒ **Pregnant Women** - Women who are pregnant or post-partum, with household income at or below a standard established by the state.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

☒ Individuals qualifying under this eligibility group must be pregnant or post-partum, as defined in 42 CFR 435.4.

Pregnant women in the last trimester of their pregnancy without dependent children are eligible for full benefits under this group in accordance with section 1931 of the Act, if they meet the income standard for state plan Parents and Other Caretaker Relatives at 42 CFR 435.110.

○ Yes ◉ No

☒ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

☒ Income standard used for this group

☒ Minimum income standard (Once entered and approved by CMS, the minimum income standard cannot be changed.)

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for pregnant women, or as of July 1, 1989, had authorizing legislation to do so.

○ Yes ◉ No

The minimum income standard for this eligibility group is 133% FPL.

☒ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for pregnant women to MAGI-equivalent standards and the determination of the maximum income standard to be used for pregnant women under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group is:

◉ The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

Medicaid Eligibility

○ The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ 185% FPL

The amount of the maximum income standard is: 208 % FPL

☑ Income standard chosen

Indicate the state's income standard used for this eligibility group:

○ The minimum income standard

◉ The maximum income standard

○ Another income standard in-between the minimum and maximum standards allowed.

☑ There is no resource test for this eligibility group.

☑ Benefits for individuals in this eligibility group consist of the following:

◉ All pregnant women eligible under this group receive full Medicaid coverage under this state plan.

○ Pregnant women whose income exceeds the income limit specified below for full coverage of pregnant women receive only pregnancy-related services.

☑ Presumptive Eligibility

The state covers ambulatory prenatal care for individuals under this group when determined presumptively eligible by a qualified entity.

◉ Yes ○ No

☑ The presumptive period begins on the date the determination is made.

☑ The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

☑ There may be no more than one period of presumptive eligibility per pregnancy.

A written application must be signed by the applicant or representative.

◉ Yes ○ No

○ The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.

◉ The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

An attachment is submitted.

☑ The presumptive eligibility determination is based on the following factors:

☑ The woman must be pregnant

☑ Household income must not exceed the applicable income standard at 42 CFR 435.116.

☒ State residency

☒ Citizenship, status as a national, or satisfactory immigration status

☑ The state uses qualified entities, as defined in section 1920A of the Act, to determine eligibility presumptively for this eligibility group.

List of Qualified Entities **S17**

A qualified entity is an entity that is determined by the agency to be capable of making presumptive eligibility determinations based on an individual's household income and other requirements, and that meets at least one of the following requirements. Select one or more of the following types of entities used to determine presumptive eligibility for this eligibility group:

☐ Furnishes health care items or services covered under the state's approved Medicaid state plan and is eligible to receive payments under the plan

☐ Is authorized to determine a child's eligibility to participate in a Head Start program under the Head Start Act

☐ Is authorized to determine a child's eligibility to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990

☐ Is authorized to determine a child's eligibility to receive assistance under the Special Supplemental Food Program for Women, Infants and Children (WIC) under section 17 of the Child Nutrition Act of 1966

☐ Is authorized to determine a child's eligibility under the Medicaid state plan or for child health assistance under the Children's Health Insurance Program (CHIP)

☐ Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801)

☐ Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs

☐ Is a state or Tribal child support enforcement agency under title IV-D of the Act

☐ Is an organization that provides emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act

☐ Is a state or Tribal office or entity involved in enrollment in the program under Medicaid, CHIP, or title IV-A of the Act

Medicaid Eligibility

☐ Is an organization that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 et seq.)

☐ Is a health facility operated by the Indian Health Service, a Tribe, or Tribal organization, or an Urban Indian Organization

☒ Other entity the agency determines is capable of making presumptive eligibility determinations:

	Name of entity	Description	
+	Qualified Provider (QP) for presumptive eligibility for pregnant women (PEPW)	Provider types eligible to enroll as a Qualified Provider include: family or general practitioner; a pediatrician; an internist; an obstetrician or gynecologist; a certified nurse midwife; an advanced practice nurse practitioner; a federally qualified health center (FQHC); a medical clinic; a rural health clinic (RHC); an outpatient hospital; a local health department; or a family planning clinic. QPs must have access to internet, phone, fax, and has been trained by FSSA or designee.	X

Medicaid Eligibility

	Name of entity	Description	
+	Qualified Provider for presumptive eligibility (PE QP)	Provider types eligible to enroll as a presumptive eligibility Qualified Provider (PE QP) include: Acute Care Hospitals, Psychiatric Hospitals, community mental health centers (CMHCs), RHCs, FQHCs, and local health departments. To be eligible, an acute care hospital, psychiatric hospital, CMHC, RHC, local health department or FQHC must: • Participate as a provider under the Indiana State Plan or under a demonstration program under Section 1115 of the Social Security Act. Local county health departments are not required to participate as a Medicaid provider. • Notify the FSSA of the provider's intention to make presumptive eligibility determinations. • Agree to make presumptive eligibility determinations consistent with state policies and procedures. • Guide individuals in the process for completing and submitting the Indiana Application for Health Coverage paperwork to the FSSA. • Complete and submit PE QP eligibility attestations through the PE enrollment process on Web interChange. CMHCs, RHCs, FQHCs, and local health departments that wish to enroll as PE QPs are provided Web interChange training. During the Web interChange training session, the CMHC, RHC, FQHC, or local health department also receive a printed copy of the HPE/PE Process Guide.	X

The state assures that it has communicated the requirements for qualified entities, at 1920A(b)(3) of the Act, ☑ and has provided adequate training to the entities and organizations involved. A copy of the training materials has been included.

An attachment is submitted.

PRA Disclosure Statement

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Medicaid Eligibility

State Name: Indiana

OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0013

Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage
Infants and Children under Age 19 **S30**

42 CFR 435.118
1902(a)(10)(A)(i)(III), (IV), (VI) and (VII)
1902(a)(10)(A)(ii)(IV) and (IX)
1931(b) and (d)

■ **Infants and Children under Age 19** - Infants and children under age 19 with household income at or below standards established by the state based on age group.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Children qualifying under this eligibility group must meet the following criteria:

■ Are under age 19

■ Have household income at or below the standard established by the state.

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

■ Income standard used for infants under age one

■ Minimum income standard

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for infants under age one, or as of July 1, 1989, had authorizing legislation to do so.

○ Yes ◉ No

The minimum income standard for infants under age one is 133% FPL.

■ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for infants under age one to MAGI-equivalent standards and the determination of the maximum income standard to be used for infants under age one.

An attachment is submitted.

The state's maximum income standard for this age group is:

◉ The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

Medicaid Eligibility

○ The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ 185% FPL

Enter the amount of the maximum income standard: 208 % FPL

■ Income standard chosen

The state's income standard used for infants under age one is:

◉ The maximum income standard

○ If not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

■ Income standard for children age one through age five, inclusive

■ Minimum income standard

The minimum income standard used for this age group is 133% FPL.

☒ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for children age one through five to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age one through five.

An attachment is submitted.

The state's maximum income standard for children age one through five is:

◉ The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

Enter the amount of the maximum income standard: 158 % FPL

☒ Income standard chosen

The state's income standard used for children age one through five is:

◉ The maximum income standard

○ If not chosen as the maximum income standard, the state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

■ Income standard for children age six through age eighteen, inclusive

■ Minimum income standard

The minimum income standard used for this age group is 133% FPL.

■ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for children age six through eighteen to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age six through age eighteen.

An attachment is submitted

The state's maximum income standard for children age six through eighteen is:

◉ The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ 133% FPL

Enter the amount of the maximum income standard: 158 % FPL

■ Income standard chosen

Medicaid Eligibility

The state's income standard used for children age six through eighteen is:

(•) The maximum income standard

( ) If not chosen as the maximum income standard, the state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

( ) If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

( ) If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

( ) If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

( ) Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

[■] There is no resource test for this eligibility group.

[■] Presumptive Eligibility

The state covers children when determined presumptively eligible by a qualified entity.

(•) Yes ( ) No

Presumptive Eligibility for Children	S16
1902(a)(47) 1920A 42 CFR 435.1101 42 CFR 435.1102	
[■] The state provides Medicaid coverage to children when determined presumptively eligible by a qualified entity under the following provisions:	

If the state has elected to cover Optional Targeted Low-Income Children (42 CFR 435.229), the income standard for presumptive eligibility is the higher of the standard used for Optional Targeted Low-Income Children or the standard used for Infants and Children under 19 (42 CFR 435.118), for that child's age.

If the state has not elected to cover Optional Targeted Low Income Children (42 CFR 435.229), the income standard for presumptive eligibility is the standard used under the Infants and Children under Age 19 eligibility group (42 CFR 435.118), for that child's age.

☑ Children under the following age may be determined presumptively eligible:

Under age 19

☑ The presumptive period begins on the date the determination is made.

☑ The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

☑ Periods of presumptive eligibility are limited as follows:

○ No more than one period within a calendar year.

○ No more than one period within two calendar years.

◉ No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

○ Other reasonable limitation:

The state requires that a written application be signed by the applicant, parent or representative, as appropriate.

◉ Yes ○ No

○ The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.

◉ The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

An attachment is submitted.

☑ The presumptive eligibility determination is based on the following factors:

☑ Household income must not exceed the applicable income standard described above, for the child's age.

☒ State residency

☒ Citizenship, status as a national, or satisfactory immigration status

☑ The state uses qualified entities, as defined in section 1920A of the Act, to determine eligibility presumptively for this eligibility group.

List of Qualified Entities **S17**

A qualified entity is an entity that is determined by the agency to be capable of making presumptive eligibility determinations based on an individual's household income and other requirements, and that meets at least one of the following requirements. Select one or more of the following types of entities used to determine presumptive eligibility for this eligibility group:

- ☐ Furnishes health care items or services covered under the state's approved Medicaid state plan and is eligible to receive payments under the plan
- ☐ Is authorized to determine a child's eligibility to participate in a Head Start program under the Head Start Act
- ☐ Is authorized to determine a child's eligibility to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990
- ☐ Is authorized to determine a child's eligibility to receive assistance under the Special Supplemental Food Program for Women, Infants and Children (WIC) under section 17 of the Child Nutrition Act of 1966
- ☐ Is authorized to determine a child's eligibility under the Medicaid state plan or for child health assistance under the Children's Health Insurance Program (CHIP)
- ☐ Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801)
- ☐ Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs
- ☐ Is a state or Tribal child support enforcement agency under title IV-D of the Act
- ☐ Is an organization that provides emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act
- ☐ Is a state or Tribal office or entity involved in enrollment in the program under Medicaid, CHIP, or title IV-A of the Act
- ☐ Is an organization that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 et seq.)
- ☐ Is a health facility operated by the Indian Health Service, a Tribe, or Tribal organization, or an Urban Indian Organization
- ☒ Other entity the agency determines is capable of making presumptive eligibility determinations:

	Name of entity	Description	

Medicaid Eligibility

	Name of entity	Description	
+	Qualified Provider	Provider types eligible to enroll as a presumptive eligibility Qualified Provider (PE QP) include: Acute Care Hospitals, Psychiatric Hospitals, community mental health centers (CMHCs), rural health clinics (RHCs), federally qualified health centers (FQHCs), and local health departments. To be eligible, an acute care hospital, psychiatric hospital, CMHC, RHC, local health department or FQHC must: • Participate as a provider under the Indiana State Plan or under a demonstration program under Section 1115 of the Social Security Act. Local county health departments are not required to participate as a Medicaid provider. • Notify the FSSA of the provider's intention to make presumptive eligibility determinations. • Agree to make presumptive eligibility determinations consistent with state policies and procedures. • Guide individuals in the process for completing and submitting the Indiana Application for Health Coverage paperwork to the FSSA. • Complete and submit PE QP eligibility attestations through the PE enrollment process on Web interChange. CMHCs, RHCs, FQHCs, and local health departments that wish to enroll as PE QPs are provided Web interChange training. During the Web interChange training session, the CMHC, RHC, FQHC, or local health department also receive a printed copy of the HPE/PE Process Guide.	X

☑ The state assures that it has communicated the requirements for qualified entities, at 1920A(b)(3) of the Act, and provided adequate training to the entities and organizations involved. A copy of the training materials has been included.

An attachment is submitted.

Medicaid Eligibility

State Name: Indiana

OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0013

Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage
Adult Group **S32**

1902(a)(10)(A)(i)(VIII)
42 CFR 435.119

The state covers the Adult Group as described at 42 CFR 435.119.

(•) Yes ( ) No

[■] **Adult Group** - Non-pregnant individuals age 19 through 64, not otherwise mandatorily eligible, with income at or below 133% FPL.

[☑] The state attests that it operates this eligibility group in accordance with the following provisions:

[■] Individuals qualifying under this eligibility group must meet the following criteria:

[■] Have attained age 19 but not age 65.

[■] Are not pregnant.

[■] Are not entitled to or enrolled for Part A or B Medicare benefits.

[■] Are not otherwise eligible for and enrolled for mandatory coverage under the state plan in accordance with 42 CFR 435, subpart B.

Note: In 209(b) states, individuals receiving SSI or deemed to be receiving SSI who do not qualify for mandatory Medicaid eligibility due to more restrictive requirements may qualify for this eligibility group if otherwise eligible.

[■] Have household income at or below 133% FPL.

[■] MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

[■] There is no resource test for this eligibility group.

[■] Parents or other caretaker relatives living with a child under the age specified below are not covered unless the child is receiving benefits under Medicaid, CHIP or through the Exchange, or otherwise enrolled in minimum essential coverage, as defined in 42 CFR 435.4.

(•) Under age 19, or

( ) A higher age of children, if any, covered under 42 CFR 435.222 on March 23, 2010:

[■] Presumptive Eligibility

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

(•) Yes ( ) No

[■] The presumptive period begins on the date the determination is made.

Medicaid Eligibility

■ The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

■ Periods of presumptive eligibility are limited as follows:

○ No more than one period within a calendar year.

○ No more than one period within two calendar years.

◉ No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

○ Other reasonable limitation:

The state requires that a written application be signed by the applicant or representative.

◉ Yes ○ No

○ The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.

◉ The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

An attachment is submitted.

■ The presumptive eligibility determination is based on the following factors:

■ The individual must meet the categorical requirements of 42 CFR 435.119.

■ Household income must not exceed the applicable income standard described at 42 CFR 435.119.

☒ State residency.

☒ Citizenship, status as a national, or satisfactory immigration status.

■ The state uses qualified entities, as defined in section 1920A of the Act, to determine eligibility presumptively for this eligibility group.

List of Qualified Entities **S17**

A qualified entity is an entity that is determined by the agency to be capable of making presumptive eligibility determinations based on an individual's household income and other requirements, and that meets at least one of the following requirements. Select one or more of the following types of entities used to determine presumptive eligibility for this eligibility group:

☐ Furnishes health care items or services covered under the state's approved Medicaid state plan and is eligible to receive payments under the plan

☐ Is authorized to determine a child's eligibility to participate in a Head Start program under the Head Start Act

☐ Is authorized to determine a child's eligibility to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990

- ☐ Is authorized to determine a child's eligibility to receive assistance under the Special Supplemental Food Program for Women, Infants and Children (WIC) under section 17 of the Child Nutrition Act of 1966
- ☐ Is authorized to determine a child's eligibility under the Medicaid state plan or for child health assistance under the Children's Health Insurance Program (CHIP)
- ☐ Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801)
- ☐ Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs
- ☐ Is a state or Tribal child support enforcement agency under title IV-D of the Act
- ☐ Is an organization that provides emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act
- ☐ Is a state or Tribal office or entity involved in enrollment in the program under Medicaid, CHIP, or title IV-A of the Act
- ☐ Is an organization that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 et seq.)
- ☐ Is a health facility operated by the Indian Health Service, a Tribe, or Tribal organization, or an Urban Indian Organization
- ☒ Other entity the agency determines is capable of making presumptive eligibility determinations:

	Name of entity	Description	

Medicaid Eligibility

	Name of entity	Description	
+	Qualified Provider	Provider types eligible to enroll as a presumptive eligibility Qualified Provider (PE QP) include: Acute Care Hospitals, Psychiatric Hospitals, community mental health centers (CMHCs), rural health clinics (RHCs), federally qualified health centers (FQHCs), and local health departments. To be eligible, an acute care hospital, psychiatric hospital, CMHC, RHC, local health department or FQHC must: • Participate as a provider under the Indiana State Plan or under a demonstration program under Section 1115 of the Social Security Act. Local county health departments are not required to participate as a Medicaid provider. • Notify the FSSA of the provider's intention to make presumptive eligibility determinations. • Agree to make presumptive eligibility determinations consistent with state policies and procedures. • Guide individuals in the process for completing and submitting the Indiana Application for Health Coverage paperwork to the FSSA. • Complete and submit PE QP eligibility attestations through the PE enrollment process on Web interChange. CMHCs, RHCs, FQHCs, and local health departments that wish to enroll as PE QPs are provided Web interChange training. During the Web interChange training session, the CMHC, RHC, FQHC, or local health department also receive a printed copy of the HPE/PE Process Guide.	X

The state assures that it has communicated the requirements for qualified entities, at 1920A(b)(3) of the Act, ☑ and has provided adequate training to the entities and organizations involved. A copy of the training materials has been included.

An attachment is submitted.

Medicaid Eligibility

State Name: Indiana

OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0013

Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage
Former Foster Care Children **S33**

42 CFR 435.150
1902(a)(10)(A)(i)(IX)

■ **Former Foster Care Children** - Individuals under the age of 26, not otherwise mandatorily eligible, who were on Medicaid and in foster care when they turned age 18 or aged out of foster care.

☑ The state attests that it operates this eligibility group under the following provisions:

■ Individuals qualifying under this eligibility group must meet the following criteria:

■ Are under age 26.

■ Are not otherwise eligible for and enrolled for mandatory coverage under the state plan, except that eligibility under this group takes precedence over eligibility under the Adult Group.

■ Were in foster care under the responsibility of the state or Tribe and were enrolled in Medicaid under the state's state plan or 1115 demonstration when they turned 18 or at the time of aging out of that state's or Tribe's foster care program.

The state elects to cover children who were in foster care and on Medicaid in any state at the time they turned 18 or aged out of the foster care system.

○ Yes ◉ No

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

◉ Yes ○ No

■ The presumptive period begins on the date the determination is made.

■ The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

■ Periods of presumptive eligibility are limited as follows:

○ No more than one period within a calendar year.

○ No more than one period within two calendar years.

◉ No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

○ Other reasonable limitation:

Medicaid Eligibility

The state requires that a written application be signed by the applicant or representative.

(•) Yes ( ) No

( ) The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.

(•) The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

An attachment is submitted.

[■] The presumptive eligibility determination is based on the following factors:

[■] The individual must meet the categorical requirements of 42 CFR 435.150.

[☒] State residency

[☒] Citizenship, status as a national, or satisfactory immigration status

[■] The state uses qualified entities, as defined in section 1920A of the Act, to determine eligibility presumptively for this eligibility group.

List of Qualified Entities **S17**

A qualified entity is an entity that is determined by the agency to be capable of making presumptive eligibility determinations based on an individual's household income and other requirements, and that meets at least one of the following requirements. Select one or more of the following types of entities used to determine presumptive eligibility for this eligibility group:

[ ] Furnishes health care items or services covered under the state's approved Medicaid state plan and is eligible to receive payments under the plan

[ ] Is authorized to determine a child's eligibility to participate in a Head Start program under the Head Start Act

[ ] Is authorized to determine a child's eligibility to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990

[ ] Is authorized to determine a child's eligibility to receive assistance under the Special Supplemental Food Program for Women, Infants and Children (WIC) under section 17 of the Child Nutrition Act of 1966

[ ] Is authorized to determine a child's eligibility under the Medicaid state plan or for child health assistance under the Children's Health Insurance Program (CHIP)

[ ] Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801)

[ ] Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs

[ ] Is a state or Tribal child support enforcement agency under title IV-D of the Act

[ ] Is an organization that provides emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act

[ ] Is a state or Tribal office or entity involved in enrollment in the program under Medicaid, CHIP, or title IV-A of the Act

Medicaid Eligibility

☐ Is an organization that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 et seq.)

☐ Is a health facility operated by the Indian Health Service, a Tribe, or Tribal organization, or an Urban Indian Organization

☒ Other entity the agency determines is capable of making presumptive eligibility determinations:

	Name of entity	Description	
+	Qualified Provider	Provider types eligible to enroll as a presumptive eligibility Qualified Provider (PE QP) include: Acute Care Hospitals, Psychiatric Hospitals, community mental health centers (CMHCs), rural health clinics (RHCs), federally qualified healthcare centers (FQHCs), and local health departments. To be eligible, an acute care hospital, psychiatric hospital, CMHC, RHC, local health department or FQHC must: • Participate as a provider under the Indiana State Plan or under a demonstration program under Section 1115 of the Social Security Act. Local county health departments are not required to participate as a Medicaid provider. • Notify the FSSA of the provider's intention to make presumptive eligibility determinations. • Agree to make presumptive eligibility determinations consistent with state policies and procedures. • Guide individuals in the process for completing and submitting the Indiana Application for Health Coverage paperwork to the FSSA. • Complete and submit PE QP eligibility attestations through the PE enrollment process on Web interChange. CMHCs, RHCs, FQHCs, and local health departments that wish to enroll as PE QPs are provided Web interChange training. During the Web interChange training session, the CMHC, RHC, FQHC, or local health department also receive a printed copy of the HPE/PE Process Guide.	X

☑ The state assures that it has communicated the requirements for qualified entities, at 1920A(b)(3) of the Act, and has provided adequate training to the entities and organizations involved. A copy of the training materials has been included.

An attachment is submitted.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage Individuals above 133% FPL	S50

1902(a)(10)(A)(ii)(XX)
1902(hh)
42 CFR 435.218

Individuals above 133% FPL - The state elects to cover individuals under 65, not otherwise mandatorily or optionally eligible, with income above 133% FPL and at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.218.

○ Yes ◉ No

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 40 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.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage *Optional Coverage of Parents and Other Caretaker Relatives*	S51

42 CFR 435.220
1902(a)(10)(A)(ii)(I)

Optional Coverage of Parents and Other Caretaker Relatives - The state elects to cover individuals qualifying as parents or other caretaker relatives who are not mandatorily eligible and who have income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.220.

○ Yes ◉ No

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 40 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.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage
Reasonable Classification of Individuals under Age 21 S52

42 CFR 435.222
1902(a)(10)(A)(ii)(I)
1902(a)(10)(A)(ii)(IV)

Reasonable Classification of Individuals under Age 21 - The state elects to cover one or more reasonable classifications of individuals under age 21 who are not mandatorily eligible and who have income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.222.

(●) Yes ( ) No

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Individuals qualifying under this eligibility group must qualify under a reasonable classification by meeting the following criteria:

■ Be under age 21, or a lower age, as defined within the reasonable classification.

■ Have household income at or below the standard established by the state, if the state has an income standard for the reasonable classification.

■ Not be eligible and enrolled for mandatory coverage under the state plan.

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered at least one reasonable classification under this eligibility group under its Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013, with income standards higher (including disregarding all income) than the current mandatory income standards for the individual's age.

(●) Yes ( ) No

The state also covered at least one reasonable classification under this group in the Medicaid state plan as of March 23, 2010 with income standards higher (including disregarding all income) than the current mandatory income standards for the individual's age.

(●) Yes ( ) No

Reasonable Classifications Covered in the Medicaid State Plan as of March 23, 2010

☑ The state attaches the approved pages from the Medicaid state plan as of March 23, 2010 to indicate the age groups, reasonable classifications, and income standards used at that time for this eligibility group.

An attachment is submitted

Current Coverage of All Children under a Specified Age

The state covers all children under a specified age limit, equal to or higher than the age limit and/or income standard used in the Medicaid state plan as of March 23, 2010, provided the income standard is higher than the current mandatory income standard for the individual's age. The age limit and/or income standard used must be no higher than any age limit and/or income standard covered in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013. Higher income standards may include the disregard of all income.

○ Yes ◉ No

Current Coverage of Reasonable Classifications Covered in the Medicaid State Plan as of March 23, 2010

The state covers reasonable classifications of children previously covered in the Medicaid state plan as of March 23, 2010, with income standards higher than the current mandatory income standard for the age group. Age limits and income standards are equal to or higher than the Medicaid state plan as of March 23, 2010, but no higher than any age limit and/or income standard for this classification covered in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013. Higher income standards may include the disregard of all income.

◉ Yes ○ No

Indicate the reasonable classifications of children that were covered in the state plan in effect as of March 23, 2010 with income standards higher than the mandatory standards used for the child's age, using age limits and income standards that are not more restrictive than used in the state plan as of as March 23, 2010 and are not less restrictive than used in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

Current Coverage of Reasonable Classifications Covered in the Medicaid State Plan as of March 23, 2010

Reasonable Classifications of Children **S11**

☐ Individuals for whom public agencies are assuming full or partial financial responsibility.

☐ Individuals in adoptions subsidized in full or part by a public agency

☐ Individuals in nursing facilities, if nursing facility services are provided under this plan

☒ Individuals receiving active treatment as inpatients in psychiatric facilities or programs, if such services are provided under this plan

Indicate the age which applies:

◉ Under age 21 ○ Under age 20 ○ Under age 19 ○ Under age 18

☒ Other reasonable classifications

	Name of classification	Description	Age Limit	
+	Dependent Children 18-21	Individuals age 18, 19, 20 who meet all AFDC requirements except for the 18 year old limitation.	Under age 21	X

Medicaid Eligibility

Enter the income standard used for these classifications. The income standard must be higher than the mandatory standard for the child's age. It may be no lower than the income standard used in the state plan as of March 23, 2010 and no higher than the highest standard used in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

Click here once STM form above is complete to view the income standards form.

Individuals receiving active treatment as inpatients in psychiatric facilities or programs, if such services are provided under this plan

☑ Income standard used

☑ Minimum income standard

The minimum income standard for this classification of children is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

☑ Maximum income standard

No income test was used (all income was disregarded) for this classification either in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

○ Yes ◉ No

☑ The state certifies that it has submitted and received approval for its converted income standards for this classification of children to MAGI-equivalent standards and the determination of the maximum income standard to be used for this classification of children under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this classification of children (which must exceed the minimum for the classification) is:

◉ The state's effective income level for this classification of children under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this classification of children under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this classification of children under a Medicaid 1115 Demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this classification of children under a Medicaid 1115 Demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:

- ○ A percentage of the federal poverty level: [ ] %
- ◉ The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should only be selected for children 19 and older, and only if the state has not elected to cover the Adult Group.
- ○ The state's TANF payment standard, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should only be selected for children 19 and older, and only if the state has not elected to cover the Adult Group.
- ○ Other dollar amount

■ Income standard chosen

Individuals qualify under this classification under the following income standard:

- ○ The minimum standard.
- ◉ The maximum income standard.
- ○ If not chosen as the maximum income standard, the state's effective income level for this classification under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.
- ○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.
- ○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under a Medicaid 1115 Demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.
- ○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under a Medicaid 1115 Demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.
- ○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income level for this classification in the state plan as of March 23, 2010, converted to a MAGI equivalent.

Dependent Children 18-21

■ Income standard used

■ Minimum income standard

The minimum income standard for this classification of children is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

☒ Maximum income standard

No income test was used (all income was disregarded) for this classification either in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

○ Yes ◉ No

☑ The state certifies that it has submitted and received approval for its converted income standards for this classification of children to MAGI-equivalent standards and the determination of the maximum income standard to be used for this classification of children under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this classification of children (which must exceed the minimum for the classification) is:

◉ The state's effective income level for this classification of children under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this classification of children under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this classification of children under a Medicaid 1115 Demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this classification of children under a Medicaid 1115 Demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:

○ A percentage of the federal poverty level: [ ] %

◉ The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should only be selected for children 19 and older, and only if the state has not elected to cover the Adult Group.

○ The state's TANF payment standard, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should only be selected for children 19 and older, and only if the state has not elected to cover the Adult Group.

○ Other dollar amount

☑ Income standard chosen

Individuals qualify under this classification under the following income standard:

○ The minimum standard.

◉ The maximum income standard.

○ If not chosen as the maximum income standard, the state's effective income level for this classification under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under a Medicaid 1115 Demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under a Medicaid 1115 Demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income level for this classification in the state plan as of March 23, 2010, converted to a MAGI equivalent.

Other Reasonable Classifications Previously Covered

The state covers reasonable classifications of children not covered in the Medicaid state plan as of March 23, 2010, but covered under the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013 with an income standard higher than the current mandatory income standard for the age group.

○ Yes ◉ No

Additional new age groups or reasonable classifications covered

If the state has not elected to cover the Adult Group (42 CFR 435.119), it may elect to cover additional new age groups or reasonable classifications that have not been covered previously. If the state covers the Adult Group, this additional option is not available, as the standard for the new age groups or classifications is lower than that used for mandatory coverage.

The state does not cover the Adult Group and elects the option to include in this eligibility group additional age groups or reasonable classifications that have not been covered previously in the state plan or under a Medicaid 1115 Demonstration. Any additional age groups or reasonable classifications not previously covered are restricted to the AFDC income standard from July 16, 1996, not converted to a MAGI-equivalent standard.

Medicaid Eligibility

○ Yes ◉ No

☒ There is no resource test for this eligibility group.

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage
Children with Non IV-E Adoption Assistance S53

42 CFR 435.227
1902(a)(10)(A)(ii)(VIII)

Children with Non IV-E Adoption Assistance - The state elects to cover children with special needs for whom there is a non IV-E adoption assistance agreement in effect with a state, who were eligible for Medicaid, or who had income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.227.

(●) Yes ( ) No

[✓] The state attests that it operates this eligibility group in accordance with the following provisions:

[■] Individuals qualifying under this eligibility group must meet the following criteria:

[■] The state adoption agency has determined that they cannot be placed without Medicaid coverage because of special needs for medical or rehabilitative care;

[■] Are under the following age (see the Guidance for restrictions on the selection of an age):

( ) Under age 21
( ) Under age 20
( ) Under age 19
(●) Under age 18

[■] MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered this eligibility group in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

(●) Yes ( ) No

The state also covered this eligibility group in the Medicaid state plan as of March 23, 2010.

(●) Yes ( ) No

[■] Individuals qualify under this eligibility group if they were eligible under the state's approved state plan prior to the execution of the adoption agreement.

The state used an income standard or disregarded all income for this eligibility group either in the Medicaid state plan as of March 23, 2010 or December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

( ) Yes (●) No

[■] There is no resource test for this eligibility group.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage Optional Targeted Low Income Children	SS4

1902(a)(10)(A)(ii)(XIV)
42 CFR 435.229 and 435.4
1905(u)(2)(B)

Optional Targeted Low Income Children - The state elects to cover uninsured children who meet the definition of optional targeted low income children at 42 CFR 435.4, who have household income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.229.

○ Yes ◉ No

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage Individuals with Tuberculosis	S55
1902(a)(10)(A)(ii)(XII) 1902(z)	
Individuals with Tuberculosis - The state elects to cover individuals infected with tuberculosis who have income at or below a standard established by the state, limited to tuberculosis-related services. ○ Yes ◉ No	

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage S57
Independent Foster Care Adolescents

42 CFR 435.226
1902(a)(10)(A)(ii)(XVII)

Independent Foster Care Adolescents - The state elects to cover individuals under an age specified by the state, less than age 21, who were in state-sponsored foster care on their 18th birthday and who meet the income standard established by the state and in accordance with the provisions described at 42 CFR 435.226.

◉ Yes ○ No

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Individuals qualifying under this eligibility group must meet the following criteria:

■ Are under the following age

◉ Under age 21

○ Under age 20

○ Under age 19

■ Were in foster care under the responsibility of a state on their 18th birthday.

■ Are not eligible and enrolled for mandatory coverage under the Medicaid state plan.

■ Have household income at or below a standard established by the state.

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered this eligibility group under its Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 demonstration as of March 23, 2010 or December 31, 2013.

◉ Yes ○ No

The state also covered this eligibility group in the Medicaid state plan as of March 23, 2010.

◉ Yes ○ No

■ The state covers children under this eligibility group, as follows (selection may not be more restrictive than the coverage in the Medicaid state plan as of March 23, 2010 until October 1, 2019, nor more liberal than the most liberal coverage in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 demonstration as of March 23, 2010 or December 31, 2013):

◉ All children under the age selected

○ A reasonable classification of children under the age selected:

■ Income standard used for this eligibility group

■ Minimum income standard

The minimum income standard for this classification of children is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

Medicaid Eligibility

☑ Maximum income standard

No income test was used (all income was disregarded) for this eligibility group either in the Medicaid state plan as of March 23, 2010 or December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

○ Yes ◉ No

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for Independent Foster Care Adolescents to MAGI-equivalent standards and the determination of the maximum income standard to be used for individuals under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group (which must exceed the minimum) is:

◉ The state's effective income level for independent foster care adolescents under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for independent foster care adolescents under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for independent foster care adolescents under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for independent foster care adolescents under the Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:

◉ A percentage of the federal poverty level: 210 %

○ The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should be selected only if Under age 21 or Under age 20 was selected, **and** if the state has not elected to cover the Adult Group.

○ The state's TANF payment standard, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should be selected only if Under age 21 or Under age 20 was selected, **and** if the state has not elected to cover the Adult Group.

○ Other dollar amount

☑ Income standard chosen

Individuals qualify under this eligibility group under the following income standard:

○ The minimum standard.

◉ The maximum income standard.

○ If not chosen as the maximum income standard, the state's effective income level for independent foster care adolescents under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for independent foster care adolescents under a Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL, or amounts by household size.

○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for independent foster care adolescents under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for independent foster care adolescents under the Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income level for independent foster care adolescents in the Medicaid state plan as of March 23, 2010, converted to a MAGI equivalent.

■ There is no resource test for this eligibility group.

PRA Disclosure Statement

Medicaid Eligibility

State Name: Indiana

OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0013

Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage
Individuals Eligible for Family Planning Services **S59**

1902(a)(10)(A)(ii)(XXI)
42 CFR 435.214

Individuals Eligible for Family Planning Services - The state elects to cover individuals who are not pregnant, and have household income at or below a standard established by the state, whose coverage is limited to family planning and related services and in accordance with provisions described at 42 CFR 435.214.

(•) Yes ( ) No

[✓] The state attests that it operates this eligibility group in accordance with the following provisions:

[■] The individual may be a male or a female.

[■] Income standard used for this group

[■] Maximum income standard

[✓] The state certifies that it has submitted and received approval for its converted income standard(s) for pregnant women to MAGI-equivalent standards and the determination of the maximum income standard to be used for this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group is the highest of the following:

(•) The state's current effective income level for the Pregnant Women eligibility group (42 CFR 435.116) under the Medicaid state plan.

( ) The state's current effective income level for pregnant women under a Medicaid 1115 demonstration.

( ) The state's current effective income level for Targeted Low-Income Pregnant Women under the CHIP state plan.

( ) The state's current effective income level for pregnant women under a CHIP 1115 demonstration.

The amount of the maximum income standard is: 208 % FPL

[■] Income standard chosen

The state's income standard used for this eligibility group is:

( ) The maximum income standard

(•) Another income standard less than the maximum standard allowed.

The amount of the income standard is: 141 % FPL

[■] MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

Medicaid Eligibility

☒ In determining eligibility for this group, the state uses the following household size:

☒ All of the members of the family are included in the household

☐ Only the applicant is included in the household

☐ The state increases the household size by one

☒ In determining eligibility for this group, the state uses the following income methodology:

◉ The state considers the income of the applicant and all legally responsible household members (using MAGI-based methodology).

○ The state considers only the income of the applicant.

☒ Benefits for this eligibility group are limited to family planning and related services described in the Benefit section.

☒ Presumptive Eligibility

The state makes family planning services and supplies available to individuals covered under this group when determined presumptively eligible by a qualified entity.

◉ Yes ○ No

The state also covers medical diagnosis and treatment services that are provided in conjunction with a family planning service in a family planning setting during the presumptive eligibility period.

○ Yes ◉ No

☒ The presumptive period begins on the date the determination is made.

☒ The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

☒ Periods of presumptive eligibility are limited as follows:

○ No more than one period within a calendar year.

○ No more than one period within two calendar years.

◉ No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

○ Other reasonable limitation:

Medicaid Eligibility

The state requires that a written application be signed by the applicant or representative.

(●) Yes ( ) No

( ) The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.

(●) The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

An attachment is submitted.

[■] The presumptive eligibility determination is based on the following factors:

[■] The individual must not be pregnant.

[■] Household income must not exceed the applicable income standard specified for this group.

[☒] State residency

[☒] Citizenship, status as a national, or satisfactory immigration status

The state uses entities, as defined in section 1920C, to determine eligibility presumptively for this eligibility group.

[■] These entities must be eligible to receive payment for services under the state's approved Medicaid state plan and determined by the state to be capable of determining presumptive eligibility for this group.

The types of entities used to determine presumptive eligibility for this eligibility group are:

Medicaid Eligibility

	Name of entity	Description	
+	Qualified Provider	Provider types eligible to enroll as a presumptive eligibility Qualified Provider (PE QP) include: Acute Care Hospitals, Psychiatric Hospitals, community mental health centers (CMHCs), rural health clinics (RHCs), federally qualified health centers (FQHCs), and local health departments. To be eligible, an acute care hospital, psychiatric hospital, CMHC, RHC, local health department or FQHC must: • Participate as a provider under the Indiana State Plan or under a demonstration program under Section 1115 of the Social Security Act. Local county health departments are not required to participate as a Medicaid provider. • Notify the FSSA of the provider's intention to make presumptive eligibility determinations. • Agree to make presumptive eligibility determinations consistent with state policies and procedures. • Guide individuals in the process for completing and submitting the Indiana Application for Health Coverage paperwork to the FSSA. • Complete and submit PE QP eligibility attestations through the PE enrollment process on Web interChange. CMHCs, RHCs, FQHCs, and local health departments that wish to enroll as PE QPs are provided Web interChange training. During the Web interChange training session, the CMHC, RHC, FQHC, or local health department also receive a printed copy of the HPE/PE Process Guide.	X

☑ The state assures that it has communicated the requirements for entities, at 1920C of the Act, and has provided adequate training to the entities and organizations involved. A copy of the training materials has been included.

An attachment is submitted.

PRA Disclosure Statement

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V.20140415

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Non-Financial Eligibility
State Residency — S88

42 CFR 435.403

State Residency

☑ The state provides Medicaid to otherwise eligible residents of the state, including residents who are absent from the state under certain conditions.

Individuals are considered to be residents of the state under the following conditions:

- ■ Non-institutionalized individuals age 21 and over, or under age 21, capable of indicating intent and who are emancipated or married, if the individual is living in the state and:
  - ■ Intends to reside in the state, including without a fixed address, or
  - ■ Entered the state with a job commitment or seeking employment, whether or not currently employed.
- ■ Individuals age 21 and over, not living in an institution, who are not capable of indicating intent, are residents of the state in which they live.
- ■ Non-institutionalized individuals under 21 not described above and non IV-E beneficiary children:
  - ■ Residing in the state, with or without a fixed address, or
  - ■ The state of residency of the parent or caretaker, in accordance with 42 CFR 435.403(h)(1), with whom the individual resides.
- ■ Individuals living in institutions, as defined in 42 CFR 435.1010, including foster care homes, who became incapable of indicating intent before age 21 and individuals under age 21 who are not emancipated or married:
  - ■ Regardless of which state the individual resides, if the parent or guardian applying for Medicaid on the individual's behalf resides in the state, or
  - ■ Regardless of which state the individual resides, if the parent or guardian resides in the state at the time of the individual's placement, or
  - ■ If the individual applying for Medicaid on the individual's behalf resides in the state and the parental rights of the institutionalized individual's parent(s) were terminated and no guardian has been appointed and the individual is institutionalized in the state.
- ■ Individuals living in institutions who became incapable of indicating intent at or after age 21, if physically present in the state, unless another state made the placement.
- ■ Individuals who have been placed in an out-of-state institution, including foster care homes, by an agency of the state.
- ■ Any other institutionalized individual age 21 or over when living in the state with the intent to reside there, and not placed in the institution by another state.
- ■ IV-E eligible children living in the state, or

Medicaid Eligibility

☒ Otherwise meet the requirements of 42 CFR 435.403.

Medicaid Eligibility

Meet the criteria specified in an interstate agreement.

◉ Yes ○ No

☒ The state has interstate agreements with the following selected states:

☒ Alabama	☒ Illinois	☒ Montana	☒ Rhode Island
☒ Alaska	☒ Indiana	☒ Nebraska	☒ South Carolina
☒ Arizona	☒ Iowa	☒ Nevada	☒ South Dakota
☒ Arkansas	☒ Kansas	☒ New Hampshire	☒ Tennessee
☒ California	☒ Kentucky	☒ New Jersey	☒ Texas
☒ Colorado	☒ Louisiana	☒ New Mexico	☒ Utah
☒ Connecticut	☒ Maine	☐ New York	☒ Vermont
☒ Delaware	☒ Maryland	☒ North Carolina	☒ Virginia
☒ District of Columbia	☒ Massachusetts	☒ North Dakota	☒ Washington
☒ Florida	☒ Michigan	☒ Ohio	☒ West Virginia
☒ Georgia	☒ Minnesota	☒ Oklahoma	☒ Wisconsin
☒ Hawaii	☒ Mississippi	☒ Oregon	☐ Wyoming
☒ Idaho	☒ Missouri	☒ Pennsylvania	

☒ The interstate agreement contains a procedure for providing Medicaid to individuals pending resolution of their residency status and criteria for resolving disputed residency of individuals who (select all that apply):

- ☒ Are IV-E eligible
- ☐ Are in the state only for the purpose of attending school
- ☐ Are out of the state only for the purpose of attending school
- ☐ Retain addresses in both states
- ☐ Other type of individual

The state has a policy related to individuals in the state only to attend school.

○ Yes ◉ No

☒ Otherwise meet the criteria of resident, but who may be temporarily absent from the state.

The state has a definition of temporary absence, including treatment of individuals who attend school in another state.

◉ Yes ○ No

Medicaid Eligibility

Provide a description of the definition:

Residence is retained until abandoned. Temporary absence from Indiana, with subsequent returns to the state or intent to return when the purpose of the absence has been accomplished, does not interrupt continuity of residence.

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Non-Financial Eligibility
Citizenship and Non-Citizen Eligibility SB9

1902(a)(46)(B)
8 U.S.C. 1611, 1612, 1613, and 1641
1903(v)(2),(3) and (4)
42 CFR 435.4
42 CFR 435.406
42 CFR 435.956

Citizenship and Non-Citizen Eligibility

☑ The state provides Medicaid to citizens and nationals of the United States and certain non-citizens consistent with requirements of 42 CFR 435.406, including during a reasonable opportunity period pending verification of their citizenship, national status or satisfactory immigration status.

■ The state provides Medicaid eligibility to otherwise eligible individuals:

■ Who are citizens or nationals of the United States; and

■ Who are qualified non-citizens as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) (8 U.S.C. §1641), or whose eligibility is required by section 402(b) of PRWORA (8 U.S.C. §1612(b)) and is not prohibited by section 403 of PRWORA (8 U.S.C. §1613); and

■ Who have declared themselves to be citizens or nationals of the United States, or an individual having satisfactory immigration status, during a reasonable opportunity period pending verification of their citizenship, nationality or satisfactory immigration status consistent with requirements of 1903(x), 1137(d), 1902(ee) of the SSA and 42 CFR 435.406, and 956.

The reasonable opportunity period begins on and extends 90 days from the date the notice of reasonable opportunity is received by the individual.

The agency provides for an extension of the reasonable opportunity period if the individual is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency needs more time to complete the verification process.

○ Yes ◉ No

The agency begins to furnish benefits to otherwise eligible individuals during the reasonable opportunity period on a date earlier than the date the notice is received by the individual.

○ Yes ◉ No

The state provides Medicaid coverage to all Qualified Non-Citizens whose eligibility is not prohibited by section 403 of PRWORA (8 U.S.C. §1613).

◉ Yes ○ No

The state elects the option to provide Medicaid coverage to otherwise eligible individuals under 21 and pregnant women, lawfully residing in the United States, as provided in section 1903(v)(4) of the Act.

○ Yes ◉ No

Medicaid Eligibility

☒ An individual is considered to be lawfully residing in the United States if he or she is lawfully present and otherwise meets the eligibility requirements in the state plan.

☒ An individual is considered to be lawfully present in the United States if he or she:

1. Is a qualified non-citizen as defined in 8 U.S.C. 1641(b) and (c);

2. Is a non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or otherwise under the immigration laws (as defined in 8 U.S.C. 1101(a)(17));

3. Is a non-citizen who has been paroled into the United States in accordance with 8 U.S.C. 1182(d)(5) for less than 1 year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;

4. Is a non-citizen who belongs to one of the following classes:

   ☒ Granted temporary resident status in accordance with 8 U.S.C. 1160 or 1255a, respectively;

   ☒ Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. §1254a, and individuals with pending applications for TPS who have been granted employment authorization;

   ☒ Granted employment authorization under 8 CFR 274a.12(c);

   ☒ Family Unity beneficiaries in accordance with section 301 of Pub. L. 101-649, as amended;

   ☒ Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;

   ☒ Granted Deferred Action status;

   ☒ Granted an administrative stay of removal under 8 CFR 241;

   ☒ Beneficiary of approved visa petition who has a pending application for adjustment of status;

5. Is an individual with a pending application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C.1231, or under the Convention Against Torture who -

   ☒ Has been granted employment authorization; or

   ☒ Is under the age of 14 and has had an application pending for at least 180 days;

6. Has been granted withholding of removal under the Convention Against Torture;

7. Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 U.S.C. 1101(a)(27)(J);

8. Is lawfully present in American Samoa under the immigration laws of American Samoa; or

9. Is a victim of severe trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Pub. L. 106-386, as amended (22 U.S.C. 7105(b));

10. Exception: An individual with deferred action under the Department of Homeland Security's deferred action for the childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (1) through (9) of this definition.

☐ Other

Medicaid Eligibility

☑ The state assures that it provides limited Medicaid services for treatment of an emergency medical condition, not related to an organ transplant procedure, as defined in 1903(v)(3) of the SSA and implemented at 42 CFR 440.255, to the following individuals who meet all Medicaid eligibility requirements, except documentation of citizenship or satisfactory immigration status and/or present an SSN:

- ▣ Qualified non-citizens subject to the 5 year waiting period described in 8 U.S.C. 1613;
- ▣ Non-qualified non-citizens, unless covered as a lawfully residing child or pregnant woman by the state under the option in accordance with 1903(v)(4) and implemented at 435.406(b).

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 40 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.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

General Eligibility Requirements
Eligibility Process **S94**

42 CFR 435, Subpart J and Subpart M

Eligibility Process

☑ The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard.

☐ The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

☒ An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

An attachment is submitted.

☐ An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

Indicate which application the agency uses for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard:

☒ The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

An attachment is submitted.

☐ An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

An attachment is submitted.

The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

◉ Yes ○ No

Indicate the other electronic means below:

	Name of Method	Description	
+	Fax	State accepts faxed applications	X

☑ The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

Parents and Other Caretaker Relatives

Pregnant Women

Infants and Children under Age 19

Redetermination Processing

☑ Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 435.916:

■ Once every 12 months

■ Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency

■ If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

■ Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):

☒ Once every 12 months

☐ Once every 6 months

☐ Other, more often than once every 12 months

Coordination of Eligibility and Enrollment

☑ The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

PRA Disclosure Statement

IN - Submission Package - IN2022MS0001O - (IN-22-0001) - Eligibility

Medicaid State Plan Eligibility

Eligibility and Enrollment Processes

Continuous Eligibility for Pregnant Women and Extended Postpartum Coverage

MEDICAID | Medicaid State Plan | Eligibility | IN2022MS0001O | IN-22-0001

CMS-10434 OMB 0938-1188

Package Header

Package ID	IN2022MS0001O	**SPA ID**	IN-22-0001
Submission Type	Official	**Initial Submission Date**	3/29/2022
Approval Date	9/8/2022	**Effective Date**	4/1/2022
Superseded SPA ID	New		
	User-Entered		

The state provides continuous eligibility for pregnant individuals and extended postpartum coverage in accordance with the following provisions:

A. Mandatory Continuous Eligibility for Pregnant Women

The state provides continuous eligibility to pregnant individuals who were eligible and enrolled under the state plan, without regard to any changes in income that otherwise would result in ineligibility, through the last day of the month in which a 60-day postpartum period (beginning on the last day of the pregnancy) ends. This extension does not apply to pregnant individuals eligible only during a period of presumptive eligibility.

B. Optional 12-Month Postpartum Continuous Eligibility for Pregnant Women

The state provides continuous eligibility to pregnant individuals who were eligible and enrolled under the state plan while pregnant (including during a period of retroactive eligibility) through the last day of the month in which a 12-month postpartum period (beginning on the last day of the pregnancy) ends. The 12-month postpartum continuous eligibility option applies for the period beginning on the effective date of this reviewable unit and is available through March 31, 2027 (or other date as specified by law).

(•) Yes

( ) No

1. This extension does not apply to pregnant individuals eligible only during a period of presumptive eligibility.
2. Full benefits are provided for a pregnant or postpartum individual under this option. This includes all items and services covered under the state plan (or waiver) that are not less in amount, duration, or scope than, or are determined by the Secretary to be substantially equivalent to, the medical assistance available for an individual described in subsection 1902 (a)(10)(A)(i) of the Act.
3. Continuous eligibility is provided to pregnant individuals eligible and enrolled under the state plan through the end of the 12-month postpartum period who would otherwise lose eligibility because of a change in circumstances, unless:

    a. The individual requests voluntary termination of eligibility;

    b. The individual ceases to be a resident of the state;

    c. The Medicaid agency determines that eligibility was determined incorrectly at the most recent determination or redetermination of eligibility because of agency error or fraud, abuse or perjury attributed to the individual; or

    d. The individual dies.

C. Additional Information (optional)

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Alternative Benefit Plan

State Name: Indiana | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0024 | OMB Expiration date: 10/31/2014

Alternative Benefit Plan Populations — ABP1

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name: Healthy Indiana Plan (HIP) 2.0 Basic

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Adult Group	Mandatory	X

Enrollment is available for all individuals in these eligibility group(s). No

Targeting Criteria (select all that apply):

☒ Income Standard.

Income Standard:

◉ Income standard is used to target households with income at or below the standard.

○ Income standard is used to target households with income above the standard.

The income standard is as follows:

◉ A percentage:

○ A specific amount

- ○ Federal Poverty Level.
- ○ SSI Federal Benefit Amount.
- ◉ Other.

Enter the Other percentage: 100

Describe:

The HIP Basic Plan is only available for individuals up to and including 100% federal poverty level (FPL) as based on MAGI income standards who do not pay a contribution to their HIP Plus Personal Wellness and Responsibility (POWER) account.

A woman who becomes pregnant while enrolled in the HIP Basic Plan may choose to transfer to the pregnancy Medicaid aid category under the State Plan. If she stays in HIP Basic, she may keep her HIP Basic benefits through the term of the pregnancy and postpartum period. Pregnant women receive additional benefits in Basic that are only available to pregnant women. For pregnant women, there are no material differences in benefits between HIP Basic and the pregnancy Medicaid aid category under the State Plan. Women who are pregnant at their regularly scheduled redetermination are not eligible to remain in HIP Basic and are transfered to the pregnancy Medicaid aid category.

Alternative Benefit Plan

☐ Disease/Condition/Diagnosis/Disorder.

☒ Other.

Other Targeting Criteria (Describe):

New adult group members who are AI/AN and participate in the 1115 demonstration will be enrolled in the HIP Plus ABP with no POWER account contribution or cost-sharing requirements, regardless of FPL

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory. Yes

Any other information the state/territory wishes to provide about the population (optional)

Enrollment in the Alternative Benefit Plan (ABP) that is the HIP Basic Plan with Essential Health Benefits (EHBs) will include non-medically frail adults between the ages of 19 and 64 with income at or below 100% of the Federal Poverty Level (FPL). All HIP Basic enrollees will be eligible for the enhanced ABP that is the HIP Plus Plan with EHBs.

Individuals with income at or below 100% FPL are eligible for HIP Plus. If they do not make the POWER account payment then they default to the HIP Basic Plan. Educational information about the differences in benefits and cost-sharing structure between HIP Basic and HIP Plus are provided in all member communications from both the state and the MCEs. This includes but is not limited to eligibility notices, welcome letters, invoices, and member handbooks. Members can also receive information about the difference in the Basic and Plus plans from all call center staff including the state call centers, the enrollment broker, and the MCE call centers. The state also makes educational information available to members online.

PRA Disclosure Statement

V.20140415

Alternative Benefit Plan

State Name: Indiana | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0024 | OMB Expiration date: 10/31/2014

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

The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan. | No

These assurances must be made by the state/territory if the Adult eligibility group is included in the ABP Population.

☐ The state/territory shall enroll all participants in the "Individuals at or below 133% FPL Age 19 through 64" (section 1902(a)(10)(A)(i)(VIII)) eligibility group in the Alternative Benefit Plan specified in this state plan amendment, except as follows: A beneficiary in the eligibility group at section 1902(a)(10)(A)(i)(VIII) who is determined to meet one of the exemption criteria at 45 CFR 440.315 will receive a choice of a benefit package that is either an Alternative Benefit Plan that includes Essential Health Benefits and is subject to all 1937 requirements or an Alternative Benefit Plan that is the state/territory's approved Medicaid state plan not subject to 1937 requirements. The state/territory's approved Medicaid state plan includes all approved state plan programs based on any state plan authority, and approved 1915(c) waivers, if the state has amended them to include the eligibility group at section 1902(a)(10)(A)(i)(VIII).

☑ The state/territory must have a process in place to identify individuals that meet the exemption criteria and the state/territory must comply with requirements related to providing the option of enrollment in an Alternative Benefit Plan defined using section 1937 requirements, or an Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan that is not subject to section 1937 requirements.

☐ Once an individual is identified, the state/territory assures it will effectively inform the individual of the following:

a) Enrollment in the specified Alternative Benefit Plan is voluntary;

b) The individual may disenroll from the Alternative Benefit Plan defined subject to section 1937 requirements at any time and instead receive an Alternative Benefit Plan defined as the approved state/territory Medicaid state plan that is not subject to section 1937 requirements; and

c) What the process is for transferring to the state plan-based Alternative Benefit Plan.

☐ The state/territory assures it will inform the individual of:

a) The benefits available as Alternative Benefit Plan coverage defined using section 1937 requirements as compared to Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan and not subject to section 1937 requirements; and

b) The costs of the different benefit packages and a comparison of how the Alternative Benefit Plan subject to 1937 requirements differs from the Alternative Benefit Plan defined as the approved Medicaid state/territory plan benefits.

How will the state/territory inform individuals about their options for enrollment? (Check all that apply)

☒ Letter

☐ Email

☒ Other

Describe:

All eligibility notices to HIP members and any notices generated when a member reports changes will indicate how to report medically frail status to the managed care entity. The medically frail confirmation process will also be described in the member manual.

Provide a copy of the letter, email text or other communication text that will be used to inform individuals about their options for enrollment.

An attachment is submitted.

When did/will the state/territory inform the individuals?

Individuals will be informed of the medically frail self-report process in their initial eligibility notice and in all notices received when the member has reported a an eligibility change. The process will also be detailed the member manual. Individuals confirmed medically frail will be enrolled in the State Plan ABP.

Self-report of medically frail status is only one avenue for members to be confirmed frail. All individuals with an active disability determination by the Social Security Administration or a confirmed diagnoses of HIV/AIDS from the Indiana State Department of Health will be confirmed medically frail without having to self report their frail status. In addition, any member that has medical claims that confirm a medically frail condition throughout the year may be confirmed medically frail by their MCE without having to self-report their status.

Please describe the state/territory's process for allowing individuals in the Section 1902(a)(10)(A)(i)(VIII) eligibility group who meet exemption criteria to disenroll from the Alternative Benefit Plan defined using section 1937 requirements and enroll in the Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan.

Individuals that are confirmed to meet the medically frail criteria by their manged care entity will not receive the benefits described in the HIP Basic or HIP Plus ABPs and do not have the option to opt into these plans. They will receive the benefits on the State Plan ABP. These benefits will be provided through the same Managed Care Entities that provide the HIP Basic and HIP Plus ABPs . The benefits of the State Plan ABP offer additional benefits in excess of what is covered in HIP Basic and HIP Plus.

☐ The state/territory assures it will document in the exempt individual's eligibility file that the individual:

a) Was informed in accordance with this section prior to enrollment;

b) Was given ample time to arrive at an informed choice; and

c) Chose to enroll in Alternative Benefit Plan coverage subject to section 1937 requirements or defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

Where will the information be documented? (Check all that apply)

☐ In the eligibility system.

☐ In the hard copy of the case record.

☒ Other

Describe:

Confirmed medically frail individuals do not have the option to select the HIP Basic and Plus Plans, but will be automatically assigned to the State Plan ABP.

What documentation will be maintained in the eligibility file? (Check all that apply)

Alternative Benefit Plan

☐ Copy of correspondence sent to the individual.

☐ Signed documentation from the individual consenting to enrollment in the Alternative Benefit Plan.

☒ Other

Describe:

Confirmed medically frail individuals do not have the option to select the HIP Basic and Plus Plans that are the Alternative Benefit Plans (ABPs) with Essential Health Benefits, but will receive the benefits from the State Plan ABP.

☐ The state/territory assures that it will maintain data that tracks the total number of individuals who have voluntarily enrolled in either Alternative Benefit Plan coverage subject to section 1937 requirements or Alternative Benefit Plan coverage defined as the state/ territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

Other information related to benefit package selection assurances for exempt participants (optional):

Confirmed medically frail individuals will receive benefits that are in all ways equivalent to State Plan ABP benefits and offer benefits not covered through the HIP Basic and Plus ABPs. Therefore, medically frail individuals will not need to have the choice to opt into these two less generous plans.

PRA Disclosure Statement

V.20140415

Alternative Benefit Plan

State Name: Indiana | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0024 | OMB Expiration date: 10/31/2014

Enrollment Assurances - Mandatory Participants — ABP2c

These assurances must be made by the state/territory if enrollment is mandatory for any of the target populations or sub-populations.

When mandatorily enrolling eligibility groups in an Alternative Benefit Plan (Benchmark or Benchmark-Equivalent Plan) that could have exempt individuals, prior to enrollment:

☑ The state/territory assures it will appropriately identify any individuals in the eligibility groups that are exempt from mandatory enrollment in an Alternative Benefit Plan or individuals who meet the exemption criteria and are given a choice of Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan, not subject to section 1937 requirements.

How will the state/territory identify these individuals? (Check all that apply)

☒ Review of eligibility criteria (e.g., age, disorder/diagnosis/condition)

Describe:

Members with disability determination from the Social Security Administration or who have been confirmed as having HIV/ AIDS by the Indiana State Department of Health will be confirmed medically frail on initial determination of eligibility.

All eligibility notices to members indicate that members can report changes in their medical condition and medically frail status to their MCE.

☒ Self-identification

Describe:

Self-identification is one of the ways frail status is identified. The primary medically frail identification method is via claims as detailed in the Other section. Members may self-identify by requesting a review of their medically frail status with their managed care entities after initial enrollment in HIP. Members that request a review of their medically frail status are subject to a verification process utilizing the Milliman underwriting guidelines as detailed below.

Once a member self-identifies as medically frail the Managed Care Entity (MCE) will validate applicant data to confirm medically frail status. The managed care entity will have 30 days as required by contract to confirm if the member is medically frail. Managed care entities may identify members as medically frail via claims received during the 30 day verification process, and members receiving health services and using pharmaceuticals to treat their medically frail conditions will likely be identified before the end of the 30 day verification period.

Confirmation may occur through applicant interview or follow-up, current treatment (claims) and/or physician medical attestation documented medical records. Members are confirmed medically frail by the managed care entity when they have a documented medically frail condition and meet the following point thresholds using the Milliman Underwriting Guidelines:

- 150 combined debit points for indicated medical, mental, or behavioral health conditions; or,
- 75 debit points for indicated behavioral health conditions; or,
- 75 debit points for indicated substance abuse conditions; or,
- Needs assistance with one of the activities of daily living.

The debit point system above provides the minimal points a member would meet to be identified as medically frail. For example, individuals who are infected with the hepatitis C virus, but have no signs of the virus, receive no medications and have normal liver functions, will be assigned 50 debit points and not qualify as medically frail. However, an individual that has abnormal liver function will be assigned 150 debit points or higher for conditions such as cirrhosis of the liver at 650 debit

points. From these examples, an individual must meet 150 debit points or higher and have a condition listed on the medically frail condition listing to be considered as having a medical condition identified as medically frail. A person that has a medical condition that falls below the 150 threshold and/or is not a condition listed on the medically frail condition listing would not be considered medically frail. A medically frail determination would be effective for 12 months and after this time is required to be reverified and updated by the MCE. The debit point system, threshold range, and extensive tables of medical conditions each assigned debit points was developed from the Millliman Underwriting Guidelines and is the methodology that will be utilized to determine a medically frail identification.

To develop the debit point system, a code list and software tool from the medical ICD-9 codes and pharmacy NDC codes was used. The use of medical and pharmacy codes in assessing claims data allows for an automated process when screening individuals for medically frail conditions on an ongoing basis.

Members identified as medically frail will receive the State Plan ABP effective the first of the month following the confirmation of their medically frail status by the managed care entity.

Individuals have the right to appeal all medically frail determinations through the state, but must first exhaust the grievance process with their managed care entity.

☒ Other

Describe:

On an ongoing basis, health and pharmacy claims data and data from medical professionals including lab results will be used in the identification and conformation of medically frail status using an automated process. Similar to verification that occurs with the member request to review frail status, members that have pharmacy or medical claims that demonstrate conditions that may qualify them for medically frail status will have their claims checked against the Milliman Underwriting Guidelines. Those that have claims over the point threshold will automatically be designated as medically frail and receive the State Plan ABP. For individuals that do not meet the medically frail threshold based on claims alone, medical records, risk assessments and lab results may be utilized to verify medically frail status.

☐ The state/territory must inform the individual they are exempt or meet the exemption criteria and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

☐ The state/territory assures that for individuals who have become exempt from enrollment in an Alternative Benefit 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 or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

How will the state/territory identify if an individual becomes exempt? (Check all that apply)

☒ Review of claims data

☒ Self-identification

☒ Review at the time of eligibility redetermination

☒ Provider identification

☐ Change in eligibility group

☐ Other

Alternative Benefit Plan

How frequently will the state/territory review the Alternative Benefit Plan population to determine if individuals are exempt from mandatory enrollment or meet the exemption criteria?

- ○ Monthly
- ○ Quarterly
- ○ Annually
- ○ Ad hoc basis
- ◉ Other

Describe:

Managed Care entities may continually assess their enrolled population to determine if an individual has claims that qualify them for medically frail status. The Managed Care Entities will alert the state when an individual qualifies for medically frail status to initiate the activation of benefits of the State Plan ABP. On an annual basis all individuals marked medically frail must be reconfirmed as medically frail by their Managed Care Entity.

Managed care entities determination of frail status is subject to review and audit by the state.

☑ The state/territory assures that it will promptly process all requests made by exempt individuals for disenrollment from the Alternative Benefit Plan and has in place a process that ensures exempt individuals have access to all standard state/territory plan services or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

Describe the process for processing requests made by exempt individuals to be disenrolled from the Alternative Benefit Plan:

Individuals that meet the medically frail criteria will not receive the HIP Basic and HIP Plus benefits described in the Alternative Benefit Plans (ABPs) and do not have the option to opt into these plans, because they do not contain enhanced benefits. Individuals that are confirmed as medically frail will be enrolled in the State Plan ABP. The benefits of the State Plan ABP as provided to HIP eligible individuals through managed care are at least as generous as the HIP Basic and Plus benefits in each benefit offered and offer additional benefits in excess of what is covered in these plans.

Other Information Related to Enrollment Assurance for Mandatory Participants (optional):

To ensure accurate and fair identification methods are in place when determining a member's medical condition, such as medically frail, the state will establish an oversight process. The State utilizes external quality control measures to ensure proper identification for medically frail individuals. The type of quality control measures utilized depends on the frail identification method used by the MCE. When the MCE identifies a member as medically frail, they must document and notify the State. The notification must include (1) the medically frail designation; (2) the date of the determination; and (3) the method used to make the medically frail determination. The following outlines the State audit procedures based on the identification method used.

• MCE identifies member as medically frail based on the Milliman Underwriting Guidelines by using the Milliman tool that conducts analysis of claims data. This can be done at any time. The tool analyzes claims to determine if the member has accrued sufficient debit points to meet the debit point thresholds that designate a member as frail. The State will review the determination and claims data on an ongoing basis throughout the enrollment period, however, determinations made by the MCEs through the use of the Milliman tool based on member claims are considered to be non-partial.

• MCE identifies member as medically frail based on supplemental data. All supplemental data used to support a frail designation must be indexed to the Milliman Underwriting Guidelines. The Milliman tool provides an automated way to analyze claims for indications of frail status, however if claims have not yet been filed, the Milliman Underwriting Guidelines may also be met through a manual process. When meeting the Milliman Underwriting Guidelines points thresholds through a manual process, the MCE must complete a generic

description of the information utilized by the MCE to support the medically frail designation. This information will be reviewed by the State or its designated vendor to independently confirm these medically frail designations. The State will also conduct audits of the MCE's medically frail determinations to ensure the Milliman Underwriting Guidelines are appropriately applied.

Medically frail audits will include review of non-claim data to form a complete picture of the health of the member. This data review could include, but not be limited to: output files from the Milliman Renewal MUGs tool indicating the number of debit points the member accumulated; completed Health Risk Assessments; documentation of attempts to make contact with their member and/or physician(s); recorded responses and supporting information indicating member impairment in Activities of Daily Living (ADLs); and supplemental information gathered by the MCE in order to make a complete decision (such as lab results, physician notes or lifestyle factors). To ensure accurate and timely review of members, the State will also monitor the average time and determination completion rate for each MCE as well as complete in depth reviews surrounding member state appeals (e.g. rate of appeals, appeals outcome statistics, number of State Fair Hearings requested) and Internet Queries (IQs).

In addition, to the specific methods described, the State's MCE audit procedures are ongoing. The State will conduct regular audits of the MCE's Medically Frail Supplemental File to determine and verify appropriate placement of medically frail members including the use of Milliman Underwriting Guidelines. If the member does not meet the medically frail criteria based upon the State's review, the State will request additional information from the MCE. The State anticipates that approximately ten percent (10%) of the total HIP population will be designated as medically frail. If at any time the State finds that a significant amount more or less than ten percent (10%) of an MCE's total HIP population is designated as medically frail, the State will initiate a random audit of the MCE population to ensure that the Milliman Underwriting Guidelines are being applied appropriately or supporting data was used properly. If any MCE is found to have a consistent issue applying the Milliman Underwriting Guidelines in a uniform fashion, the State's will take the appropriate corrective actions.

The State's oversight processes, as explained, focus on ensuring the member receives the proper health services needed which include the appropriate health designation.

PRA Disclosure Statement

V.20140415

Alternative Benefit Plan

State Name: Indiana | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0024 | OMB Expiration date: 10/31/2014

Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package — ABP3

Select one of the following:

- ○ The state/territory is amending one existing benefit package for the population defined in Section 1.
- ◉ The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package: HIP Basic Plan

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

- ◉ Benchmark Benefit Package.
- ○ Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

- ○ The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).
- ○ State employee coverage that is offered and generally available to state employees (State Employee Coverage):
- ○ A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):
- ◉ Secretary-Approved Coverage.
  - ○ The state/territory offers benefits based on the approved state plan.
  - ◉ The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.

Please briefly identify the benefits, the source of benefits and any limitations:

Indiana will use benefits from the largest commercial HMO by enrollment that was a plan option for the State's commercial EHB benchmark. The commercial HMO selected as the base benchmark plan for the HIP Basic ABP complies with the regulations set forth for alternative health benefit plans under §440.347 as related to the essential health benefits (EHBs). The state's methodology in selecting the plan design was to ensure the benefits of the ABP that is the State Plan are at least as generous as the HIP Basic and Plus benefits. The HIP Basic Plan provides limited coverage that excludes dental and vision services, except as required under EPSDT. The formulary for the prescription drug benefit must support the coverage and non-coverage requirements for legend drugs by Indiana Medicaid, found in 405 IAC 5-24-3. The HIP Basic ABP offers additional benefits beyond the base benchmark for pregnant women. If a woman becomes pregnant, she will have the option to maintain her current HIP Basic Plan benefits with extended services for pregnant women.

Selection of Base Benchmark Plan

The state/territory must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

Alternative Benefit Plan

The Base Benchmark Plan is the same as the Section 1937 Coverage option. No

Indicate which Benchmark Plan described at 45 CFR 156.100(a) the state/territory will use as its Base Benchmark Plan:

- ○ Largest plan by enrollment of the three largest small group insurance products in the state's small group market.
- ○ Any of the largest three state employee health benefit plans by enrollment.
- ○ Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- ◉ Largest insured commercial non-Medicaid HMO.

Plan name: Advantage 1001

Other Information Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional):

The state assures that all services in the base benchmark have been accounted for throughout the benefit chart in ABP5. The state assures the accuracy of all information in ABP5 depicting amount, duration and scope parameters of services authorized in the current approved Medicaid state plan and covered on the selected base benchmark plan.

PRA Disclosure Statement

V.20140415

Alternative Benefit Plan

State Name: Indiana | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0024 | OMB Expiration date: 10/31/2014

Alternative Benefit Plan Cost-Sharing **ABP4**

☐ Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A. Yes

☐ The state/territory has completed and attached to this submission Attachment 4.18-F to indicate the Alternative Benefit Plan's cost-sharing provisions that are different from those otherwise approved in the state plan.

An attachment is submitted.

Other Information Related to Cost Sharing Requirements (optional):

A description of the cost sharing requirements for the HIP Basic Plan are contained in Indiana's HIP 2.0 1115 Demonstration.

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.

V.20140415

Alternative Benefit Plan

State Name: Indiana

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: IN - 22 - 0009

Benefits Description ABP5

The state/territory proposes a "Benchmark-Equivalent" benefit package. No

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

Base Benchmark Commercial HMO
Advantage HMO
Basic Plan

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary-Approved

Alternative Benefit Plan

■ 1. Essential Health Benefit: Ambulatory patient services Collapse All ☐

Benefit Provided: Primary Care Physician (PCP) Services Office Visit
Source: Base Benchmark Commercial HMO
Remove
Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Office visit services include supplies for treatment of the illness or injury, medical consultations, procedures performed in the physician's office, second opinion consultations and specialist treatment services provided by a PCP.

For second opinion consultations, the Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Specialty Physician Visits
Source: Base Benchmark Commercial HMO
Remove
Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Referral Physician Office Visit included.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Home Health Services
Source: Secretary-Approved Other
Remove
Authorization: Other
Provider Qualifications: Medicaid State Plan

Amount Limit:
100 visits per year

Duration Limit:
None

Scope Limit:
Services covered only if not considered custodial care and are prescribed in writing by a participating physician as medically necessary, in place of inpatient hospital care or convalescent nursing home and services provided under physician's care.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Services include skilled medical services; nursing care given or supervised by RN; nutritional counseling furnished or supervised by RD; home hospice services; home health aides; laboratory services, drugs, and medicines prescribed by a physician in connection with home health care; and medical social services. Home hospice services are considered a separate service.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Outpatient Surgery

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Outpatient medical and surgical hospital services are covered when medically necessary. Includes diagnostic invasive procedures that may or may not require anesthesia.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Allergy Testing

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Alternative Benefit Plan

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes allergy procedures-administration of serum

Remove

Benefit Provided:

Chemotherapy-Outpatient

Source:

Base Benchmark Commercial HMO

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes outpatient therapeutic injections which are medically necessary and may not be self-administered. For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided:

IV Infusion Services

Source:

Base Benchmark Commercial HMO

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes coverage for outpatient infusion therapy.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Alternative Benefit Plan

Remove

Benefit Provided: Radiation Therapy- Outpatient

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes coverage for outpatient services.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided: Dialysis

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage provided for outpatient (including home) dialysis services provided by a participating provider. For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Remove

Benefit Provided: Outpatient Services

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes colonoscopy and pacemaker. Benefits provided are PCP, specialty and referral for all physician services in an outpatient facility.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Dental- Limited Covered Services- Accident/Injury

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Treatment complete within 1 year from initiation

Duration Limit:

None

Scope Limit:

Coverage not provided for orthodontia, dental procedures, repair of injury caused by an intrinsic force, such as the force of the upper and lower jaw in chewing, repair of artificial teeth, dentures or bridges and other dental services.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Injury to sound and natural teeth including teeth that have been filled, capped or crowned.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, to report injury to insurer and receive follow-up care within specified timeframe, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Urgent Care- Walk-ins

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage includes after hours care.

Benefit Provided: Routine Foot Care

Source: Secretary-Approved Other

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: 6 visits per year

Duration Limit: None

Scope Limit:

Coverage not provided for supportive devices of the feet, including but not limited to foot orthotics, corrective shoes, arch supports for the treatment of plantar fasciitis, flat feet, fallen arches, weak feet, chronic foot strain, corns, bunions

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Scope limit continued- and calluses.
Covered when medically necessary for the treatment of diabetes and lower extremity circulatory diseases. For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Voluntary Sterilization for Males

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Clinical Trials for Cancer Treatment

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Items and services that are not routine care costs or unrelated to the care method will not be covered.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

The clinical trial must be approved or funded by one of the following: National Institute of Health; cooperative group of research facilities that have an established peer review program that is approved by a National Institute of Health or center; FDA; United States Department of Veterans Affairs; United States Department of Defense; institutional review board of an institution located in Indiana that has a multiple project assurance contract approved by the National Institute of the Office for Human Research Protections; and research entity that meets eligibility criteria for a support grant from a National Institutes of Health center.

Coverage provided for routine care costs that are incurred in the course of a clinical trial.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, review of clinical trial to ensure qualified, review of routine costs related to clinical trial and a justification of services rendered for the medical needs of the member.

Add

Alternative Benefit Plan

■ 2. Essential Health Benefit: Emergency services

Collapse All ☐

Benefit Provided: Emergency Department Services

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Medical care provided outside of the U.S. is not covered

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Emergency room included.

Benefit Provided: Emergency Transportation: Ambulance/Air Ambulance

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Other medically necessary ambulance transport (ambulance, medi-van or similar medical ground, air or water transport to or from the hospital or both ways and transfer from a hospital to a lower level of care) is covered.

For other medically necessary transportation, authorization may be required in which the Managed Care Entities (MCEs) may require other details, such as general member information, to contact PCP for other types of transportation related services and a justification of services rendered for the medical needs of the member.

Add

Alternative Benefit Plan

☑ 3. Essential Health Benefit: Hospitalization Collapse All ☐

Benefit Provided: General Inpatient Hospital Care

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Benefit does not include personal comfort items, including those services and supplies not directly related to care, such as guest meals, accommodations or personal hygiene products, and room and board when temporary leave permitted.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services include semi-private room and board (private room provided when medically necessary); intensive care unit/coronary care unit; inpatient cardiac rehabilitation and rehabilitation therapy; general nursing care; use of operating room or delivery suite; surgical and anesthesia services and supplies; ordinary casts; splints and dressings; drugs and oxygen used in hospital; laboratory and x-ray examinations; electrocardiograms; special duty nursing (when requested by a physician and certified as medically necessary); and inpatient specialty pharmaceuticals.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, review of medical necessity, authorization by acting physician, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Inpatient Physician Services

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit includes PCP, specialty and may require a referral for physician services in the hospital.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Alternative Benefit Plan

Remove

Benefit Provided: Inpatient Surgical Services

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Benefit does not include bariatric surgery, surgical and nonsurgical treatment of TMJ, personal comfort items, including those services and supplies not directly related to care, such as guest meals, accommodations or personal hygiene products,

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Scope Limit continued- and room and board when temporary leave permitted.

Surgical hospital services are covered when medically necessary. Services include semi-private room and board (private room provided when medically necessary); intensive care unit/coronary care unit; general nursing care; use of operating room or delivery suite; surgical and anesthesia services and supplies; ordinary casts; splints and dressings; drugs and oxygen used in hospital; laboratory and x-ray examinations; electrocardiograms; special duty nursing (when requested by a physician and certified as medically necessary); and inpatient specialty pharmaceuticals.

Surgical operations may include replacement of diseased tissue removed while a member.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided: Non-cosmetic Reconstructive Surgery

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: Services begin within 1 year of the accident

Duration Limit: None

Scope Limit:

Benefit does not include personal comfort items, including those services and supplies not directly related to care, such as guest meals, accommodations or personal hygiene products, and room and board when temporary leave permitted.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Surgical hospital services are covered when medically necessary and approved by physician. Reconstructive procedures performed to restore or improve impaired physical function or defects resulting from an accident.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided: Mastectomy- Reconstructive Surgery

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Benefit does not include personal comfort items, including those services and supplies not directly related to care, such as guest meals, accommodations or personal hygiene products, and room and board when temporary leave permitted.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Surgical hospital services are covered when medically necessary and approved by physician. Covered services include reconstruction of the breast upon which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications at all stages of mastectomy, including lymphedemas.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided: Transplants

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Human organ and tissue transplant services for both the recipient and the donor, when the recipient is a member. No coverage is provided for the donor or the recipient when the recipient is not a member. Specialty Care Physician (SCP) provides pre-transplant evaluation. Non-experimental, non-investigational organ and other transplants are covered. Donor's medical expenses covered if the person receiving the transplant is a member, and donor's expenses are not covered by another issuer.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided: Congenital Abnormalities

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Benefit does not include personal comfort items, including those services and supplies not directly related to care, such as guest meals, accommodations or personal hygiene products, and room and board when temporary leave permitted.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Surgical hospital services are covered when medically necessary and approved by physician.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided: Anesthesia

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage includes anesthesia services and supplies.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Alternative Benefit Plan

Benefit Provided: Hospice Care

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Room and board services are not covered when temporary leave permitted.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

This benefit may be provided in hospitals, skilled nursing facilities, and freestanding hospice centers. Covered services include semi-private room (private room provided when medically necessary). Hospice care provided if terminal illness, in accordance with a treatment plan before admission to the program. Treatment plan must provide statement from physician that life expectancy is 6 months or less. Concurrent care is provided to children (19 & 20 year olds).

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Medical Social Services

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Hospital services to assist member and family in understanding and coping with the emotional and social problems affecting health status.

Benefit Provided: Dialysis

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Inpatient dialysis services provided by a participating provider.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Chemotherapy

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes coverage for inpatient services.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Radiation Therapy

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes coverage for inpatient services.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as

general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Add

Alternative Benefit Plan

☑ 4. Essential Health Benefit: Maternity and newborn care

Collapse All ☐

Benefit Provided:
Obstetric Care

Source:
State Plan 1905(a)

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Limits equivalent to State Plan

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage is provided from the State Plan under the physician benefit and includes various obstetrical services such as antepartum and postpartum visits, laboratory and x-ray (ultrasound) services and other services as medically necessary and appropriate. The benefit provides for antepartum services up to 14 visits for normal pregnancies. High-risk pregnancies may allow for additional visits. Postpartum services includes 2 visits within 60 days of delivery.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Add

Alternative Benefit Plan

Collapse All ☐

■ 5. Essential Health Benefit: Mental health and substance use disorder services including behavioral health treatment

☑ The state/territory assures that it does not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.

Remove

Benefit Provided: Mnetal/Behavioral Health Inpatient

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Benefit does not include hypnotherapy, behavioral modification, or milieu therapy when used to treat conditions that are not recognized as mental disorders; personal comfort items; and room and board when temporary leave available

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefits include evaluation and treatment in a psychiatric day facility and electroconvulsive therapy. Coverage may also include partial hospitalization depending on the type of services provided.
These services are not provided through institutions of mental disease (IMDs).

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided: Mental/Behavioral Health Outpatient

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Coverage does not include self-help training or other related forms of non-medical self care; marriage counseling; hypnotherapy, behavioral modification, or milieu therapy when used to treat conditions that are not recognized as mental disorders.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage applies to individual therapy and group therapy sessions. Benefit may also include partial hospitalization depending on the type of services provided.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as

general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided: Substance Abuse Inpatient Treatment

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: up to 15 days in a calendar month

Duration Limit: None

Scope Limit:

Members 21 through 64 years of age in facilities that qualify as institutions for mental disease. Members can be authorized for up to 15 days in a calendar month.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit does not include services and supplies for the treatment of co-dependency or caffeine addiction; personal comfort items; and room and board when temporary leave permitted.

Benefit includes detoxification for alcohol or other drug addiction. Coverage may also include partial hospitalization depending on the type of services provided.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided: Substance Abuse Outpatient Treatment

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Benefit does not include services and supplies unrelated to mental health for the treatment of codependency or caffeine addiction.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage includes detoxification for alcohol or other drug addiction. Benefit may also include partial hospitalization depending on the type of services provided.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of

treatment.

Add

■ 6. Essential Health Benefit: Prescription drugs

☑ The state/territory assures that the ABP prescription drug benefit plan is the same as under the approved Medicaid State Plan for prescribed drugs.

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):	Authorization:	Provider Qualifications:
☒ Limit on days supply	Yes	State licensed
☒ Limit on number of prescriptions		
☒ Limit on brand drugs		
☒ Other coverage limits		
☒ Preferred drug list		

Coverage that exceeds the minimum requirements or other:

The prescription drug benefit will cover at least one drug in every category and class or the number of drugs covered in each category and class as the base benchmark, whichever is greater. The formulary must support the coverage and non-coverage requirements for legend drugs by Indiana Medicaid, found in 405 IAC 5-24-3. In addition, the exact drugs covered under the formulary may vary by the Managed Care Entities (MCEs). Prescription supply is limited to 90 days.

For authorization, Managed Care Entities may require prior authorization requirements, such as general member information, a justification of need for Rx related to the medical needs of the member and a planned course of treatment, if applicable, as related to the number Rx provided and duration of treatment. Prior authorization requirements for prescription drugs may vary by MCE, but will comply with Mental Health Parity requirements. MCEs will be required to have a process in place to allow drugs that are medically necessary, but not included on the formulary to be accessed by members.

Alternative Benefit Plan

☑ 7. Essential Health Benefit: Rehabilitative and habilitative services and devices — Collapse All ☐

☑ The state/territory assures that it is not imposing limits on habilitative services and devices that are more stringent than limits on rehabilitative services (45 CFR 156.115(a)(5)(ii)). Further, the state/territory understands that separate coverage limits must also be established for rehabilitative and habilitative services and devices. Combined rehabilitative and habilitative limits are allowed, if these limits can be exceeded based on medical necessity.

Remove

Benefit Provided: Physical Therapy, Occupational Therapy, Speech The

Source: Secretary-Approved Other

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: 60 combined visits annually.

Duration Limit: None

Scope Limit:

Rehabilitative and habilitative services are offered at parity and have distinct benefit limits. Coverage does not include nonsurgical treatment of TMJ.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Amount limit continued- As an outpatient benefit, coverage is limited to 60 combined visits annually for PT, OT, ST, cardiac and pulmonary rehabilitation.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Remove

Benefit Provided: Durable Medical Equipment (DME)

Source: Secretary-Approved Other

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: 15 mo rental cap;1 every 5 yr per member- replac

Duration Limit: None

Scope Limit:

DME does not include corrective shoes, arch supports, dental prostheses, deluxe equipment, common first aid supplies and non-durable supplies. Other non-covered services include but not limited to equipment not suitable for home use.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit includes but not limited to wheel chairs, crutches, respirators, traction equipment, hospital beds, monitoring devices, oxygen-breathing apparatus and insulin pumps. Training for use of DME is also covered and applicable rental fees. Covered services are only for the basic type of DME necessary to provide for medical needs and does not include non-durable supplies that are not an integral part of the DME set-up.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided: Prosthetics

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Benefit does not include foot orthotics, devices solely for comfort or convenience and devices from a nonaccredited provider.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

A prosthetic device means an artificial arm or leg or any portion thereof. Orthotic devices are also covered under this benefit as custom fabricated braces or supports designed as a component of an artificial arm or leg. Covered services include the purchase, replacement or adjustment of artificial limbs when required due to a change in your physical condition or body size due to normal growth.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Remove

Benefit Provided: Corrective Appliances

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Benefit does not include but not limited to artificial or prosthetic limbs, cochlear implants, dental appliances, dentures, foot orthotics, corrective shoes, arch supports for plantar fasciitis, flat feet, fallen arches and corns.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit must be medically necessary and used to restore function or to replace body parts. Benefit includes but not limited to hemodialysis equipment, breast prostheses, back braces, artificial eyes, one pair eyeglasses due to cataract surgery, ostomy supplies and prosthetics (all prosthetics except prosthetic limbs). Coverage not intended for non-durable appliances.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Cardiac Rehabilitation

Source: Secretary-Approved Other

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: 60 combined visits annually.

Duration Limit: None

Scope Limit: Rehabilitative services are offered at parity and share the same, comparable benefit limits.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Amount limit continued- As an outpatient benefit, coverage is limited to 60 combined visits annually for PT, OT, ST and pulmonary rehabilitation.

Benefit includes services for the improvement of cardiac disease or dysfunction.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Medical Supplies

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Benefit does not include non-durable supplies and/or convenience items.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit includes casts, dressings, splints and other devices used for reduction of fractures and dislocations

Benefit Provided: Pulmonary Rehabilitation

Source: Secretary-Approved Other

Remove

Alternative Benefit Plan

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
60 combined visits annually

Duration Limit:
None

Scope Limit:
Benefit does not include formalized and pre-designed rehabilitation programs for pulmonary conditions. Rehabilitative services are offered at parity and share the same, comparable benefit limits.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Amount limit continued- As an outpatient benefit, coverage is limited to 60 combined visits annually for PT, OT, ST and cardiac rehabilitation.

Benefit consists of services that are for the improvement of pulmonary disease or dysfunction that has a poor response to treatment. Examples of poor response include but are not limited to patients with respiratory failure, frequent emergency room visits, progressive dyspnea, hypoxemia or hypercapnia. For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Skilled Nursing Facility (SNF)

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
100 days per benefit period.

Duration Limit:
None

Scope Limit:
A SNF does not include any institution or portion of any institution that is primarily for rest, the aged, nonskilled care, or care of mental diseases or substance abuse. Room and board services are not covered when temporary leave permitted.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Covered services include semi-private room (private room provided when medically necessary), drugs, specialty pharmaceuticals, medical social services, short term physical, speech, occupational therapies (subject to limits) and other services generally provided.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Autism Spectrum Disorder Services

Source:
Secretary-Approved Other

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
60 combined visits annually.

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Amount limit continued- As an outpatient benefit, coverage is limited to 60 combined visits annually for PT, OT, ST, cardiac and pulmonary rehabilitation.

Benefit, formerly known as Pervasive Development Disorder (PDD), is a state mandate that must be covered as outlined in the Indiana insurance code.

Benefit provides coverage for Asperger's syndrome and autism. Coverage for services are provided as prescribed by the treating physician in accordance with the treatment plan.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Hearing Aids

Source:
State Plan 1905(a)

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
1 per member every 5 years.

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Medically frail populations will receive State Plan benefits.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Home Health:Medical Supplies, Equipment and Applia

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Benefit does not include non-durable supplies and/or convenience items.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefits include medical supplies in connection with home health care.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Benefit Provided:
Inpatient Cardiac Rehabilitation

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
90 days annual maximum.

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit includes services for the improvement of cardiac disease or dysfunction.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Inpatient Rehabilitation Therapy

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
90 days annual maximum

Duration Limit:
None

Alternative Benefit Plan

Scope Limit:

Rehabilitative and habilitative services are offered at parity and share the same, comparable benefit limits.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage includes physical, occupational, speech and pulmonary therapy of acute illness or injury to the extent that significant potential exists for progress toward a previous level of functioning.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Add

Alternative Benefit Plan

■ 8. Essential Health Benefit: Laboratory services — Collapse All ☐

Benefit Provided: Lab Tests
Source: Base Benchmark Commercial HMO
Remove
Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Coverage does not include lab expenses related to physical exams when provided for employment, school, sports' programs, travel, immigration, administrative purposes or insurance purposes.
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Benefit provided as outpatient services when medically necessary.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: X-Rays
Source: Base Benchmark Commercial HMO
Remove
Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Coverage does not include x-ray expenses related to physical exams when provided for employment, school, sports' programs, travel, immigration, administrative purposes or insurance purposes.
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Benefit provided as outpatient services when medically necessary.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Imaging- MRI, CT, and PET
Source: Base Benchmark Commercial HMO
Remove
Authorization: Other
Provider Qualifications: Medicaid State Plan

Alternative Benefit Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit provided as outpatient services when medically necessary. Coverage also includes MRA and SPECT scan.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Pathology

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit provided as outpatient services when medically necessary.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Radiology

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit provided as outpatient services when medically necessary.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: EKG and EEG

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit provided as outpatient services when medically necessary.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Add

Alternative Benefit Plan

■ 9. Essential Health Benefit: Preventive and wellness services and chronic disease management Collapse All ☐

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Remove

Benefit Provided: Preventive Care Services

Source: Base Benchmark Commercial HMO

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Physician services for wellness and preventive services include but are not limited to routine physical exam, routine total blood cholesterol screening, routine gynecological services and routine immunizations. Includes (1) all preventive items or services that have a rating of 'A' or 'B' by the United States Preventive Task Force (USPSTF); (2) Immunizations recommended for the individuals age and health status by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC); (3) for infants, children, adolescents and adults, preventive care and screenings included in the Health Resources and Services Administration's (HRSA) Bright Futures comprehensive guidelines; and (4) preventive screenings for women as recommended by the Institute of Medicine (IOM).

Remove

Benefit Provided: Diabetes Self Management Training

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Covered services are limited to physician authorized visits after receiving a diagnosis of diabetes; after receiving a diagnosis that represents a significant change in symptoms or condition and there is a medically necessary change in self-management; and for re-education or refresher training.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Alternative Benefit Plan

Benefit Provided: Health Education

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: 3 visits

Duration Limit: None

Scope Limit:

Classes in nutrition or smoking cessation will be approved up to 3 visits when referred by your physician

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit provided by the PCP as part of preventive health care and other health education classes approved by the insurer.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Routine Prostate Specific Antigen (PSA) Test

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

One test annually for an individual who is at least 50 years old or less than 50 if at high risk for prostate cancer.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

None

Add

Alternative Benefit Plan

☑ 10. Essential Health Benefit: Pediatric services including oral and vision care

Collapse All ☐

Remove

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
State Plan 1905(a)

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
EPSDT is required in the ABP for 19 and 20 year olds.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services provided under EPSDT may include preventive and diagnostic services that are medically necessary and may need continued treatment.

In accordance with CMS regulation, individuals covered under EPSDT are not subject to the IMD exclusion

Add

☐ 11. Other Covered Benefits from Base Benchmark Collapse All ☒

☒ 12. Base Benchmark Benefits Not Covered due to Substitution or Duplication Collapse All ☐

Base Benchmark Benefit that was Substituted: Infertility Diagnoses: substitution
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Infertility Diagnoses benefit offered in the base benchmark was removed and replaced in EHB 1 by substitution with part of the actuarial value of Male Sterilization procedures which are not covered on the base benchmark. Coverage for voluntary Male Sterilization procedures comes from the coverage provided on the State Plan.

Base Benchmark Benefit that was Substituted: Routine Foot Care: substitution
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

The benefit is covered. A more restrictive limit of 6 visits per year was added. In EHB 1, this has been substituted with the remaining actuarial value from the male sterilization benefit. There is no limit on Routine Foot Care in the base benchmark.

Base Benchmark Benefit that was Substituted: Home Health Services: substitution
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

The benefit is covered. Within the benefit, training of family members to provide home health services is a non-covered benefit. In EHB 1, this sub-benefit was substituted with the actuarial value remaining from the male sterilization benefit.

Base Benchmark Benefit that was Substituted: Urgent Care-Walkins: substitution
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

The benefit is covered. Within the benefit, physician home visits is a non-covered benefit. In EHB 1, this sub-benefit was substituted with the actuarial value remaining from the male sterilization benefit.

Base Benchmark Benefit that was Substituted: Maternity Services: duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was duplicated with the Medicaid State Plan Obstetric benefit in EHB 4.

Base Benchmark Benefit that was Substituted: Maternity - Delivery: duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was duplicated with the Medicaid State Plan Obstetric benefit in EHB 4.

Base Benchmark Benefit that was Substituted: Durable Medical Equipment (DME): substitution

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

The benefit is covered. The limits for a 15 month rental cap and 5 year replacement for equipment were added. In EHB 7, this has been substituted with the actuarial value remaining from adding hearing aids as a benefit from the State Plan. There is no limit on Durable Medical Equipment in the base benchmark.

Base Benchmark Benefit that was Substituted: PT, OT, ST: substitution

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

The benefit is covered. Within the benefit, the service limits are covered as an annual limit combined for therapies. In EHB 7, the service limits for limits per condition have been substituted with the actuarial value remaining from adding hearing aids as a benefit from the State Plan. The base benchmark allows for 60 combined visits per distinct condition or episode.

Base Benchmark Benefit that was Substituted: Cardiac Rehabilitation: substitution

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

The benefit is covered. Within the benefit, the service limits are covered as an annual limit combined for therapies. In EHB 7, the service limits for limits per condition have been substituted with the actuarial value remaining from adding hearing aids as a benefit from the State Plan. The base benchmark allows for 60 combined visits per distinct condition or episode.

Base Benchmark Benefit that was Substituted: Pulmonary Rehabilitation: substitution

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

The benefit is covered. Within the benefit, the service limits are covered as an annual limit combined for therapies. In EHB 7, the service limits for limits per condition have been substituted with hearing aids. In addition, formalized and pre-designed rehabilitation programs for pulmonary conditions have also been substituted with hearing aids. Both substitutions were completed with the actuarial value remaining from adding hearing aids as a benefit from the State Plan. The base benchmark allows for 60 combined visits per distinct condition or episode.

Alternative Benefit Plan

Base Benchmark Benefit that was Substituted: Autism Spectrum Disorder Services: substitution

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

The benefit is covered. Within the benefit, the service limits are covered as an annual limit combined for therapies. In EHB 7, the service limits for limits per condition have been substituted with the actuarial value remaining from adding hearing aids as a benefit from the State Plan. The base benchmark allows for 60 combined visits per distinct condition or episode.

Base Benchmark Benefit that was Substituted: Applied Behavior Analysis: substitution

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

In EHB 7, ABA has been substituted with the actuarial value remaining from adding hearing aids as a benefit from the State Plan.

Base Benchmark Benefit that was Substituted: Non-Surgical Treatment Option Morbid Obesity: dupl

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

In EHB 9, the benefit is covered under preventive and wellness services. The ACA preventive services provides coverage above the benefit limits.

Add

Alternative Benefit Plan

☒ 13. Other Base Benchmark Benefits Not Covered Collapse All ☐

Base Benchmark Benefit not Included in the Alternative Benefit Plan: Adult Vision
Source: Base Benchmark
Remove

Explain why the state/territory chose not to include this benefit:
Adult vision is covered in the base benchmark plan, but it is an excepted benefit and therefore not an Essential Health Benefit.

Base Benchmark Benefit not Included in the Alternative Benefit Plan: Newborn Child Coverage
Source: Base Benchmark
Remove

Explain why the state/territory chose not to include this benefit:
Benefit is excluded since the ABP is for ages 19-64. Newborns born to members will be covered through Medicaid for children. The newborn coverage includes the initial newborn examinations.

Base Benchmark Benefit not Included in the Alternative Benefit Plan: Emergency Services Outside the U.S.
Source: Base Benchmark
Remove

Explain why the state/territory chose not to include this benefit:
Emergency care provided outside the U.S. is covered in the base benchmark plan. Non-emergency services are not covered. To conform with Medicaid standards, the benefit will not be covered in the ABP.

Base Benchmark Benefit not Included in the Alternative Benefit Plan: Lodging and Transportation for Transplants (Donor)
Source: Base Benchmark
Remove

Explain why the state/territory chose not to include this benefit:
Transportation and lodging services for the donor are covered under the base benchmark plan subject to a dollar limit, these services are not considered an EHB and are considered a non-covered benefit for the ABP.

Add

Alternative Benefit Plan

☒ 14. Other 1937 Covered Benefits that are not Essential Health Benefits Collapse All ☐

Other 1937 Benefit Provided: Chiropractic Care - Pregnancy Benefit

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: Limits equivalent to State Plan

Duration Limit: None

Scope Limit: None

Other:

Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. Coverage provided is subject to program restrictions.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Other 1937 Benefit Provided: Non-emergency Transportation - Pregnancy Benefit

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other:

Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. Coverage provided is subject to program restrictions.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment

Other 1937 Benefit Provided: Medicaid Rehabilitation Option (MRO)- Pregnancy Be

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. MRO services are designed to assist in the rehabilitation of the consumer‘s optimum functional ability in daily living activities.

Other 1937 Benefit Provided:
Dental Services - Pregnancy Benefit

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Limits equivalent to State Plan

Duration Limit:
None

Scope Limit:
None

Other:
Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. The dental benefits include State Plan equivalent benefits.

For authorization, the dental insurer may require prior authorization requirements, such as general member information and a justification for the type of dental services rendered based on the medical needs of the member

Other 1937 Benefit Provided:
TMJ - Pregnancy Benefit

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:

Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. Coverage includes treatment of temporomandibular joint (TMJ) disorder.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, documentation of non-surgical treatment and duration prior to surgery and a justification of services rendered for the medical needs and circumstances of the member.

Other 1937 Benefit Provided: Adult Vision - Pregnancy Benefit

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: Limits equivalent to the State Plan

Duration Limit: None

Scope Limit: None

Other:

Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. The benefits include State Plan equivalent benefits.

For authorization, the vision insurer may require prior authorization requirements, such as general member information and a justification for the type of vision services rendered based on the medical needs of the member.

Other 1937 Benefit Provided: Health Education - Smoking Cess -Pregnancy Benefit

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: 12 week course

Duration Limit: None

Scope Limit: None

Other:

Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. The benefit includes up to 12 weeks in a smoking cessation course providing treatment and counseling.
For authorization, the Managed Care Entity (MCE) may require prior authorization requirements, such as general member information and a justification for the type of services rendered based on the medical needs of the member.

Other 1937 Benefit Provided:
Osteopathic Manipulative Treatment (OMT)

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
State Plan benefit.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Other 1937 Benefit Provided:
Residential Treatment

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:

Duration Limit:

Scope Limit:
Statewide average length of stay of 30 calendar days, based on medical necessity.

Other:
Services provided to individuals in IMDs with an SUD diagnosis when determined medically necessary by the MCO utilization review staff and in accordance with an individualized service plan.

Room and board costs are not considered allowable costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a).

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Other 1937 Benefit Provided:
Qualifying Clinical Trials

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Alternative Benefit Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Confirming coverage of routine patient costs in qualifying clinical trials as required under Section 1905(a)(30) and 1905(gg) of the Social Security Act. Coverage is provided as defined in the State Plan Attachment 3.1-A under item 30.

Add

☐ 15. Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)

Collapse All ☐

PRA Disclosure Statement

Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) for the purpose of standardizing data. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. 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 0938-1188. 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.

V.20190808

Alternative Benefit Plan

State Name: Indiana | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0024 | OMB Expiration date: 10/31/2014

Benefits Assurances — ABP7

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age. Yes

☑ The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).

☑ The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act.

Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

◉ Through an Alternative Benefit Plan.

○ Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Other Information regarding how ESPDT benefits will be provided to participants under 21 years of age (optional):

Prescription Drug Coverage Assurances

☑ The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

☑ The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.

☑ The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.

☑ The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

Other Benefit Assurances

☑ The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.

☑ The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.

- [x] The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.

- [x] The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.

- [x] The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

- [x] The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.

- [ ] The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.

- [x] The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

PRA Disclosure Statement

V.20140415

Alternative Benefit Plan

State Name: Indiana | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0024 | OMB Expiration date: 10/31/2014

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.

Identify the date the managed care program was approved by CMS: Dec., 14, 2007

Describe program below:

The HIP 2.0 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 2.0, members who consistently make required contributions to their POWER account will maintain access to the HIP Plus plan that includes enhanced benefits, such as 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 three managed care entities ("MCE"), Anthem, MDwise, and Managed Health Services. These same MCE's will provide HIP 2.0 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 coverage has initiated, 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 2.0, 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 2.0 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 2.0.

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.

V.20140417

Alternative Benefit Plan

State Name: Indiana | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0024 | OMB Expiration date: 10/31/2014

Employer Sponsored Insurance and Payment of Premiums	ABP9
The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package.	No
The state/territory otherwise provides for payment of premiums.	No
Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:	

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.

V.20140415

Alternative Benefit Plan

State Name: Indiana | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0024 | OMB Expiration date: 10/31/2014

General Assurances — ABP10

Economy and Efficiency of Plans

☑ The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit 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.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services. Yes

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.

☑ The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).

☑ The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

PRA Disclosure Statement

V.20140415

Alternative Benefit Plan

State Name: Indiana | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0024 | OMB Expiration date: 10/31/2014

Payment Methodology — ABP11

Alternative Benefit Plans - Payment Methodologies

☑ The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.

An attachment is submitted.

V.20140415

Alternative Benefit Plan

State Name: Indiana | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0025 | OMB Expiration date: 10/31/2014

Alternative Benefit Plan Populations — ABP1

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name: Healthy Indiana Plan (HIP) 2.0 Plus

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Adult Group	Mandatory	X

Enrollment is available for all individuals in these eligibility group(s). No

Targeting Criteria (select all that apply):

☒ Income Standard.

Income Standard:

○ Income standard is used to target households with income at or below the standard.

○ Income standard is used to target households with income above the standard.

The income standard is as follows:

◉ A percentage:

○ A specific amount

○ Federal Poverty Level.

○ SSI Federal Benefit Amount.

◉ Other.

Enter the Other percentage: 133

Describe:

HIP Plus is the benefit option for all eligible individuals with income up to and including 133% of the federal poverty level (FPL) as based on MAGI income standards who make a contribution to their Personal Wellness and Responsibility (POWER) account.

A woman who becomes pregnant while enrolled in the HIP Plus Plan may choose to transfer to the pregnancy Medicaid aid category. If she stays in HIP Plus, she may keep her HIP Plus benefits through the term of her pregnancy and postpartum period. Pregnant women receive additional benefits in Plus that are only available to pregnant women. For pregnant women, there is no material difference between the benefits covered under the pregnancy Medicaid aid category and the HIP Plus benefits. Women who are pregnant at their annual redetermination are not eligible to remain in HIP Plus and will be transfered to the pregnancy Medicaid aid category.

Alternative Benefit Plan

☐ Disease/Condition/Diagnosis/Disorder.

☒ Other.

Other Targeting Criteria (Describe):

New adult group members who are AI/AN and participate in the 1115 demonstration will be enrolled in the HIP Plus ABP with no POWER account contribution or cost-sharing requirements, regardless of FPL

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory. Yes

Any other information the state/territory wishes to provide about the population (optional)

Enrollment in the Alternative Benefit Plan (ABP) that is the HIP Plus Plan with Essential Health Benefits (EHBs) will include non-medically frail adults between the ages of 19 and 64 with income up to and including 133% of the Federal Poverty Level (FPL) as based on MAGI income standards.

Individuals with income at or below 100% FPL are eligible for HIP Plus. If they do not make the POWER account payment then they default to the HIP Basic Plan. Educational information about the differences in benefits and cost-sharing structure between HIP Basic and HIP Plus are provided in all member communications from both the state and the MCEs. This includes but is not limited to eligibility notices, welcome letters, invoices, and member handbooks. Members can also receive information about the difference in the Basic and Plus plans from all call center staff including the state call centers, the enrollment broker, and the MCE call centers. The state also makes educational information available to members online.

PRA Disclosure Statement

V.20140415

Alternative Benefit Plan

State Name: Indiana | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0025 | OMB Expiration date: 10/31/2014

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

ABP2a

The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan.

No

These assurances must be made by the state/territory if the Adult eligibility group is included in the ABP Population.

☐ The state/territory shall enroll all participants in the "Individuals at or below 133% FPL Age 19 through 64" (section 1902(a)(10)(A)(i)(VIII)) eligibility group in the Alternative Benefit Plan specified in this state plan amendment, except as follows: A beneficiary in the eligibility group at section 1902(a)(10)(A)(i)(VIII) who is determined to meet one of the exemption criteria at 45 CFR 440.315 will receive a choice of a benefit package that is either an Alternative Benefit Plan that includes Essential Health Benefits and is subject to all 1937 requirements or an Alternative Benefit Plan that is the state/territory's approved Medicaid state plan not subject to 1937 requirements. The state/territory's approved Medicaid state plan includes all approved state plan programs based on any state plan authority, and approved 1915(c) waivers, if the state has amended them to include the eligibility group at section 1902(a)(10)(A)(i)(VIII).

☑ The state/territory must have a process in place to identify individuals that meet the exemption criteria and the state/territory must comply with requirements related to providing the option of enrollment in an Alternative Benefit Plan defined using section 1937 requirements, or an Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan that is not subject to section 1937 requirements.

☐ Once an individual is identified, the state/territory assures it will effectively inform the individual of the following:

a) Enrollment in the specified Alternative Benefit Plan is voluntary;

b) The individual may disenroll from the Alternative Benefit Plan defined subject to section 1937 requirements at any time and instead receive an Alternative Benefit Plan defined as the approved state/territory Medicaid state plan that is not subject to section 1937 requirements; and

c) What the process is for transferring to the state plan-based Alternative Benefit Plan.

☐ The state/territory assures it will inform the individual of:

a) The benefits available as Alternative Benefit Plan coverage defined using section 1937 requirements as compared to Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan and not subject to section 1937 requirements; and

b) The costs of the different benefit packages and a comparison of how the Alternative Benefit Plan subject to 1937 requirements differs from the Alternative Benefit Plan defined as the approved Medicaid state/territory plan benefits.

How will the state/territory inform individuals about their options for enrollment? (Check all that apply)

☒ Letter

☐ Email

☒ Other

Describe:

All eligibility notices to HIP members and any notices generated when a member reports changes will indicate how to report medically frail status to the managed care entity. The medically frail confirmation process will also be described in the member manual.

Provide a copy of the letter, email text or other communication text that will be used to inform individuals about their options for enrollment.

An attachment is submitted.

When did/will the state/territory inform the individuals?

Individuals will be informed of the medically frail self-report process in their initial eligibility notice and in all notices received when the member has reported a an eligibility change. The process will also be detailed the member manual. Individuals confirmed medically frail will be enrolled in the State Plan ABP.

Self-report of medically frail status is only one avenue for members to be confirmed frail. All individuals with an active disability determination by the Social Security Administration or a confirmed diagnoses of HIV/AIDS from the Indiana State Department of Health will be confirmed medically frail without having to self report their frail status. In addition, any member that has medical claims that confirm a medically frail condition throughout the year may be confirmed medically frail by their MCE without having to self-report their status.

Please describe the state/territory's process for allowing individuals in the Section 1902(a)(10)(A)(i)(VIII) eligibility group who meet exemption criteria to disenroll from the Alternative Benefit Plan defined using section 1937 requirements and enroll in the Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan.

Individuals that are confirmed to meet the medically frail criteria by their manged care entity will not receive the benefits described in the HIP Basic or HIP Plus ABPs and do not have the option to opt into these plans. They will receive the benefits on the State Plan ABP. These benefits will be provided through the same Managed Care Entities that provide the HIP Basic and HIP Plus ABPs . The benefits of the State Plan ABP offer additional benefits in excess of what is covered in HIP Basic and HIP Plus.

☐ The state/territory assures it will document in the exempt individual's eligibility file that the individual:

a) Was informed in accordance with this section prior to enrollment;

b) Was given ample time to arrive at an informed choice; and

c) Chose to enroll in Alternative Benefit Plan coverage subject to section 1937 requirements or defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

Where will the information be documented? (Check all that apply)

☐ In the eligibility system.

☐ In the hard copy of the case record.

☒ Other

Describe:

Confirmed medically frail individuals do not have the option to select the HIP Basic and Plus Plans, but will be automatically assigned to the State Plan ABP.

What documentation will be maintained in the eligibility file? (Check all that apply)

Alternative Benefit Plan

☐ Copy of correspondence sent to the individual.

☐ Signed documentation from the individual consenting to enrollment in the Alternative Benefit Plan.

☒ Other

Describe:

Confirmed medically frail individuals do not have the option to select the HIP Basic and Plus Plans that are the Alternative Benefit Plans (ABPs) with Essential Health Benefits, but will receive the benefits from the State Plan ABP.

☐ The state/territory assures that it will maintain data that tracks the total number of individuals who have voluntarily enrolled in either Alternative Benefit Plan coverage subject to section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

Other information related to benefit package selection assurances for exempt participants (optional):

Confirmed medically frail individuals will receive benefits that are in all ways equivalent to State Plan ABP benefits and offer benefits not covered through the HIP Basic and Plus ABPs. Therefore, medically frail individuals will not need to have the choice to opt into these two less generous plans.

PRA Disclosure Statement

V.20140415

Alternative Benefit Plan

State Name: Indiana | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0025 | OMB Expiration date: 10/31/2014

Enrollment Assurances - Mandatory Participants — ABP2c

These assurances must be made by the state/territory if enrollment is mandatory for any of the target populations or sub-populations.

When mandatorily enrolling eligibility groups in an Alternative Benefit Plan (Benchmark or Benchmark-Equivalent Plan) that could have exempt individuals, prior to enrollment:

☑ The state/territory assures it will appropriately identify any individuals in the eligibility groups that are exempt from mandatory enrollment in an Alternative Benefit Plan or individuals who meet the exemption criteria and are given a choice of Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan, not subject to section 1937 requirements.

How will the state/territory identify these individuals? (Check all that apply)

☒ Review of eligibility criteria (e.g., age, disorder/diagnosis/condition)

Describe:

Members with disability determination from the Social Security Administration or who have been confirmed as having HIV/AIDS by the Indiana State Department of Health will be confirmed medically frail on initial determination of eligibility.

All eligibility notices to members indicate that members can report changes in their medical condition and medically frail status to their MCE.

☒ Self-identification

Describe:

Self-identification is one of the ways frail status is identified. The primary medically frail identification method is via claims as detailed in the Other section. Members may self-identify by requesting a review of their medically frail status with their managed care entities after initial enrollment in HIP. Members that request a review of their medically frail status are subject to a verification process utilizing the Milliman underwriting guidelines as detailed below.

Once a member self-identifies as medically frail the Managed Care Entity (MCE) will validate applicant data to confirm medically frail status. The managed care entity will have 30 days as required by contract to confirm if the member is medically frail. Managed care entities may identify members as medically frail via claims received during the 30 day verification process, and members receiving health services and using pharmaceuticals to treat their medically frail conditions will likely be identified before the end of the 30 day verification period.

Confirmation may occur through applicant interview or follow-up, current treatment (claims) and/or physician medical attestation documented medical records. Members are confirmed medically frail by the managed care entity when they have a documented medically frail condition and meet the following point thresholds using the Milliman Underwriting Guidelines:

- 150 combined debit points for indicated medical, mental, or behavioral health conditions; or,
- 75 debit points for indicated behavioral health conditions; or,
- 75 debit points for indicated substance abuse conditions; or,
- Needs assistance with one of the activities of daily living.

The debit point system above provides the minimal points a member would meet to be identified as medically frail. For example, individuals who are infected with the hepatitis C virus, but have no signs of the virus, receive no medications and have normal liver functions, will be assigned 50 debit points and not qualify as medically frail. However, an individual that has abnormal liver function will be assigned 150 debit points or higher for conditions such as cirrhosis of the liver at 650 debit

points. From these examples, an individual must meet 150 debit points or higher and have a condition listed on the medically frail condition listing to be considered as having a medical condition identified as medically frail. A person that has a medical condition that falls below the 150 threshold and/or is not a condition listed on the medically frail condition listing would not be considered medically frail. A medically frail determination would be effective for 12 months and after this time is required to be reverified and updated by the MCE. The debit point system, threshold range, and extensive tables of medical conditions each assigned debit points was developed from the Millliman Underwriting Guidelines and is the methodology that will be utilized to determine a medically frail identification.

To develop the debit point system, a code list and software tool from the medical ICD-9 codes and pharmacy NDC codes was used. The use of medical and pharmacy codes in assessing claims data allows for an automated process when screening individuals for medically frail conditions on an ongoing basis.

Members identified as medically frail will receive the State Plan ABP effective the first of the month following the confirmation of their medically frail status by the managed care entity.

Individuals have the right to appeal all medically frail determinations through the state, but must first exhaust the grievance process with their managed care entity.

☒ Other

Describe:

On an ongoing basis, health and pharmacy claims data and data from medical professionals including lab results will be used in the identification and conformation of medically frail status using an automated process. Similar to verification that occurs with the member request to review frail status, members that have pharmacy or medical claims that demonstrate conditions that may qualify them for medically frail status will have their claims checked against the Milliman Underwriting Guidelines. Those that have claims over the point threshold will automatically be designated as medically frail and receive the State Plan ABP. For individuals that do not meet the medically frail threshold based on claims alone, medical records, risk assessments and lab results may be utilized to verify medically frail status.

☐ The state/territory must inform the individual they are exempt or meet the exemption criteria and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

☐ The state/territory assures that for individuals who have become exempt from enrollment in an Alternative Benefit 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 or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

How will the state/territory identify if an individual becomes exempt? (Check all that apply)

☒ Review of claims data

☒ Self-identification

☒ Review at the time of eligibility redetermination

☒ Provider identification

☐ Change in eligibility group

☐ Other

Alternative Benefit Plan

How frequently will the state/territory review the Alternative Benefit Plan population to determine if individuals are exempt from mandatory enrollment or meet the exemption criteria?

- ○ Monthly
- ○ Quarterly
- ○ Annually
- ○ Ad hoc basis
- ◉ Other

Describe:

Managed Care entities may continually assess their enrolled population to determine if an individual has claims that qualify them for medically frail status. The Managed Care Entities will alert the state when an individual qualifies for medically frail status to initiate the activation of benefits of the State Plan ABP. On an annual basis all individuals marked medically frail must be reconfirmed as medically frail by their Managed Care Entity.

Managed care entities determination of frail status is subject to review and audit by the state.

☑ The state/territory assures that it will promptly process all requests made by exempt individuals for disenrollment from the Alternative Benefit Plan and has in place a process that ensures exempt individuals have access to all standard state/territory plan services or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

Describe the process for processing requests made by exempt individuals to be disenrolled from the Alternative Benefit Plan:

Individuals that meet the medically frail criteria will not receive the HIP Basic and HIP Plus benefits described in the Alternative Benefit Plans (ABPs) and do not have the option to opt into these plans, because they do not contain enhanced benefits. Individuals that are confirmed as medically frail will be enrolled in the State Plan ABP. The benefits of the State Plan ABP as provided to HIP eligible individuals through managed care are at least as generous as the HIP Basic and Plus benefits in each benefit offered and offer additional benefits in excess of what is covered in these plans.

Other Information Related to Enrollment Assurance for Mandatory Participants (optional):

To ensure accurate and fair identification methods are in place when determining a member's medical condition, such as medically frail, the state will establish an oversight process. The State utilizes external quality control measures to ensure proper identification for medically frail individuals. The type of quality control measures utilized depends on the frail identification method used by the MCE. When the MCE identifies a member as medically frail, they must document and notify the State. The notification must include (1) the medically frail designation; (2) the date of the determination; and (3) the method used to make the medically frail determination. The following outlines the State audit procedures based on the identification method used.

• MCE identifies member as medically frail based on the Milliman Underwriting Guidelines by using the Milliman tool that conducts analysis of claims data. This can be done at any time. The tool analyzes claims to determine if the member has accrued sufficient debit points to meet the debit point thresholds that designate a member as frail. The State will review the determination and claims data on an ongoing basis throughout the enrollment period, however, determinations made by the MCEs through the use of the Milliman tool based on member claims are considered to be non-partial.

• MCE identifies member as medically frail based on supplemental data. All supplemental data used to support a frail designation must be indexed to the Milliman Underwriting Guidelines. The Milliman tool provides an automated way to analyze claims for indications of frail status, however if claims have not yet been filed, the Milliman Underwriting Guidelines may also be met through a manual process. When meeting the Milliman Underwriting Guidelines points thresholds through a manual process, the MCE must complete a generic

description of the information utilized by the MCE to support the medically frail designation. This information will be reviewed by the State or its designated vendor to independently confirm these medically frail designations. The State will also conduct audits of the MCE's medically frail determinations to ensure the Milliman Underwriting Guidelines are appropriately applied.

Medically frail audits will include review of non-claim data to form a complete picture of the health of the member. This data review could include, but not be limited to: output files from the Milliman Renewal MUGs tool indicating the number of debit points the member accumulated; completed Health Risk Assessments; documentation of attempts to make contact with their member and/or physician(s); recorded responses and supporting information indicating member impairment in Activities of Daily Living (ADLs); and supplemental information gathered by the MCE in order to make a complete decision (such as lab results, physician notes or lifestyle factors). To ensure accurate and timely review of members, the State will also monitor the average time and determination completion rate for each MCE as well as complete in depth reviews surrounding member state appeals (e.g. rate of appeals, appeals outcome statistics, number of State Fair Hearings requested) and Internet Queries (IQs).

In addition, to the specific methods described, the State's MCE audit procedures are ongoing. The State will conduct regular audits of the MCE's Medically Frail Supplemental File to determine and verify appropriate placement of medically frail members including the use of Milliman Underwriting Guidelines. If the member does not meet the medically frail criteria based upon the State's review, the State will request additional information from the MCE. The State anticipates that approximately ten percent (10%) of the total HIP population will be designated as medically frail. If at any time the State finds that a significant amount more or less than ten percent (10%) of an MCE's total HIP population is designated as medically frail, the State will initiate a random audit of the MCE population to ensure that the Milliman Underwriting Guidelines are being applied appropriately or supporting data was used properly. If any MCE is found to have a consistent issue applying the Milliman Underwriting Guidelines in a uniform fashion, the State's will take the appropriate corrective actions.

The State's oversight processes, as explained, focus on ensuring the member receives the proper health services needed which include the appropriate health designation.

PRA Disclosure Statement

V.20140415

Alternative Benefit Plan

State Name: Indiana | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0025 | OMB Expiration date: 10/31/2014

Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package — ABP3

Select one of the following:

- ○ The state/territory is amending one existing benefit package for the population defined in Section 1.
- ◉ The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package: HIP Plus Plan

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

- ◉ Benchmark Benefit Package.
- ○ Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

- ○ The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).
- ○ State employee coverage that is offered and generally available to state employees (State Employee Coverage):
- ○ A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):
- ◉ Secretary-Approved Coverage.
  - ○ The state/territory offers benefits based on the approved state plan.
  - ◉ The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.

Please briefly identify the benefits, the source of benefits and any limitations:

Indiana will use benefits from the largest commercial HMO by enrollment that was a plan option for the State's commercial EHB benchmark. The commercial HMO selected as the base benchmark plan for the HIP Plus ABP complies with the regulations set forth for alternative health benefit plans under §440.347 as related to the essential health benefits (EHBs). The state's methodology in selecting the plan design was to ensure the benefits of the ABP that is the State Plan are at least as generous as the HIP Basic and Plus benefits. The HIP Plus Plan provides comprehensive coverage that includes dental and vision services, TMJ and bariatric surgery. The prescription drug benefit will include all of the drugs in the HIP Basic formulary, which contains the coverage and non-coverage requirements for legend drugs by Indiana Medicaid, found in 405 IAC 5-24-3. The HIP Plus ABP offers additional benefits beyond the base benchmark for pregnant women. If a woman becomes pregnant, she will have the option to maintain her current HIP Plus Plan benefits with extended services for pregnant women.

Selection of Base Benchmark Plan

The state/territory must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

Alternative Benefit Plan

The Base Benchmark Plan is the same as the Section 1937 Coverage option. No

Indicate which Benchmark Plan described at 45 CFR 156.100(a) the state/territory will use as its Base Benchmark Plan:

- ○ Largest plan by enrollment of the three largest small group insurance products in the state's small group market.
- ○ Any of the largest three state employee health benefit plans by enrollment.
- ○ Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- ◉ Largest insured commercial non-Medicaid HMO.

Plan name: Advantage 1001

Other Information Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional):

The state assures that all services in the base benchmark have been accounted for throughout the benefit chart in ABP5. The state assures the accuracy of all information in ABP5 depicting amount, duration and scope parameters of services authorized in the current approved Medicaid state plan and covered on the selected base benchmark plan.

PRA Disclosure Statement

V.20140415

Alternative Benefit Plan

State Name: Indiana | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0025 | OMB Expiration date: 10/31/2014

Alternative Benefit Plan Cost-Sharing — ABP4

☐ Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A. Yes

☐ The state/territory has completed and attached to this submission Attachment 4.18-F to indicate the Alternative Benefit Plan's cost-sharing provisions that are different from those otherwise approved in the state plan.

An attachment is submitted.

Other Information Related to Cost Sharing Requirements (optional):

Authorization for the cost sharing provisions for the HIP Plus Plan are contained in Indiana's HIP 2.0 1115 Demonstration.

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.

V.20140415

Alternative Benefit Plan

State Name: Indiana

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: IN - 22 - 0006

Benefits Description ABP5

The state/territory proposes a "Benchmark-Equivalent" benefit package. No

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

Base Benchmark Commercial HMO
Advantage HMO
Plus Plan

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary-Approved

Alternative Benefit Plan

■ 1. Essential Health Benefit: Ambulatory patient services Collapse All ☐

Benefit Provided: Primary Care Physician (PCP) Services Office Visit
Source: Base Benchmark Commercial HMO
Remove

Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Office visit services include supplies for treatment of the illness or injury, medical consultations, procedures performed in the physician's office, second opinion consultations and specialist treatment services provided by a PCP.

For second opinion consultations, the Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Specialty Physician Visits
Source: Base Benchmark Commercial HMO
Remove

Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Referral Physician Office Visit included.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Home Health Services
Source: Secretary-Approved Other
Remove

Authorization: Other
Provider Qualifications: Medicaid State Plan

Amount Limit:
100 visits per year

Duration Limit:
None

Scope Limit:
Services covered only if not considered custodial care and are prescribed in writing by a participating physician as medically necessary, in place of inpatient hospital care or convalescent nursing home and services provided under physician's care.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Services include skilled medical services; nursing care given or supervised by RN; nutritional counseling furnished or supervised by RD; home hospice services; home health aides; laboratory services, drugs, and medicines prescribed by a physician in connection with home health care; and medical social services. Home hospice services are considered a separate service.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Outpatient Surgery

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Outpatient medical and surgical hospital services are covered when medically necessary. Includes diagnostic invasive procedures that may or may not require anesthesia.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Allergy Testing

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes allergy procedures-administration of serum.

Remove

Benefit Provided:

Chemotherapy-Outpatient

Source:

Base Benchmark Commercial HMO

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes outpatient therapeutic injections which are medically necessary and may not be self-administered.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided:

IV Infusion Services

Source:

Base Benchmark Commercial HMO

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes coverage for outpatient infusion therapy.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Radiation Therapy- Outpatient

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes coverage for outpatient services.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Dialysis

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage provided for outpatient (including home) dialysis services provided by a participating provider.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Outpatient Services

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes colonoscopy and pacemaker. Benefits provided are PCP, specialty and referral for all physician services in an outpatient facility.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Dental- Limited Covered Services- Accident/Injury

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Treatment complete within 1 year from initiation.

Duration Limit:

None

Scope Limit:

Coverage not provided for orthodontia, dental procedures, repair of injury caused by an intrinsic force, such as the force of the upper and lower jaw in chewing, repair of artificial teeth, dentures or bridges.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Injury to sound and natural teeth including teeth that have been filled, capped or crowned.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, to report injury to insurer and receive follow-up care within specified timeframe, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Urgent Care- Walk-ins

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage includes after hours care.

Benefit Provided: Routine Foot Care

Source: Secretary-Approved Other

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: 6 visits per year

Duration Limit: None

Scope Limit:

Coverage not provided for supportive devices of the feet, including but not limited to foot orthotics, corrective shoes, arch supports for the treatment of plantar fasciitis, flat feet, fallen arches, weak feet, chronic foot strain, corns, bunions

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Scope limit continued- and calluses.

Covered when medically necessary for the treatment of diabetes and lower extremity circulatory diseases. For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Voluntary Sterilization for Males

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Clinical Trials for Cancer Treatment

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Alternative Benefit Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Items and services that are not routine care costs or unrelated to the care method will not be covered.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

The clinical trial must be approved or funded by one of the following: National Institute of Health; cooperative group of research facilities that have an established peer review program that is approved by a National Institute of Health or center; FDA; United States Department of Veterans Affairs; United States Department of Defense; institutional review board of an institution located in Indiana that has a multiple project assurance contract approved by the National Institute of the Office for Human Research Protections; and research entity that meets eligibility criteria for a support grant from a National Institutes of Health center.

Coverage provided for routine care costs that are incurred in the course of a clinical trial.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, review of clinical trial to ensure qualified, review of routine costs related to clinical trial and a justification of services rendered for the medical needs of the member.

Add

Alternative Benefit Plan

☑ 2. Essential Health Benefit: Emergency services — Collapse All ☐

Benefit Provided: Emergency Department Services

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Medical care provided outside of the U.S. is not covered

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Emergency room included

Benefit Provided: Emergency Transportation: Ambulance/Air Ambulance

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Other medically necessary ambulance transport (ambulance, medi-van or similar medical ground, air or water transport to or from the hospital or both ways and transfer from a hospital to a lower level of care) is covered.

For other medically necessary transportation, authorization may be required in which the Managed Care Entities (MCEs) may require other details, such as general member information, to contact PCP for other types of transportation related services and a justification of services rendered for the medical needs of the member.

Add

Alternative Benefit Plan

■ 3. Essential Health Benefit: Hospitalization — Collapse All ☐

Benefit Provided: General Inpatient Hospital Care
Source: Base Benchmark Commercial HMO
Remove

Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None

Scope Limit:

Benefit does not include personal comfort items, including those services and supplies not directly related to care, such as guest meals, accommodations or personal hygiene products, and room and board when temporary leave permitted.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services include semi-private room and board (private room provided when medically necessary); intensive care unit/coronary care unit; inpatient cardiac rehabilitation and rehabilitation therapy; general nursing care; use of operating room or delivery suite; surgical and anesthesia services and supplies; ordinary casts; splints and dressings; drugs and oxygen used in hospital; laboratory and x-ray examinations; electrocardiograms; special duty nursing (when requested by a physician and certified as medically necessary); and inpatient specialty pharmaceuticals.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, review of medical necessity, authorization by acting physician, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Inpatient Physician Services
Source: Base Benchmark Commercial HMO
Remove

Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit includes PCP, specialty and may require a referral for physician services in the hospital.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Inpatient Surgical Services
Source: Base Benchmark Commercial HMO
Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Benefit does not include bariatric surgery, surgical and nonsurgical treatment of TMJ, personal comfort items, including those services and supplies not directly related to care, such as guest meals, accommodations or personal hygiene products,

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Scope Limit continued- and room and board when temporary leave permitted.

Surgical hospital services are covered when medically necessary. Services include semi-private room and board (private room provided when medically necessary); intensive care unit/coronary care unit; general nursing care; use of operating room or delivery suite; surgical and anesthesia services and supplies; ordinary casts; splints and dressings; drugs and oxygen used in hospital; laboratory and x-ray examinations; electrocardiograms; special duty nursing (when requested by a physician and certified as medically necessary); and inpatient specialty pharmaceuticals.

Surgical operations may include replacement of diseased tissue removed while a member.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Non-Cosmetic Reconstructive Surgery

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Services begin within 1 year of the accident.

Duration Limit:
None

Scope Limit:
Benefit does not include personal comfort items, including those services and supplies not directly related to care, such as guest meals, accommodations or personal hygiene products, and room and board when temporary leave permitted.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Surgical hospital services are covered when medically necessary and approved by physician.
Reconstructive procedures performed to restore or improve impaired physical function or defects resulting from an accident.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Mastectomy- Reconstructive Surgery

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Benefit does not include personal comfort items, including those services and supplies not directly related to care, such as guest meals, accommodations or personal hygiene products, and room and board when temporary leave permitted.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Surgical hospital services are covered when medically necessary and approved by physician. Covered services include reconstruction of the breast upon which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications at all stages of mastectomy, including lymphedemas.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Transplants

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Human organ and tissue transplant services for both the recipient and the donor, when the recipient is a member. No coverage is provided for the donor or the recipient when the recipient is not a member. Specialty Care Physician (SCP) provides pre-transplant evaluation. Non-experimental, non-investigational organ and other transplants are covered. Donor's medical expenses covered if the person receiving the transplant is a member, and donor's expenses are not covered by another issuer.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Alternative Benefit Plan

Benefit Provided: Congenital Abnormalities

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Benefit does not include personal comfort items, including those services and supplies not directly related to care, such as guest meals, accommodations or personal hygiene products, and room and board when temporary leave permitted.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Surgical hospital services are covered when medically necessary and approved by physician.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Anesthesia

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage includes anesthesia services and supplies.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Hospice Care

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Room and board services are not covered when temporary leave permitted.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

This benefit may be provided in hospitals, skilled nursing facilities, and freestanding hospice centers. Covered services include semi-private room (private room provided when medically necessary). Hospice care provided if terminal illness, in accordance with a treatment plan before admission to the program. Treatment plan must provide statement from physician that life expectancy is 6 months or less. Concurrent care is provided to children (19 & 20 year olds).

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided:
Medical Social Services

Source:
Base Benchmark Commercial HMO

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Hospital services to assist member and family in understanding and coping with the emotional and social problems affecting health status.

Remove

Benefit Provided:
Dialysis

Source:
Base Benchmark Commercial HMO

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Inpatient dialysis services provided by a participating provider.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided: Chemotherapy

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes coverage for inpatient services.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided: Radiation Therapy

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes coverage for inpatient services.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Add

Alternative Benefit Plan

☑ 4. Essential Health Benefit: Maternity and newborn care Collapse All ☐

Benefit Provided:
Obstetric Care

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Limits equivalent to State Plan

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage is provided from the State Plan under the physician benefit and includes various obstetrical services such as antepartum and postpartum visits, laboratory and x-ray (ultrasound) services and other services as medically necessary and appropriate. The benefit provides for antepartum services up to 14 visits for normal pregnancies. High-risk pregnancies may allow for additional visits. Postpartum services includes 2 visits within 60 days of delivery.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Add

Collapse All ☐

■ 5. Essential Health Benefit: Mental health and substance use disorder services including behavioral health treatment

☑ The state/territory assures that it does not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.

Remove

Benefit Provided: Mental/Behavioral Health Inpatient

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Benefit does not include hypnotherapy, behavioral modification, or milieu therapy when used to treat conditions that are not recognized as mental disorders; personal comfort items; and room and board when temporary leave available.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefits include evaluation and treatment in a psychiatric day facility and electroconvulsive therapy. Coverage may also include partial hospitalization depending on the type of services provided. These services are not provided through institutions of mental disease (IMDs).

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided: Mental/Behavioral Health Outpatient

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Coverage does not include self-help training or other related forms of non-medical self care; marriage counseling; hypnotherapy, behavioral modification, or milieu therapy when used to treat conditions that are not recognized as mental disorders.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage applies to individual therapy and group therapy sessions. Benefit may also include partial hospitalization depending on the type of services provided.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as

general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided: Substance Abuse Inpatient Treatment

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: up to 15 days in a calendar month

Duration Limit: None

Scope Limit:

Members 21 through 64 years of age in facilities that qualify as institutions for mental disease. Members can be authorized for up to 15 days in a calendar month.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit does not include services and supplies for the treatment of co-dependency or caffeine addiction; personal comfort items; and room and board when temporary leave permitted.

Benefit includes detoxification for alcohol or other drug addiction. Coverage may also include partial hospitalization depending on the type of services provided.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided: Substance Abuse Outpatient Treatment

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Benefit does not include services and supplies unrelated to mental health for the treatment of codependency
or caffeine addiction.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage includes detoxification for alcohol or other drug addiction. Benefit may also include partial hospitalization depending on the type of services provided.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a

planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Add

■ 6. Essential Health Benefit: Prescription drugs

☑ The state/territory assures that the ABP prescription drug benefit plan is the same as under the approved Medicaid State Plan for prescribed drugs.

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):	Authorization:	Provider Qualifications:
☒ Limit on days supply	Yes	State licensed
☒ Limit on number of prescriptions		
☒ Limit on brand drugs		
☒ Other coverage limits		
☒ Preferred drug list		

Coverage that exceeds the minimum requirements or other:

The prescription drug benefit will cover at least one drug in every category and class or the number of drugs covered in each category and class as the base benchmark, whichever is greater. The Plus Plan will have a formulary that will include coverage for all of the drugs in the HIP Basic formulary, which contains the coverage and non-coverage requirements for legend drugs by Indiana Medicaid, found in 405 IAC 5-24-3. The Plus Plan pharmacy benefit provides additional enhanced benefits that include the following:

- Access to many brand name drugs without prior authorization requirements;
- 90 day prescription supplies;
- Mail order pharmacy benefit;
- Medication Therapy Management (MTM) Services; and
- No copayment for any filled prescription.

These additional pharmacy services are only available to individuals enrolled in the HIP Plus Plan. In addition, the exact drugs covered under the formulary may vary by the Managed Care Entities (MCEs).

For authorization, Managed Care Entities may require prior authorization requirements, such as general member information, a justification of need for Rx related to the medical needs of the member and a planned course of treatment, if applicable, as related to the number Rx provided and duration of treatment. Prior authorization requirements for prescription drugs may vary by MCE, but will comply with Mental Health Parity requirements. MCEs will be required to have a process in place to allow drugs that are medically necessary, but not included on the formulary to be accessed by members.

Alternative Benefit Plan

☑ 7. Essential Health Benefit: Rehabilitative and habilitative services and devices — Collapse All ☐

☑ The state/territory assures that it is not imposing limits on habilitative services and devices that are more stringent than limits on rehabilitative services (45 CFR 156.115(a)(5)(ii)). Further, the state/territory understands that separate coverage limits must also be established for rehabilitative and habilitative services and devices. Combined rehabilitative and habilitative limits are allowed, if these limits can be exceeded based on medical necessity.

Remove

Benefit Provided: Physical Therapy, Occupational Therapy, Speech The

Source: Secretary-Approved Other

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: 75 combined visits annually.

Duration Limit: None

Scope Limit:

Rehabilitative and habilitative services are offered at parity and have distinct benefit limits. Coverage does not include nonsurgical treatment of TMJ.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Amount limit continued- As an outpatient benefit, coverage is limited to 75 combined visits annually for PT, OT, ST, cardiac and pulmonary rehabilitation.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided: Durable Medical Equipment (DME)

Source: Secretary-Approved Other

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: 15 mo rental cap;1 every 5 yr per member- replacem

Duration Limit: None

Scope Limit:

DME does not include corrective shoes, arch supports, dental prostheses, deluxe equipment, common first aid supplies and non-durable supplies. Other non-covered services include but not limited to equipment not suitable for home use.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit includes but not limited to wheel chairs, crutches, respirators, traction equipment, hospital beds, monitoring devices, oxygen-breathing apparatus and insulin pumps. Training for use of DME is also covered and applicable rental fees. Covered services are only for the basic type of DME necessary to provide for medical needs and does not include non-durable supplies that are not an integral part of the DME set-up.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided: Prosthetics

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Benefit does not include foot orthotics, devices solely for comfort or convenience and devices from a non-accredited provider.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

A prosthetic device means an artificial arm or leg or any portion thereof. Orthotic devices are also covered under this benefit as custom fabricated braces or supports designed as a component of an artificial arm or leg. Covered services include the purchase, replacement or adjustment of artificial limbs when required due to a change in your physical condition or body size due to normal growth.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided: Corrective Appliances

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Benefit does not include but not limited to artificial or prosthetic limbs, cochlear implants, dental appliances, dentures, foot orthotics, corrective shoes, arch supports for plantar fasciitis, flat feet, fallen arches and corns.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit must be medically necessary and used to restore function or to replace body parts. Benefit includes but not limited to hemodialysis equipment, breast prostheses, back braces, artificial eyes, one pair eyeglasses due to cataract surgery, ostomy supplies and prosthetics (all prosthetics except prosthetic limbs). Coverage not intended for non-durable appliances.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided: Cardiac Rehabilitation

Source: Secretary-Approved Other

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: 75 combined visits annually.

Duration Limit: None

Scope Limit: Rehabilitative services are offered at parity and share the same, comparable benefit limits.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Amount limit continued- As an outpatient benefit, coverage is limited to 75 combined visits annually for PT, OT, ST and pulmonary rehabilitation.

Benefit includes services for the improvement of cardiac disease or dysfunction.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided: Medical Supplies

Source: Base Benchmark Commercial HMO

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Benefit does not include non-durable supplies and/or convenience items.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit includes casts, dressings, splints and other devices used for reduction of fractures and dislocations.

Remove

Benefit Provided: Pulmonary Rehabilitation

Source: Secretary-Approved Other

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
75 combined visits annually.

Duration Limit:
None

Scope Limit:
Benefit does not include formalized and pre-designed rehabilitation programs for pulmonary conditions. Rehabilitative services are offered at parity and share the same, comparable benefit limits.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Amount limit continued- As an outpatient benefit, coverage is limited to 75 combined visits annually for PT, OT, ST and cardiac rehabilitation.

Benefit consists of services that are for the improvement of pulmonary disease or dysfunction that has a poor response to treatment. Examples of poor response include but are not limited to patients with respiratory failure, frequent emergency room visits, progressive dyspnea, hypoxemia or hypercapnia.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Skilled Nursing Facility (SNF)

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
100 days per benefit period.

Duration Limit:
None

Scope Limit:
A SNF does not include any institution or portion of any institution that is primarily for rest, the aged, nonskilled
care, or care of mental diseases or substance abuse. Room and board services are not covered when temporary leave permitted.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Covered services include semi-private room (private room provided when medically necessary), drugs, specialty pharmaceuticals, medical social services, short term physical, speech, occupational therapies (subject to limits) and other services generally provided.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Autism Spectrum Disorder Services

Source:
Secretary-Approved Other

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
75 combined visits annually.

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Amount limit continued- As an outpatient benefit, coverage is limited to 75 combined visits annually for PT, OT, ST, cardiac and pulmonary rehabilitation.

Benefit, formerly known as Pervasive Development Disorder (PDD), is a state mandate that must be covered as outlined in the Indiana insurance code.

Benefit provides coverage for Asperger's syndrome and autism. Coverage for services are provided as prescribed by the treating physician in accordance with the treatment plan.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Hearing Aids

Source:
State Plan 1905(a)

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
1 per member every 5 years

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Medically frail populations will receive State Plan benefits.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided: Home Health:Medical Supplies, Equipment and Applia

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Benefit does not include non-durable supplies and/or convenience items.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefits include medical supplies in connection with home health care.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided: Inpatient Cardiac Rehabilitation

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: 90 days annual maximum.

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit includes services for the improvement of cardiac disease or dysfunction.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided: Inpatient Rehabilitation Therapy

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: 90 days annual maximum.

Duration Limit: None

Alternative Benefit Plan

Scope Limit:

Rehabilitative and habilitative services are offered at parity and share the same, comparable benefit limits.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage includes physical, occupational, speech and pulmonary therapy of acute illness or injury to the extent that significant potential exists for progress toward a previous level of functioning.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Add

Alternative Benefit Plan

☑ 8. Essential Health Benefit: Laboratory services Collapse All ☐

Benefit Provided: Lab Tests

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Coverage does not include lab expenses related to physical exams when provided for employment, school, sports' programs, travel, immigration, administrative purposes or insurance purposes.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit provided as outpatient services when medically necessary.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: X-Rays

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Coverage does not include x-ray expenses related to physical exams when provided for employment, school, sports' programs, travel, immigration, administrative purposes or insurance purposes.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit provided as outpatient services when medically necessary.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Imaging- MRI, CT, and PET

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit provided as outpatient services when medically necessary. Coverage also includes MRA and SPECT scan.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided:
Pathology

Source:
Base Benchmark Commercial HMO

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit provided as outpatient services when medically necessary.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided:
Radiology

Source:
Base Benchmark Commercial HMO

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit provided as outpatient services when medically necessary.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided: EKG and EEG

Source: Base Benchmark Commercial HMO

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit provided as outpatient services when medically necessary.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Add

Alternative Benefit Plan

■ 9. Essential Health Benefit: Preventive and wellness services and chronic disease management Collapse All ☐

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided: Preventive Care Services

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Physician services for wellness and preventive services include but are not limited to routine physical exam, routine total blood cholesterol screening, routine gynecological services and routine immunizations. Includes (1) all preventive items or services that have a rating of 'A' or 'B' by the United States Preventive Task Force (USPSTF); (2) Immunizations recommended for the individuals age and health status by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC); (3) for infants, children, adolescents and adults, preventive care and screenings included in the Health Resources and Services Administration's (HRSA) Bright Futures comprehensive guidelines; and (4) preventive screenings for women as as recommended by the Institute of Medicine (IOM).

Benefit Provided: Routine Prostate Specific Antigen (PSA) Test

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: One test annually for an individual who is at least 50 years old or less than 50 if at high risk for prostate cancer.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: None

Benefit Provided: Diabetes Self Management Training

Source: Base Benchmark Commercial HMO

Remove

Alternative Benefit Plan

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Covered services are limited to physician authorized visits after receiving a diagnosis of diabetes; after receiving a diagnosis that represents a significant change in symptoms or condition and there is a medically necessary change in self-management; and for re-education or refresher training.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Health Education

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
3 visits.

Duration Limit:
None

Scope Limit:
Classes in nutrition or smoking cessation will be approved up to 3 visits when referred by your physician.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit provided by the PCP as part of preventive health care and other health education classes approved by the insurer.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Add

Alternative Benefit Plan

☑ 10. Essential Health Benefit: Pediatric services including oral and vision care

Collapse All ☐

Remove

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
State Plan 1905(a)

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
EPSDT is required in the ABP for 19 and 20 year olds.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services provided under EPSDT may include preventive and diagnostic services that are medically necessary and may need continued treatment.
In accordance with CMS regulation, individuals covered under EPSDT are not subject to the IMD exclusion.

Add

☐ 11. Other Covered Benefits from Base Benchmark Collapse All ☐

☒ 12. Base Benchmark Benefits Not Covered due to Substitution or Duplication Collapse All ☐

Base Benchmark Benefit that was Substituted: Infertility Diagnoses: substitution
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Infertility Diagnoses benefit offered in the base benchmark was removed and replaced in EHB 1 by substitution with part of the actuarial value of Male Sterilization procedures which are not covered on the base benchmark. Coverage for Male Sterilization procedures comes from the coverage provided on the State Plan.

Base Benchmark Benefit that was Substituted: Routine Foot Care: substitution
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

The benefit is covered. A more restrictive limit of 6 visits per year was added. In EHB 1, this has been substituted with the remaining actuarial value from the male sterilization benefit. There is no limit on Routine Foot Care in the base benchmark.

Base Benchmark Benefit that was Substituted: Home Health Services: substitution
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

The benefit is covered. Within the benefit, training of family members to provide home health services is a non-covered benefit. In EHB 1, this sub-benefit was substituted with the actuarial value remaining from the male sterilization benefit.

Base Benchmark Benefit that was Substituted: Urgent Care- Walk-ins: substitution
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

The benefit is covered. Within the benefit, physician home visits is a non-covered benefit. In EHB 1, this sub-benefit was substituted with the actuarial value remaining from the male sterilization benefit.

Base Benchmark Benefit that was Substituted: Maternity Services: duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was duplicated with the Medicaid State Plan Obstetric benefit in EHB 4.

Base Benchmark Benefit that was Substituted: Maternity - Delivery: duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

This benefit was duplicated with the Medicaid State Plan Obstetric benefit in EHB 4.

Base Benchmark Benefit that was Substituted: Durable Medical Equipment (DME): substitution

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

The benefit is covered. The limits for a 15 month rental cap and 5 year replacement for equipment were added. In EHB 7, this has been substituted with the actuarial value remaining from adding hearing aids as a benefit from the State Plan. There is no limit on Durable Medical Equipment in the base benchmark.

Base Benchmark Benefit that was Substituted: PT, OT, ST: substitution

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

The benefit is covered. Within the benefit, the service limits are covered as an annual limit combined for therapies. In EHB 7, service limits for limits per condition have been substituted with the actuarial value remaining from adding hearing aids as a benefit from the State Plan. The base benchmark allows for 75 combined visits per distinct condition or episode.

Base Benchmark Benefit that was Substituted: Cardiac Rehabilitation: substitution

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

The benefit is covered. Within the benefit, the service limits are covered as an annual limit combined for therapies. In EHB 7, the service limits for limits per condition have been substituted with the actuarial value remaining from adding hearing aids as a benefit from the State Plan. The base benchmark allows for 75 combined visits per distinct condition or episode.

Base Benchmark Benefit that was Substituted: Pulmonary Rehabilitation: substitution

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

The benefit is covered. Within the benefit, the service limits are covered as an annual limit combined for therapies. In EHB 7, the service limits for limits per condition have been substituted with hearing aids. In addition, formalized and pre-designed rehabilitation programs for pulmonary conditions have also been substituted with hearing aids. Both substitutions were completed with the actuarial value remaining from adding hearing aids as a benefit from the State Plan. The base benchmark allows for 75 combined visits per distinct condition or episode.

Alternative Benefit Plan

Base Benchmark Benefit that was Substituted: Autism Spectrum Disorder Services: substitution

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

The benefit is covered. Within the benefit, the service limits are covered as an annual limit combined for therapies. In EHB 7, the service limits for limits per condition have been substituted with the actuarial value remaining from adding hearing aids as a benefit from the State Plan. The base benchmark allows for 75 combined visits per distinct condition or episode.

Base Benchmark Benefit that was Substituted: Applied Behavior Analysis: substitution

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

In EHB 7, ABA has been substituted with the actuarial value remaining from adding hearing aids as a benefit from the State Plan.

Base Benchmark Benefit that was Substituted: Non Surgical Treatment Option Morbid Obesity: dupl

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

In EHB 9, the benefit is covered under preventive and wellness services. The ACA preventive services provides coverage beyond the benefit limits.

Add

Alternative Benefit Plan

☒ 13. Other Base Benchmark Benefits Not Covered Collapse All ☐

Base Benchmark Benefit not Included in the Alternative Benefit Plan: Adult Vision
Source: Base Benchmark
Remove

Explain why the state/territory chose not to include this benefit:
Adult vision is covered in the base benchmark plan, but it is an excepted benefit and therefore not an Essential Health Benefit.

Base Benchmark Benefit not Included in the Alternative Benefit Plan: Newborn Child Coverage
Source: Base Benchmark
Remove

Explain why the state/territory chose not to include this benefit:
Benefit is excluded since the ABP is for ages 19-64. Newborns born to members will be covered through Medicaid for children. The newborn coverage includes the initial newborn examinations.

Base Benchmark Benefit not Included in the Alternative Benefit Plan: Emergency Services Outside the U.S.
Source: Base Benchmark
Remove

Explain why the state/territory chose not to include this benefit:
Emergency care provided outside the U.S. is covered in the base benchmark plan. Non-emergency services are not covered. To conform with Medicaid standards, the benefit will not be covered in the ABP.

Base Benchmark Benefit not Included in the Alternative Benefit Plan: Lodging and Transportation for Transplants (Donor)
Source: Base Benchmark
Remove

Explain why the state/territory chose not to include this benefit:
Transportation and lodging services for the donor are covered under the base benchmark plan subject to a dollar limit, these services are not considered an EHB and are considered a non-covered benefit for the ABP.

Add

Alternative Benefit Plan

☒ 14. Other 1937 Covered Benefits that are not Essential Health Benefits Collapse All ☐

Other 1937 Benefit Provided:
Dental: Adult

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Services limits provided in other box.

Duration Limit:
None

Scope Limit:
Limited to basic commercial package.

Other:
The dental benefits include evaluations and cleanings (2 per person per benefit year); bitewing x-rays (4 xrays per person per benefit year); comprehensive x-rays (1 complete set every 5 years); minor restorative orcorrective services, such as fillings or extractions (4 combined per person per benefit year); and major restorative services, such as crowns (1 per person per benefit year).

For authorization, the dental insurer may require prior authorization requirements, such as general member information and a justification for the type of dental services rendered based on the medical needs of the member.

Other 1937 Benefit Provided:
Adult Vision

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Service limits provided in other box.

Duration Limit:
None

Scope Limit:
None

Other:
The vision benefits include routine exam (1 every 2 years); eyeglasses, including frames and lenses (1 pair every 5 years if there is not a sufficient change in prescription (vision), loss, irreparable damage, or theft); frames include but not limited to plastic or metal; replacement eyeglasses (covered when medical necessity guidelines met or due to loss, theft or damage beyond repair); contact lenses (covered for medical necessity, such as facial deformity or allergy to frame prevents wearing eyeglasses); vision surgeries (covered for medical necessity); and vision training therapies (covered for medical necessity).

Not all frames and lenses are covered, unless medically necessary. Members may choose to upgrade frames and lenses and pay the difference.

For authorization, vision insurer may require prior authorization requirements, such as general member information and a justification for the type of vision services rendered based on the medical needs of the member or the dollar amount of the service.

Other 1937 Benefit Provided:
TMJ

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
State Plan benefit. Coverage includes treatment of temporomandibular joint (TMJ) disorder.
For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, documentation of non-surgical treatment and duration prior to surgery and a justification of services rendered for the medical needs and circumstances of the member

Other 1937 Benefit Provided:
Bariatric Surgery

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Benefit does not include personal comfort items, including those services and supplies not directly related to care, such as guest meals, accommodations or personal hygiene products, and room and board when temporary leave permitted.

Other:
State Plan Benefit. To be eligible for this benefit the member must meet the following criteria:
1) Have morbid obesity that has persisted for at least five years duration, and physician-supervised nonsurgical
medical treatment has been unsuccessful for at least 6 consecutive months; or
2) Member has successfully achieved weight loss after participating in physician-supervised non-surgical medical treatment, but has been unsuccessful at maintaining weight loss for two years [> 3 kg (6.6 lb.) weight gain].

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, physician documentation and documentation of attempt to follow nonsurgical treatment and duration prior to surgery, documentation of pre- and post-operative expectations, behavioral health evaluation, consultation reports from other specialists and a justification of services rendered for the medical needs and circumstances of the member.

Other 1937 Benefit Provided:
Chiropractic Care - Pregnancy Benefit

Alternative Benefit Plan

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Limits equivalent to State Plan.

Duration Limit:
None

Scope Limit:
None

Other:
Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. Coverage provided is subject to program restrictions.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Other 1937 Benefit Provided:
Non-emergency Transportation - Pregnancy Benefit

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. Coverage provided is subject to program restrictions.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Other 1937 Benefit Provided:
Medicaid Rehabilitation Option (MRO)- Pregnancy Be

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. MRO services are designed to assist in the rehabilitation of the consumer‘s optimum functional ability in daily living activities.

Other 1937 Benefit Provided:
Dental Services- Pregnancy Benefit

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Limits equivalent to State Plan

Duration Limit:
None

Scope Limit:
None

Other:
Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. The dental benefits include State Plan equivalent benefits.

For authorization, the dental insurer may require prior authorization requirements, such as general member information and a justification for the type of dental services rendered based on the medical needs of the member.

Other 1937 Benefit Provided:
Health Education - Smoking Cess -Pregnancy Benefit

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
12 week course.

Duration Limit:
None

Scope Limit:
None

Other:

Benefit is only offered to women who become pregnant while enrolled in HIP and include State Plan equivalent benefits which are more generous than the benefits offered in the base benchmark plan. The benefit includes up to 12 weeks in a smoking cessation course providing treatment and counseling.
For authorization, the Manged Care Entity (MCE) may require prior authorization requirements, such as general member information and a justification for the type of services rendered based on the medical needs of the member.

Remove

Other 1937 Benefit Provided:

Osteopathic Manipulative Treatment (OMT)

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

State Plan benefit.

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Other 1937 Benefit Provided:

Residential Treatment

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Duration Limit:

Scope Limit:

Statewide average length of stay of 30 calendar days, based on medical necessity.

Other:

Services provided to individuals in IMDs with an SUD diagnosis when determined medically necessary by the MCO utilization review staff and in accordance with an individualized service plan.
Room and board costs are not considered allowable costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a).

For authorization, Managed Care Entities (MCEs) may require prior authorization requirements, such as general member information, a justification of services rendered for the medical needs of the member and a

planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Other 1937 Benefit Provided:
Chiropractic Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
1 visit per day/6 visits per covered benefit year

Duration Limit:

Scope Limit:
Annual limit of six spinal manipulation visits per covered person per benefit year. One visit per day.

Other:
Benefit offered to HIP Plus and included in State Plan. Self-referral, a Provider referral is not required. No Prior Authorization is needed. Coverage available for covered services provided by a licensed chiropractor when rendered within the scope of the practice of chiropractic.

Other 1937 Benefit Provided:
Qualifying Clinical Trials

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Confirming coverage of routine patient costs in qualifying clinical trials as required under Section 1905(a)(30) and 1905(gg) of the Social Security Act. Coverage is provided as defined in the State Plan Attachment 3.1-A under item 30.

Add

☐ 15. Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)

Collapse All ☐

PRA Disclosure Statement

Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) for the purpose of standardizing data. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. 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 0938-1188. 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.

V.20190808

Alternative Benefit Plan

State Name: Indiana | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0025 | OMB Expiration date: 10/31/2014

Benefits Assurances — ABP7

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age. Yes

☑ The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).

☑ The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act.

Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

◉ Through an Alternative Benefit Plan.

○ Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Other Information regarding how ESPDT benefits will be provided to participants under 21 years of age (optional):

Prescription Drug Coverage Assurances

☑ The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

☑ The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.

☑ The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.

☑ The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

Other Benefit Assurances

☑ The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.

☑ The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.

Alternative Benefit Plan

- [x] The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.

- [x] The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.

- [x] The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

- [x] The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.

- [ ] The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.

- [x] The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

PRA Disclosure Statement

V.20140415

Alternative Benefit Plan

State Name: Indiana | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0025 | OMB Expiration date: 10/31/2014

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 HIP 2.0 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 2.0, members who consistently make required contributions to their POWER account will maintain access to the HIP Plus plan that includes enhanced benefits, such as 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 three managed care entities ("MCE"), Anthem, MDwise, and Managed Health Services. These same MCE's will provide HIP 2.0 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 2.0, 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 2.0 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 2.0.

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.

V.20140417

Alternative Benefit Plan

State Name: Indiana Attachment 3.1-L- [ ] OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0025 OMB Expiration date: 10/31/2014

Employer Sponsored Insurance and Payment of Premiums	ABP9
The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package.	No
The state/territory otherwise provides for payment of premiums.	No

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

PRA Disclosure Statement

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V.20140415

Alternative Benefit Plan

State Name: Indiana | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0025 | OMB Expiration date: 10/31/2014

General Assurances — ABP10

Economy and Efficiency of Plans

☑ The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit 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.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services. Yes

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.

☑ The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).

☑ The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

PRA Disclosure Statement

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V.20140415

Alternative Benefit Plan

State Name: Indiana | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0025 | OMB Expiration date: 10/31/2014

Payment Methodology **ABP11**

Alternative Benefit Plans - Payment Methodologies

☑ The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.

An attachment is submitted.

PRA Disclosure Statement

V.20140415

Alternative Benefit Plan

State Name: Indiana

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0014

OMB Expiration date: 10/31/2014

Alternative Benefit Plan Populations — ABP1

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name: Healthy Indiana Plan (HIP) Link

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Parents and Other Caretaker Relatives	Voluntary	X
+	Transitional Medical Assistance	Voluntary	X
+	Pregnant Women	Voluntary	X
+	Adult Group	Mandatory	X

Enrollment is available for all individuals in these eligibility group(s). No

Targeting Criteria (select all that apply):

☐ Income Standard.

☐ Disease/Condition/Diagnosis/Disorder.

☒ Other.

Other Targeting Criteria (Describe):

To be HIP Link eligible an individual must: (1) be eligible for and/or enrolled in the Healthy Indiana Plan, (2) be eligible to enroll in HIP Link qualifying employer sponsored insurance (ESI) plan, and (3) elect to enroll in such ESI through HIP Link.

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory. Yes

Any other information the state/territory wishes to provide about the population (optional)

To enroll in HIP Link an individual must have access to qualifying ESI and elect to enroll in that ESI through HIP Link. Not all individuals eligible for and/or enrolled in HIP will be eligible for the HIP Link ABP since they may not have access to or be eligible to enroll in qualifying ESI or they may not elect to enroll in ESI through HIP Link. Individuals not eligible for HIP Link due to lacking access to affordable employer sponsored insurance, or who are eligible but who choose not to enroll in HIP Link will be enrolled in either the HIP Basic or HIP Plus ABPs or the ABP that is the State Plan as applicable to the individual.

Individuals who enroll in HIP Link and are pregnant at their annual redetermination may elect to remain in the HIP Link ABP or transfer to Medicaid for pregnant women. Individuals age 19 and 20 will have access to EPSDT services outside of the scope of their HIP Link qualifying ESI.

Alternative Benefit Plan

PRA Disclosure Statement

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V.20140415

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-L- ☐ OMB Expiration date: 10/31/2014

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

The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan.

No

These assurances must be made by the state/territory if the Adult eligibility group is included in the ABP Population.

☑ The state/territory shall enroll all participants in the "Individuals at or below 133% FPL Age 19 through 64" (section 1902(a)(10)(A)(i)(VIII)) eligibility group in the Alternative Benefit Plan specified in this state plan amendment, except as follows: A beneficiary in the eligibility group at section 1902(a)(10)(A)(i)(VIII) who is determined to meet one of the exemption criteria at 45 CFR 440.315 will receive a choice of a benefit package that is either an Alternative Benefit Plan that includes Essential Health Benefits and is subject to all 1937 requirements or an Alternative Benefit Plan that is the state/territory's approved Medicaid state plan not subject to 1937 requirements. The state/territory's approved Medicaid state plan includes all approved state plan programs based on any state plan authority, and approved 1915(c) waivers, if the state has amended them to include the eligibility group at section 1902(a)(10)(A)(i)(VIII).

☑ The state/territory must have a process in place to identify individuals that meet the exemption criteria and the state/territory must comply with requirements related to providing the option of enrollment in an Alternative Benefit Plan defined using section 1937 requirements, or an Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan that is not subject to section 1937 requirements.

☑ Once an individual is identified, the state/territory assures it will effectively inform the individual of the following:

a) Enrollment in the specified Alternative Benefit Plan is voluntary;

b) The individual may disenroll from the Alternative Benefit Plan defined subject to section 1937 requirements at any time and instead receive an Alternative Benefit Plan defined as the approved state/territory Medicaid state plan that is not subject to section 1937 requirements; and

c) What the process is for transferring to the state plan-based Alternative Benefit Plan.

☑ The state/territory assures it will inform the individual of:

a) The benefits available as Alternative Benefit Plan coverage defined using section 1937 requirements as compared to Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan and not subject to section 1937 requirements; and

b) The costs of the different benefit packages and a comparison of how the Alternative Benefit Plan subject to 1937 requirements differs from the Alternative Benefit Plan defined as the approved Medicaid state/territory plan benefits.

How will the state/territory inform individuals about their options for enrollment? (Check all that apply)

☒ Letter

☐ Email

☒ Other

Describe:

All HIP Link enrollees must make two distinct opt-in choices to enroll in HIP Link: (1) the HIP Link enrollee must have requested HIP Link as their coverage option and (2) the HIP Link enrollee must separately enroll with the employer in a HIP Link eligible health plan by completing the employer's enrollment paperwork.

Applicants may enroll in HIP Link by making the selection of HIP Link on the application and providing the HIP Link employer information. Current HIP members and conditional HIP members may make the election to enroll in HIP Link by calling the Division of Family Resources and using the change reporting process to request a transfer from HIP to HIP Link. No applicant or member is enrolled in or transfered to HIP Link without making an affirmative selection of HIP Link either through the application for health coverage or through the change reporting process. In addition, to be HIP Link eligible an applicant must have completed the group health coverage enrollment paperwork with their employer and already be receiving ESI benefits or have an employer confirmed start date for ESI benefits for HIP Link eligibility to be established.

Prior to enrollment in HIP Link the applicant's or member's employer will verify that the applicant or member is enrolled in HIP Link eligible ESI plan. Once the employer receives a request for verification, the employer will have five business days to complete the verification. If the employer does not complete the verification in five business days, current member's will remain in HIP Plus, HIP Basic, or HIP State Plan benefits, as applicable. Applicants will be enrolled into HIP as a HIP Plus or HIP State Plan Plus conditional member. The employer's failure to comply with the five day time line does not prevent the applicant from requesting HIP Link again in the future, but rater it establishes a specific time frame for the employer to help ensure timely enrollment into HIP Link when requested by the applicant. Verification of HIP Link eligibility can be appealed by the member to the state through the standard appeals process, and members may also request, via the change reporting process, to have their HIP Link eligibility verified again at any time. Appeals of HIP Link eligibility are handled by the state through the standard appeals process. If the employer confirms the applicant's or member's enrollment in HIP Link eligible ESI benefits, HIP Link benefits will begin as described below.

For current HIP members, as with other changes to HIP eligibility, HIP Link benefits begin the first of the month following the employer's verification of active enrollment in ESI, such that there is no overlap between HIP and HIP Link coverage. For example, if the employer confirms in July that the employee is eligible for and enrolled in HIP Link eligible ESI as of July 3rd, then the HIP member will transfer to HIP Link on August 1st. If the employer confirms in July that the employee ESI benefits will begin August 17th, then the HIP Member will transfer from their active HIP benefits to HIP Link on September 1.

For new applicants, HIP Link benefits begin the first day of the month where employer confirms the member was actively enrolled in ESI on the first of the month. For example, if the employer confirms in July that the applicant was enrolled in HIP Link eligible ESI on July 1, then HIP Link benefits will begin July 1. If the employer confirms in July that the applicant's ESI benefits will begin August 17th, then the applicant may enroll in HIP pending their HIP Link enrollment effective September 1. Individuals that lose eligibility for HIP Link due to loss of access to employer sponsored insurance will be immediately transfered from HIP Link to HIP Plus or HIP State Plan Plus as applicable for the individuals eligibility group, individuals that lose access to ESI will not experience a gap in coverage during the transition back to HIP coverage.

Current members that request a transfer to HIP Link will be notified at the time of request that selection of HIP Link will mean that they will be enrolled HIP Link until their next annual redetermination or the end of their employers insurance, which could be up to a period of 12 months depending on when the member requests the transfer to HIP Link. Information will be provided when the member requests a HIP Link transfer on the opt-out at anytime option for frail members and how to contact the enrollment broker for benefits counseling. Members may withdraw requests for transfers to HIP Link as long as the employer has not verified that the member is enrolled in ESI and the member has not been receiving premium reimbursement checks.

Members eligible to disenroll from HIP Link due to medically frail status may do so at any time. To disenroll, medically frail individuals utilize the change reporting process to request transfer from HIP Link to HIP Plus. When the medically frail individual makes the request, they will receive a form by mail which they must complete to attest to their medically frail condition. Effective the first of the month following the receipt of the completed form by the state, the medically frail individual will be transfered from HIP Link to HIP State Plan Plus. Members will have to separately contact their employer to disenroll from the employer sponsored insurance.

All applicants and HIP members that request a transfer to HIP Link will receive an eligibility notice from the state that informs them if their HIP Link eligibility was verified with their employer and if so, what their HIP Link start date is. This notice also provides information on how to access enrollment counseling for information on the differences between the HIP and HIP Link benefit packages, advises the member that individuals with serious medical or mental health conditions may transfer from HIP to HIP Link at any time, and informs the member that those age 19 and 20 will receive EPSDT benefits that includes all medically necessary 1905(a) benefits via use of the HIP Link card if these benefits are not provided under their employer health plan. Information on enrollment counseling and the ability for some groups to transfer from HIP Link to HIP at any time is also included in member materials and HIP Link marketing and informational materials accessible through the HIP Link website.

The time between the receipt of the member eligibility notice, and the start of the HIP Link benefits will vary based on the date which the applicant or member has active enrollment in HIP Link eligible ESI. The applicant may receive their HIP Link approval notice during the month in which their HIP Link enrollment begins if they are already enrolled in ESI. Or the applicants that have a waiting period for ESI enrollment will receive the HIP Link eligibility notice in the month or months prior to the start of HIP Link enrollment. During any applicable ESI waiting period, the member may access the standard HIP conditional enrollment process to gain coverage for the months between authorization and the start of their HIP Link benefits.

Regardless of the HIP Link start date, at any time applicants, prospective applicants, or members can contact the enrollment broker for counseling on the differences between HIP Link and the applicable HIP benefits. All members seeking counseling who are medically frail based on their case record will receive counseling from the enrollment broker about the the differences between the individual's current HIP State Plan Basic or HIP State Plan Plus benefits and the benefits available under the HIP Link approved ESI as well as counseling on cost-sharing. The enrollment broker will have access to the benefit documents provided by the HIP Link approved employer health plans and the HIP Link Employer Counseling Team's plan review notes to assist them in advising the member on the differences between HIP Basic and HIP Plus and HIP State Plan benefits and cost sharing. For applicants and prospective applicants, the enrollment broker will advise the individuals that if they have a health condition that may qualify them as medically frail then they may qualify for enhanced benefits under the HIP option that are not available under the HIP Link option. Enrollment counseling is not required for applicants or members to enroll in HIP Link, but it is an option for all prospective HIP Link enrollees, including the medically frail. Enrollment counseling continues to be available after the individual enrolls in HIP Link to help individuals decide if HIP Link remains the best coverage option. The medically frail can leverage ongoing enrollment counseling to support decision making around transferring from HIP Link to HIP.

In addition to the eligibility notice and enrollment counseling tailored to the benefits and cost sharing of the specific employer sponsored health plan, HIP Link members will also receive a member manual that serves as a comprehensive program guide and covers content relevant to members from eligibility, calculation of their contribution and the member prepayment schedule. The member manual includes information on the benefits in HIP Link and the potential benefit differences between their HIP Link employer plan and the benefits available in HIP. The member manual details benefits that are available to the medically frail through the HIP State Plan benefit option. The member manual provides reference for the qualifying events, including becoming medically frail, that allow an individual to transfer from HIP Link back to HIP and provides a guide of how to request a transfer to HIP utilizing the change reporting process. All HIP Link members will receive a HIP Link member manual when they enroll into HIP Link.

Provide a copy of the letter, email text or other communication text that will be used to inform individuals about their options for enrollment.

An attachment is submitted.

When did/will the state/territory inform the individuals?

Applicants and current members that request a transfer to HIP Link will receive notification on the times outlined above. Depending on the start date of their HIP Link eligible ESI, applicants may be directly enrolled into HIP Link effective the first of the month in which they receive their eligibility notice.

Alternative Benefit Plan

Please describe the state/territory's process for allowing individuals in the Section 1902(a)(10)(A)(i)(VIII) eligibility group who meet exemption criteria to disenroll from the Alternative Benefit Plan defined using section 1937 requirements and enroll in the Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan.

The medically frail may disenroll from HIP Link at any time by contacting the Division of Family Resources and utilizing the existing change reporting process to request a transfer from HIP Link to HIP. Individuals requesting a transfer from HIP Link to HIP due to medically frail status are provided with a health condition questionnaire. To complete the transfer the individual must complete the questionnaire. The health conditions indicated by the individual are not subject to verification to transfer from HIP Link to HIP. The transfer to HIP will occur effective the first of the month following the receipt of the medically frail attestation form.

☑ The state/territory assures it will document in the exempt individual's eligibility file that the individual:

a) Was informed in accordance with this section prior to enrollment;

b) Was given ample time to arrive at an informed choice; and

c) Chose to enroll in Alternative Benefit Plan coverage subject to section 1937 requirements or defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

Where will the information be documented? (Check all that apply)

☐ In the eligibility system.

☐ In the hard copy of the case record.

☒ Other

Describe:

All individuals that enroll in HIP Link will may access options counseling through the enrollment broker and will be informed that upon enrollment into HIP Link they will be covered by their employer sponsored insurance and not HIP. Individuals that call for options counseling will have their request for counseling documented in the enrollment brokers call tracking system. Information on how to access options counseling for HIP Link is provided in general HIP Link marketing and outreach materials, including materials posted online, member manuals and other member material, all specific notices that go to individuals requesting HIP Link, and by the call center when members ask about HIP Link or request a transfer from HIP to HIP Link.

What documentation will be maintained in the eligibility file? (Check all that apply)

☐ Copy of correspondence sent to the individual.

☐ Signed documentation from the individual consenting to enrollment in the Alternative Benefit Plan.

☒ Other

Describe:

Eligibility notices sent to HIP Link members inform all members of the option for enrollment counseling via the enrollment broker and that individuals who are medically frail may disenroll at any time through the change reporting process. For individuals that contact the enrollment broker for specific options counseling, record that the individual took part in the enrollment counseling will be noted in the individuals record. Depending on if the individual contacts the enrollment broker for HIP Link options counseling during the application process or after being determined eligible for HIP, the record of the counseling process may be associated with the member's name as provided to the enrollment broker, or the members identification number.

Alternative Benefit Plan

☑ The state/territory assures that it will maintain data that tracks the total number of individuals who have voluntarily enrolled in either Alternative Benefit Plan coverage subject to section 1937 requirements or Alternative Benefit Plan coverage defined as the state/ territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

Other information related to benefit package selection assurances for exempt participants (optional):

PRA Disclosure Statement

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V.20131219

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-L- ☐ OMB Expiration date: 10/31/2014

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

These assurances must be made by the state/territory if the ABP Population includes any eligibility groups other than or in addition to the Adult eligibility group.

When offering voluntary enrollment in an Alternative Benefit Plan (Benchmark or Benchmark-Equivalent), prior to enrollment:

☑ The state/territory must inform the individual they are exempt and the state/territory must comply with all requirements related to voluntary enrollment.

☑ The state/territory assures it will effectively inform individuals who voluntary enroll of the following:

a) Enrollment is voluntary;

b) The individual may disenroll from the Alternative Benefit Plan at any time and regain immediate access to full standard state/territory plan coverage;

c) What the process is for disenrolling.

☑ The state/territory assures it will inform the individual of:

a) The benefits available under the Alternative Benefit Plan; and

b) The costs of the different benefit packages and a comparison of how the Alternative Benefit Plan differs from the approved Medicaid state/territory plan.

How will the state/territory inform individuals about voluntary enrollment? (Check all that apply.)

☒ Letter

☐ Email

☒ Other:

Describe:

All HIP Link enrollees must make two distinct opt-in choices to enroll in HIP Link: (1) the HIP Link enrollee must have requested HIP Link as their coverage option and (2) the HIP Link enrollee must separately enroll with the employer in a HIP Link eligible health plan by completing the employer's enrollment paperwork. This opt in process for HIP Link is the same for populations that cannot have mandatory enrollment into an ABP including low income parents and caretakers, low income 19 and 20 year olds, individuals eligible for transitional medical assistance, and pregnant women who elect to stay in HIP Link at their annual redetermination.

Enrollment for these voluntary applicants follows the same process as described in ABP 2(a). The voluntary enrollment process is the same for all members enrolling into HIP Link. Members with these eligibility types can be distinguished when the member calls to request a transfer to HIP Link. When requesting a transfer these members will be informed that they may opt out of HIP Link at any time. Information on opting out of HIP Link is also included in the members eligibility notice, member manual, and general program FAQs. All materials and member contacts also advise the member that the enrollment broker can provide more detailed benefit information on the differences between HIP and HIP Link.

When members that are eligible for voluntary enrollment in the HIP Link ABP elect to disenroll from HIP Link they do so by contacting the Division of Family Resources utilizing the change reporting process and request to be transfered from HIP Link to HIP. The transfer is effective the first of the month following the receipt of the transfer request. The member is responsible for disenrolling from the employer sponsored insurance once the coverage is effective.

Like all applicants and HIP members that request a transfer to HIP Link, those eligible for voluntary enrollment in the ABP will receive an eligibility notice from the state that informs them if their HIP Link eligibility was verified with their employer and if so, what their HIP Link start date is. This notice also provides information on how to access enrollment counseling for information on the differences between the HIP and HIP Link benefit packages, advises the member that individuals exempt from mandatory enrollment may transfer from HIP to HIP Link at any time, and informs the member that those age 19 and 20 will receive EPSDT benefits that includes all medically necessary 1905(a) benefits via use of the HIP Link card if these benefits are not provided under their employer health plan. Information on enrollment counseling and the ability for some groups to transfer from HIP Link to HIP at any time is also included in member materials and HIP Link marketing and informational materials accessible through the HIP Link website.

All members seeking counseling who are exempt from mandatory enrollment in ABP based on their case record, including Section 1931 low-income parents and caretakers, pregnant women, and transitional medical assistance, will receive counseling from the enrollment broker about the the differences between the individual's current HIP State Plan benefits and the benefits available under the HIP Link approved ESI as well as counseling on cost-sharing. The enrollment broker will have access to the benefit documents provided by the HIP Link approved employer health plans and the HIP Link Employer Counseling Team's plan review notes to assist them in advising the member on the differences between HIP Basic, HIP Plus, and the HIP State Plan benefits. For applicants and prospective applicants, the enrollment broker will ask basic income questions and advise individuals with income levels that may qualify them as a low-income parent and caretaker that they may be eligible for additional benefits not present in commercial coverage through the HIP State Plan benefit package if they are found eligible for those benefits in HIP. Enrollment counseling is not required for applicants or members to enroll in HIP Link, but it is an option for all prospective HIP Link enrollees including low-income parents and caretakers, transitional medical assistance, and pregnant women. Enrollment counseling continues to be available after the individual enrolls in HIP Link to help individuals decide if HIP Link remains the best coverage option. Those exempt from mandatory enrollment in an ABP can leverage ongoing enrollment counseling to support decision making around transferring from HIP Link to HIP.

In addition to the eligibility notice and enrollment counseling tailored to the benefits and cost sharing of the specific employer sponsored health plan, HIP Link members will also receive a member manual that serves as a comprehensive program guide and covers content relevant to members from eligibility, calculation of their contribution and the member prepayment schedule. The member manual includes information on the benefits in HIP Link and the potential benefit differences between their HIP Link employer plan and the benefits available in HIP. The member manual details benefits that are available to the populations exempt from mandatory enrollment in an ABP through the HIP State Plan benefit option. The member manual provides reference for the qualifying events, including becoming medically frail, that allow an individual to transfer from HIP Link back to HIP and provides a guide of how to request a transfer to HIP utilizing the change reporting process. All HIP Link members will receive a HIP Link member manual when they enroll into HIP Link.

Provide a copy of the letter, email text or other communication text that will be used to inform individuals about voluntary enrollment.

An attachment is submitted.

When did/will the state/territory inform the individuals?

Applicants and current members that request a transfer to HIP Link will receive notification on the times outlined above. Depending on the start date of their HIP Link eligible ESI, applicants may be directly enrolled into HIP Link effective the first of the month in which they receive their eligibility notice.

Please describe the state/territory's process for allowing voluntarily enrolled individuals to disenroll.

Section 1931 Parents and Caretakers, low-income 19 and 20 year olds, individuals eligible for transitional medical assistance, and pregnant women may disenroll from HIP Link at any time by contacting the Division of Family Resources and utilizing the existing change reporting process to request a transfer from HIP Link to HIP. Disenrollment for these populations will be effective the first of the month following the disenrollment request.

☑ The state/territory assures it will document in the exempt individual's eligibility file that the individual:

a) Was informed in accordance with this section prior to enrollment;

b) Was given ample time to arrive at an informed choice; and

c) Voluntarily and affirmatively chose to enroll in the Alternative Benefit Plan.

Where will the information be documented? (Check all that apply.)

☐ In the eligibility system.

☐ In the hard copy of the case record.

☒ Other:

Describe:

All individuals that enroll in HIP Link will may access options counseling through the enrollment broker and will be informed that upon enrollment into HIP Link they will be covered by their employer sponsored insurance and not HIP. Individuals that call for options counseling will have their request for counseling documented in the enrollment brokers call tracking system. Information on how to access options counseling for HIP Link is provided in general HIP Link marketing and outreach materials, including materials posted online, member manuals and other member material, all specific notices that go to individuals requesting HIP Link, and by the call center when members ask about HIP Link or request a transfer from HIP to HIP Link.

What documentation will be maintained in the eligibility file? (Check all that apply.)

☐ Copy of correspondence sent to the individual.

☐ Signed documentation from the individual consenting to enrollment in the Alternative Benefit Plan.

☒ Other:

Describe:

Eligibility notices sent to HIP Link members inform all members of the option for enrollment counseling via the enrollment broker. That individuals who are exempt from mandatory ABP enrollment may disenroll at any time through the change reporting process is detailed in the HIP Link member manual . For individuals that contact the enrollment broker for specific options counseling, record that the individual took part in the enrollment counseling will be noted in the individuals record. Depending on if the individual contacts the enrollment broker for HIP Link options counseling during the application process or after being determined eligible for HIP, the record of the counseling process may be associated with the member's name as provided to the enrollment broker, or the members identification number.

☑ The state/territory assures that it will maintain data that tracks the total number of individuals who have voluntarily enrolled in an Alternative Benefit Plan and the total number who have disenrolled.

Other Information Related to Enrollment Assurance for Voluntary Participants (optional):

PRA Disclosure Statement

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V.20131219

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-L- ☐

OMB Expiration date: 10/31/2014

Enrollment Assurances - Mandatory Participants — ABP2c

These assurances must be made by the state/territory if enrollment is mandatory for any of the target populations or sub-populations.

When mandatorily enrolling eligibility groups in an Alternative Benefit Plan (Benchmark or Benchmark-Equivalent Plan) that could have exempt individuals, prior to enrollment:

☑ The state/territory assures it will appropriately identify any individuals in the eligibility groups that are exempt from mandatory enrollment in an Alternative Benefit Plan or individuals who meet the exemption criteria and are given a choice of Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan, not subject to section 1937 requirements.

How will the state/territory identify these individuals? (Check all that apply)

☒ Review of eligibility criteria (e.g., age, disorder/diagnosis/condition)

Describe:

Individuals that are already enrolled in HIP may request transfer to HIP Link at any time. Medically frail HIP enrollees will be identified in HIP and if they request to transfer to Link, they may return to HIP through the standard change reporting process.

☒ Self-identification

Describe:

Individuals that develop a condition that qualifies as medically frail may report this condition at any time to the state through the standard change reporting process. If an individual reports that they have developed a condition that qualifies them as medically frail, they may leave HIP Link at any time by completing and returning the health condition frail questionnaire. If they request a transfer from HIP Link to HIP, their condition will be verified at the start of their HIP enrollment.

☐ Other

☑ The state/territory must inform the individual they are exempt or meet the exemption criteria and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

☑ The state/territory assures that for individuals who have become exempt from enrollment in an Alternative Benefit 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 or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

How will the state/territory identify if an individual becomes exempt? (Check all that apply)

☐ Review of claims data

☒ Self-identification

☐ Review at the time of eligibility redetermination

☐ Provider identification

☐ Change in eligibility group

☐ Other

How frequently will the state/territory review the Alternative Benefit Plan population to determine if individuals are exempt from mandatory enrollment or meet the exemption criteria?

○ Monthly

○ Quarterly

○ Annually

○ Ad hoc basis

◉ Other

Describe:

Individuals enrolled in HIP Link who are medically frail may leave HIP Link at any time and return to HIP. Transfers from HIP Link to HIP are effective the first of the month following the receipt of the medically frail questionnaire. To return to enrollment in HIP, the individual will report that they have developed a condition, complete and return the health condition questionnaire, and request to transfer from HIP Link to HIP. Individuals transfered to HIP will have their condition verified in accordance with the HIP Plus or HIP Basic ABP medically frail verification process utilizing the Milliman Underwriting Guidelines.

☑ The state/territory assures that it will promptly process all requests made by exempt individuals for disenrollment from the Alternative Benefit Plan and has in place a process that ensures exempt individuals have access to all standard state/territory plan services or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

Describe the process for processing requests made by exempt individuals to be disenrolled from the Alternative Benefit Plan:

The medically frail may disenroll from HIP Link at any time by contacting the Division of Family Resources and utilizing the change reporting process to request a transfer from HIP Link to HIP. Individuals requesting a transfer from HIP Link to HIP due to medically frail status are provided with a health condition questionnaire and to complete the transfer the individual must complete the questionnaire. The health conditions indicated by the individual are not subject to verification to transfer from HIP Link to HIP but will be verified in HIP as detailed by the HIP Basic and HIP Plus ABPs.

Other Information Related to Enrollment Assurance for Mandatory Participants (optional):

Individuals who have depleted funds in their power account are subject to additional cost-effectiveness analysis and may be transferred back to HIP Plus or Basic.

PRA Disclosure Statement

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-L- ☐ OMB Expiration date: 10/31/2014

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

Select one of the following:

- ○ The state/territory is amending one existing benefit package for the population defined in Section 1.
- ◉ The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package: HIP Link

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

- ◉ Benchmark Benefit Package.
- ○ Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

- ○ The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).
- ○ State employee coverage that is offered and generally available to state employees (State Employee Coverage):
- ○ A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):
- ◉ Secretary-Approved Coverage.
  - ○ The state/territory offers benefits based on the approved state plan.
  - ◉ The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.

Please briefly identify the benefits, the source of benefits and any limitations:

The HIP Link benefits are benchmarked to the Indiana Essential Health Benefits Benchmark. Through 2017 the Indiana Essential Health Benefit Benchmark is the Anthem Small Group Blue Access PPO plan. HIP Link coverage will be offered through employer sponsored health plans. To be eligible for HIP Link, employer sponsored health plans will be reviewed by the state to confirm that (1) the Indiana Department of Insurance has already certified the plan as meeting the Indiana Essential Health Benefit requirements, (2) that the Indiana Family and Social Services HIP Link Employer Counseling Team has reviewed the benefits offered in the plan and indicated that the plan meets the HIP Link minimum value requirements and essential health benefit requirements that are the floor of coverage as detailed in ABP 5.

Variation in benefits from the essential benefits offered in the Indiana essential health benefits is permitted when one of the following pathways to review and approve Employer Plans for HIP Link ABP is utilized:
* For plans found compliant by the Indiana Department of Insurance for the QHP or small group essential health benefits, no further EHB review is needed. These plans are substantially equal to the HIP Link ABP.
*After determination by the state that EHB is met in each ESI plan, plans that are found to offer benefits at least equal to the floor of coverage in the HIP Link ABP are considered substantially equal to the ABP.
*For ESI plans with variations in benefits from the HIP Link ABP floor of coverage there are two paths:

a. Use the benchmark-equivalent pathway to determine aggregate actuarial value of an ESI plan and compare it to the actuarial value of the HIP Link ABP, following the process described in 440.335 and 440.340, OR
b. Demonstrate actuarial equivalence on a benefit to benefit basis within the same EHB category for those different benefit/s offered in the ESI plan to those offered in the HIP Plink ABP

If the employee plan has the same set of benefits as the HIP Link base benchmark, but is more limited in its amount, duration and scope, the state will ensure that these services are provided to the level in the base benchmark through the HIP Link POWER account.

EPSDT services for 19 and 20 year olds are assured separately without limitations and are covered through the HIP Link member eligibility card and POWER account. All other benefits and limitations are detailed in ABP 5, the HIP 2.0 1115 demonstration, and the associated HIP Link protocol.

Selection of Base Benchmark Plan

The state/territory must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

The Base Benchmark Plan is the same as the Section 1937 Coverage option. No

Indicate which Benchmark Plan described at 45 CFR 156.100(a) the state/territory will use as its Base Benchmark Plan:

- (●) Largest plan by enrollment of the three largest small group insurance products in the state's small group market.
- ( ) Any of the largest three state employee health benefit plans by enrollment.
- ( ) Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- ( ) Largest insured commercial non-Medicaid HMO.

Plan name: Anthem Blue PPO SG Option 6

Other Information Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional):

The state assures that all services in the base benchmark have been accounted for throughout the benefit chart found in ABP5.
The state assures the accuracy of all information in ABP5 depicting amount, duration and scope parameters of services authorized in the base benchmark.

PRA Disclosure Statement

V.20131219

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- ☐

Alternative Benefit Plan Cost-Sharing — ABP4

☐ Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A. Yes

☐ The state/territory has completed and attached to this submission Attachment 4.18-F to indicate the Alternative Benefit Plan's cost-sharing provisions that are different from those otherwise approved in the state plan.

An attachment is submitted.

Other Information Related to Cost Sharing Requirements (optional):

A description of the HIP Link cost sharing is contained Indiana's HIP 2.0 1115 Demonstration and associated HIP Link protocol.

V.20131219

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- [ ]

Benefits Description **ABP5**

The state/territory proposes a "Benchmark-Equivalent" benefit package. No

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

Blue 5 Blue Access PPO Medical Option 6 Rx Option G
Anthem Ins Companies Inc (Anthem BCBS)

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary-Approved

Alternative Benefit Plan

1. Essential Health Benefit: Ambulatory patient services — Collapse All

Benefit Provided: Primary Care Visit to Treat an Injury or Illness
Source: Base Benchmark Small Group — Remove
Authorization: Other
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Specialist visit
Source: Base Benchmark Small Group — Remove
Authorization: Other
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Other practitioner office visit (e.g. nurse, PA)
Source: Base Benchmark Small Group
Authorization: Other
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None

Scope Limit:

None

Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Outpatient facility (e.g. Amb. surgery center)

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Outpatient surgery physician/surgical services

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Alternative Benefit Plan

Benefit Provided: Private Duty Nursing

Source: Base Benchmark Small Group

Remove

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: 82 visit per plan year, 164 per lifetime

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Base benchmark contained a $50,000 per benefit period (benchmark plan limit) which is equal to 82 visits per benefit period in the Indiana EHB. $100,000 per lifetime (benchmark plan limit) is equal to 164 visits per lifetime in the Indiana EHB. Limit applies to in-home setting, service is non-covered in an inpatient setting.

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Urgent Care Centers or Facilities

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Home Health Care Services

Source: Base Benchmark Small Group

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: 90 visits per plan year

Duration Limit: None

Scope Limit:

Member must be confined to the home for medical reasons and be physically unable to obtain needed medical services on an outpatient basis. Custodial care is not covered.

Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Home Health Care includes professional, technical, and health aide services. Does not include in home manipulation therapy.

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Dialysis

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Radiation Therapy

Source:

Base Benchmark Small Group

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general

member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided: Chemotherapy

Source: Base Benchmark Small Group

Remove

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Infusion Therapy

Source: Base Benchmark Small Group

Remove

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Renal Dialysis/Hemodialysis

Source: Base Benchmark Small Group

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Remove

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Allergy Treatment

Source: Base Benchmark Small Group

Remove

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Dental Services for accidental injury

Source: Base Benchmark Small Group

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Coverage for treatment performed within 12 months of injury. Damage to teeth due to chewing or biting not considered accidental injury and is not covered.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit limited to $3,000 of coverage. For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is

not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided:

Clinical trials for cancer treatment

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Voluntary sterilization for males

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

TMJ

Source:

Base Benchmark Small Group

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Alternative Benefit Plan

Amount Limit: None

Duration Limit: None

Remove

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Chiropractic

Source: Base Benchmark Small Group

Remove

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: 12 visits per plan year

Duration Limit: None

Scope Limit:

Covers spinal manipulation and manual medical intervention services including OMT. Services not covered in an in home setting.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Visit limit is for all manipulation treatments including chiropractic and osteopathic manipulation treatment.

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Add

Alternative Benefit Plan

2. Essential Health Benefit: Emergency services — Collapse All

Benefit Provided: Emergency Department Services

Source: Base Benchmark Small Group — Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Emergency Transportation (e.g. Ambulance)

Source: Base Benchmark Small Group — Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Coverage for transportation to emergency services only.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

☑ 3. Essential Health Benefit: Hospitalization Collapse All ☐

Benefit Provided: Inpatient hospital services (e.g. Hospital stay)

Source: Base Benchmark Small Group

Remove

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Inpatient physician and surgical services

Source: Base Benchmark Small Group

Remove

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Human organ and tissue transplant services

Source: Base Benchmark Small Group

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: Other

Duration Limit: None

Scope Limit:

Medically necessary human organ and tissue transplant services. When a human organ or tissue transplant is provided from a living donor to a covered person, both the recipient and the donor may receive the benefits of the health plan.

Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Unrelated Donor Searches is limited to $30,000 per transplant.

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Non-cosmetic reconstructive surgery

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Mastectomy - Reconstructive surgery

Source:

Base Benchmark Small Group

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general

member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided:

Anesthesia

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Add

Alternative Benefit Plan

4. Essential Health Benefit: Maternity and newborn care — Collapse All

Benefit Provided: Prenatal and postnatal care

Source: Base Benchmark Small Group — Remove

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Surrogate services not covered

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Delivery and all inpatient services for maternity

Source: Base Benchmark Small Group — Remove

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Surrogate services not covered

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Add

5. Essential Health Benefit: Mental health and substance use disorder services including behavioral health treatment

Collapse All ☐

Benefit Provided: Mental/behavioral health outpatient services

Source: Base Benchmark Small Group

Remove

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Mental/behavioral health inpatient services

Source: Base Benchmark Small Group

Remove

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Custodial care and residential treatment services are not covered.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Substance abuse disorder outpatient services

Source: Base Benchmark Small Group

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Remove

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Substance abuse disorder inpatient services

Source: Base Benchmark Small Group

Remove

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Custodial care and residential treatment services are not covered.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Add

6. Essential Health Benefit: Prescription drugs

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):	Authorization:	Provider Qualifications:
☒ Limit on days supply	Yes	State licensed
☒ Limit on number of prescriptions		
☒ Limit on brand drugs		
☒ Other coverage limits		
☒ Preferred drug list		

Coverage that exceeds the minimum requirements or other:

The prescription drug benefit will offer comprehensive coverage substantially equivalent to the state essential health benefit benchmark. Formularies may vary by employer plan. All formularies will be reviewed for comprehensiveness and compliance with the CCIIO non-discriminatory benefit design checks as detailed in the ABP 5 supplemental plan review information.

Prescription supply may be limited to 30 days for retail pharmacy and up to 90 days for mail service.

Exclusions or non covered drugs may include over the counter drugs and drugs with over the counter equivalents; Drugs for weight loss; Nutritional and/or dietary supplements; drugs for the treatment of sexual or erectile dysfunction or inadequacies; fertility drugs; human growth hormone for children born small for gestational age; treatment of onchomycosis.

Exact coverage may vary by approved HIP Link employer plan. For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Alternative Benefit Plan

7. Essential Health Benefit: Rehabilitative and habilitative services and devices — Collapse All

Benefit Provided: Skilled Nursing Facility

Source: Base Benchmark Small Group — Remove

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: 90 days per plan year

Duration Limit: None

Scope Limit: Custodial care is not covered.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Physical, Speech and Occupational Therapy

Source: Base Benchmark Small Group — Remove

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: 20 visits per therapy per plan year

Duration Limit: None

Scope Limit: Visit limit includes both rehabilitative and rehabilitative services

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage provided for at least 20 visits for each of the following: physical therapy, occupational therapy, speech therapy.

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Durable medical equipment

Source: Base Benchmark Small Group

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Remove

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment. Rental caps and time frame limitations may vary between plans.

Benefit Provided: Vision correction after surgery or accident

Source: Base Benchmark Small Group

Remove

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Covered if medically necessary.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Inpatient rehabilitation therapy

Source: Base Benchmark Small Group

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: 60 days per benefit year

Duration Limit: None

Scope Limit: Pulmonary rehab in the acute inpatient setting is not covered.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Limit is combined for all inpatient rehabilitation types. For authorization, the member's primary coverage

provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided: Prosthetics

Source: Base Benchmark Small Group

Remove

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Covered if medically necessary.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

A prosthetic device means an artificial arm or leg or any portion of limb. Covered services include the purchase, replacement or adjustment of artificial limbs when required due to a change in a benficiaries physical condition or body size due to normal growth.

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Othotics

Source: Base Benchmark Small Group

Remove

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Covered if medically necessary.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Orthotic devices are covered under this benefit as braces or supports designed as part of the artificial arm or leg.

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Alternative Benefit Plan

Benefit Provided: Medical supplies

Source: Base Benchmark Small Group

Remove

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Covered if medically necessary.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit includes but may not be limited to diabetic supplies and equipment, casts, dressings, splints, and other devices used for reduction of fractures and dislocations.

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Hospice Services

Source: Base Benchmark Small Group

Remove

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: To be eligible for Hospice benefits, the patient must have a life expectancy of six months or less, as confirmed by the attending Physician. Covered Services will continue if the Member lives longer than six months. Housekeeping services not covered

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Autism Services

Source: Base Benchmark Small Group

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Remove

Scope Limit: See below.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage is provided for the treatment of pervasive developmental disorders. Treatment is limited to services prescribed by a physician in accordance with a treatment plan. Pervasive developmental disorder means a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Cardiac Therapy

Source: Base Benchmark Small Group

Remove

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: 36 visits per plan year

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage provided for 36 visits of cardiac therapy.

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Pulmonary Therapy

Source: Base Benchmark Small Group

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: 20 visits per plan year

Duration Limit: None

Scope Limit:

None

Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage provided for 20 visits per plan year.

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Add

Alternative Benefit Plan

8. Essential Health Benefit: Laboratory services — Collapse All

Benefit Provided: Diagnostic test (e.g. lab work)
Source: Base Benchmark Small Group
Remove

Authorization: Other
Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None
Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Imaging (e.g. CT/PET scans, EKGs, MRIs)
Source: Base Benchmark Small Group
Remove

Authorization: Other
Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None
Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided: Pathology
Source: Base Benchmark Small Group

Authorization: Other
Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None
Duration Limit: None

Alternative Benefit Plan

Scope Limit:

Covered if medically necessary.

Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Radiology

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Covered if medically necessary.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Add

☑ 9. Essential Health Benefit: Preventive and wellness services and chronic disease management Collapse All ☐

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided:
Preventive care, screening, immunization

Source:
Base Benchmark Small Group

Remove

Authorization:
Other

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Preventive care provided in accordance with minimum requirements.

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Diabetes education

Source:
Base Benchmark Small Group

Authorization:
Other

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Coverage for palliative foot care, medical supplies, equipment, and education for diabetes care for all diabetics.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Diabetes Self Management Training for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when: medically necessary; ordered in writing by a physician or a podiatrist; and provided by a health care professional who is licensed, registered, or certified under state law.

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general

member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided:

Routine PSA test

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

1 per year

Duration Limit:

None

Scope Limit:

Coverage for individuals who are at least 50 years old or less than 50 if high risk for prostate cancer. Covered if medically necessary.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Add

Alternative Benefit Plan

10. Essential Health Benefit: Pediatric services including oral and vision care — Collapse All

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Available to enrollees age 20 and under

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
This benefit will be provided by Medicaid if the service or treatment is not covered on the employer plan or if the employer plan limits coverage of any medically necessary 1905(a) benefit to the EPSDT population.

Add

Alternative Benefit Plan

☐ 11. Other Covered Benefits from Base Benchmark Collapse All ☐

☐ 12. Base Benchmark Benefits Not Covered due to Substitution or Duplication Collapse All ☐

Alternative Benefit Plan

☒ 13. Other Base Benchmark Benefits Not Covered Collapse All ☐

Base Benchmark Benefit not Included in the Alternative Benefit Plan:

Non-emergency care when traveling outside the U.S.

Source: Base Benchmark

Remove

Explain why the state/territory chose not to include this benefit:

This benefit is in the Indiana EHB base benchmark and may be included in HIP Link approved plans. This benefit is not considered an essential health benefit for the ABP and health plans will not be disqualified from HIP Link if they do not offer this coverage. This services is not permissible under federal Medcaid rules.

Base Benchmark Benefit not Included in the Alternative Benefit Plan:

Transplant Services- Transportation and Lodging

Source: Base Benchmark

Remove

Explain why the state/territory chose not to include this benefit:

This benefit has a $10,000 dollar limit that cannot be converted to a service limit. It is not considered an essential health benefit. HIP Link employer plans may offer this benefit but the $10,000 of coverage for this benefit is not required for HIP Link.

Add

☐ 14. Other 1937 Covered Benefits that are not Essential Health Benefits Collapse All ☐

☐ 15. Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)

Collapse All ☐

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.

V.20131219

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-L- ☐

OMB Expiration date: 10/31/2014

Benefits Assurances — ABP7

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age. Yes

☑ The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).

☑ The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act.

Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

○ Through an Alternative Benefit Plan.

◉ Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Per 42 CFR 440.345, please describe how the additional benefits will be provided, how access to additional benefits will be coordinated and how beneficiaries and providers will be informed of these processes in order to ensure individuals have access to the full EPSDT benefit.

Indicate whether additional EPSDT benefits will be provided through fee-for-service or contracts with a provider:

◉ State/territory provides additional EPSDT benefits through fee-for-service.

○ State/territory contracts with a provider for additional EPSDT services.

Other Information regarding how ESPDT benefits will be provided to participants under 21 years of age (optional):

HIP Link participants under age 21 can access EPSDT services when they visit a Medicaid enrolled provider and present their HIP Link card. EPSDT services will be covered in addition to coverage provided by the employer plan and will be covered beyond any limits present in the employer plan.

Prescription Drug Coverage Assurances

☑ The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

☑ The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.

☑ The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.

☑ The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

Other Benefit Assurances

Alternative Benefit Plan

- ☑ The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.
- ☑ The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.
- ☑ The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.
- ☑ The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.
- ☑ The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.
- ☑ The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.
- ☑ The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.
- ☑ The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

PRA Disclosure Statement

V.20131219

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- ☐

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:

☐ Managed care.

☐ Fee-for-service.

☒ Other service delivery system.

Other Service Delivery Model

Name of service delivery system:

HIP Employer Benefit Link - Premium Assistance

Provide a narrative description of the model:

HIP Link is an optional defined contribution insurance program for all HIP eligible individuals who have access to HIP Link qualifying employer sponsored insurance (ESI). HIP Link allows HIP eligible individuals to choose to enroll into their qualifying ESI instead of into HIP. This option increases choice for beneficiaries and also reduces crowd out of private health insurance.

HIP Link maintains HIP's consumer directed framework by providing enrolled individuals with a HIP Link Personal Wellness and Responsibility (POWER) account valued at $4,000. This Health Savings like account holds the state's defined contribution for ESI coverage of $4,000 and will cover the premiums and out of pocket costs associated with enrollment in ESI. Additionally, the account serves as supplemental coverage for medical expenses incurred during the employer's annual coverage period. Like HIP Plus, individuals enrolled in HIP Link will be required to contribute 2 percent of their income towards the cost of their employer sponsored insurance. Premiums will be deducted from the employee's paycheck as usual, and the state will send the employee prepayment for the difference between the premium amount and their 2 percent POWER account contribution.

The individual who elects to enroll into HIP Link will receive the benefits offered by the HIP Link qualified employer health insurance instead of the HIP Plus, HIP Basic, or HIP State Plan benefits as applicable. HIP Link beneficiaries will access benefits provided through their employer sponsored insurance and limited additional benefits as specified in this ABP.

The state will provide HIP participants with support as they contemplate enrolling in HIP or HIP Link. The state's enrollment broker will provide counseling to assist them with their decision. The enrollment broker will have access to information detailing the benefits in each employer sponsored plan and will be able to explain the differences between HIP and HIP Link, as well as answering questions about HIP Link.

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-L- [ ]

OMB Expiration date: 10/31/2014

Employer Sponsored Insurance and Payment of Premiums — ABP9

The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package.	No
The state/territory otherwise provides for payment of premiums.	Yes

Provide a description including the population covered, the amount of premium assistance by population, required contributions, cost-effectiveness test requirements, and benefits information.

HIP Link is an optional defined contribution insurance program for all HIP eligible individuals including individuals eligible in the adult group, as low income parent and caretakers or 19 and 20 year olds, or TMA eligibles who have access to HIP Link qualifying employer sponsored insurance (ESI). As detailed in ABP 1, HIP Link also offers the opportunity for continued coverage under employer sponsored insurance for women who are pregnant at their redetermination. HIP Link allows these HIP eligible individuals to choose to enroll into their qualifying ESI instead of into HIP or Medicaid as applicable.

HIP Link enrollees receive a HIP Link card, in addition to the insurance card supplied by the ESI health plan, which serves as proof of their supplemental coverage. At the time of service, enrollees will present both the ESI primary and HIP Link supplemental coverage cards Providers will bill the ESI as primary insurance coverage. The portion of cost that is defined as individual responsibility in the form of a deductible, copay, or coinsurance is then submitted to HIP Link by the provider. HIP Link will pay the member's portion of the service. Provided the individual has HIP Link funds and uses a provider that is both in network with Medicaid and with their primary insurance, they will not be responsible for any cost sharing for services covered by their primary insurance. If the individual does not have sufficient HIP Link funds or uses a provider that is not in network for Medicaid but is in-network for their primary insurance, they will responsible for the maximum allowable Medicaid cost sharing amounts. Cost sharing will not be applied to pregnant members, Native American Members, or members that have met their 5 percent of quarterly income cost sharing limit.

HIP Link provides enrolled individuals with a $4,000 HIP Link Personal Wellness and Responsibility (POWER) account. This health savings-like account holds the state's defined contribution for ESI coverage of $4,000 and will cover the premiums and out of pocket costs associated with enrollment in ESI.

When two or more individuals in a family are enrolled together, the HIP Link accounts are combined. For example, enrolled spouses will have a combined $8,000 HIP Link account. Like an account for a single enrolled employee, a portion of the combined account is allocated to the ESI premiums, and the remainder of the account covers the out-of-pocket costs for ESI on a first in-first out basis, regardless of which enrolled Link individual the claim applied to.

Individuals enrolled in HIP Link will be required to contribute 2 percent of their income towards the cost of their employer sponsored insurance. Premiums will be deducted from the employee's paycheck as usual, and the state will mail the employee pre-payment checks for the difference between the premium amount and their 2 percent POWER account contribution. Individuals 2 percent contributions are in addition to the $4,000 provided by the state to cover premiums and out of pocket costs. Once a month, the HIP Link enrolled ESI policy holder will receive a check prospectively from the state for the difference between their 2 percent required contributions and their required premium payments for the next month. To ensure that the pre-payment to the individual is accurate, on a monthly basis all HIP Link eligible employers will confirm the HIP Link member's continued eligibility for ESI and the premium amounts that will be deducted for the next month's coverage.

To be eligible for HIP Link, an employer plan must meet the HIP Link affordability test. Plan affordability is a function of the premiums the employer applies to employees and eligible dependents enrolled in their plan, the plan deductibles, coinsurance, out-of-pocket maximums and any funds in the form of Health Reimbursement Accounts (HRA) that are provided by the employer to cover the costs of coverage. Since some of these requirements may vary by employer, it is possible that a small group plan that is HIP Link eligible with one employer is not HIP Link eligible with another employer due to a higher premium amount or not offering an HRA.

The state's actuary, Milliman Inc., has developed a plan affordability tool that takes inputs of employee premium contribution amounts, plan deductibles, out of pocket maximums, average coinsurance, and employer HRA contributions. These inputs are compared to the funding available in the HIP Link POWER account ($4,000 for an individual and $8,000 for a couple, etc.), average HIP Link enrollee 2% contribution limits, the projected costs of coverage on HIP Link with the applicable cost sharing limits, and the costs of coverage in HIP. If the affordability tool analysis determines that the employer plan is less costly than standard HIP, then the plan will be considered affordable and eligible for HIP Link.

Individuals enrolled in HIP Link will receive the benefits offered by the HIP Link qualified employer health insurance instead of the HIP Plus, HIP Basic, or HIP State Plan benefits as applicable. HIP Link beneficiaries will access benefits provided through their employer sponsored insurance. Benefits offered on the employer plan are reviewed for alignment with the ABP which are based on the state essential health benefits and that coverage in all EHB categories, with the exception of pediatric dental and vision is required.

HIP Link will also cover services, required by the alternative benefit plan that may not be covered by the primary insurer including family planning at non-network providers, 72 hour emergency supply of pharmaceuticals, FQHC and RHC services, and non-emergency transportation for low-income parents and caretakers. Payments for these services will come from the HIP Link POWER account and be accessed by providers submitting claims to HIP Link utilizing the information on the member's HIP Link card. Low-income parents and caretakers, transitional medical assistance, or women that become pregnant and elect to stay in HIP Link at their redetermination period, will have access to non-emergency transportation benefits. These services will be reimbursed at state plan Medicaid reimbursement rates.

HIP Link members that complete a year of coverage in HIP Link will be eligible for rollover. HIP Link rollover is similar to HIP Basic Rollover in the initial coverage year and will be based on the amount remaining in the HIP Link POWER account. HIP Link enrollees may reduce their future year's HIP Link contribution amount by up to 50 percent based on the percentage of HIP Link funds remaining in their HIP Link account. In future years of HIP Link enrollment, HIP Link enrollees may be eligible to increase this rollover to 100 percent if they participate in an employee wellness program or complete recommended preventive services.

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

The beneficiary will receive a benefit package that includes a wrap of the following: FQHC and RHC services, family planning services, EPSDT for individuals under 21 and, for applicable populations as specified in this ABP SPA, non-emergency transportation. Further information related to ABP9 is contained in Indiana's HIP 2.0 1115 Demonstration and associated HIP Link protocol.

PRA Disclosure Statement

V.20131219

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-L- ☐ OMB Expiration date: 10/31/2014

General Assurances — ABP10

Economy and Efficiency of Plans

☑ The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit 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.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services. Yes

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.

☑ The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).

☑ The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

PRA Disclosure Statement

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V.20131219

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-L- ☐

OMB Expiration date: 10/31/2014

Payment Methodology **ABP11**

Alternative Benefit Plans - Payment Methodologies

☑ The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.

An attachment is submitted.

PRA Disclosure Statement

V.20131219

Medicaid Premiums and Cost Sharing

State Name: Indiana

OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0004

Expiration date: 10/31/2014

Cost Sharing Requirements — G1

1916
1916A
42 CFR 447.50 through 447.57 (excluding 447.55)

The state charges cost sharing (deductibles, co-insurance or co-payments) to individuals covered under Medicaid. Yes

☑ The state assures that it administers cost sharing in accordance with sections 1916 and 1916A of the Social Security Act and 42 CFR 447.50 through 447.57.

General Provisions

☑ The cost sharing amounts established by the state for services are always less than the amount the agency pays for the service.

■ No provider may deny services to an eligible individual on account of the individual's inability to pay cost sharing, except as elected by the state in accordance with 42 CFR 447.52(e)(1).

■ The process used by the state to inform providers whether cost sharing for a specific item or service may be imposed on a beneficiary and whether the provider may require the beneficiary to pay the cost sharing charge, as a condition for receiving the item or service, is (check all that apply):

☐ The state includes an indicator in the Medicaid Management Information System (MMIS)

☐ The state includes an indicator in the Eligibility and Enrollment System

☐ The state includes an indicator in the Eligibility Verification System

☐ The state includes an indicator on the Medicaid card, which the beneficiary presents to the provider

☒ Other process

Description:

Cost sharing amounts and policies for all populations are outlined in the Indiana Health Coverage Program (IHCP) Provider Manual. Provider reference materials, such as the medical policy manual and the modules, describing Medicaid policy is available on IndianaMedicaid.com. Providers are instructed to utilize the modules during IHCP provider workshops, at the IHCP annual seminar, within banners and bulletins, during provider association meetings, and when communicating with OMPP staff. Providers were informed of the cost-sharing policy via bulletin which was disseminated by email and is currently archived on IndianaMedicaid.com. The Indiana Office of Medicaid Policy and Planning has formed a communications team to efficiently distribute material and policy changes to providers. The team has a timeline for publications to describe the processes affected by CoreMMIS and any policy updates. Once CoreMMIS has been implemented, tentatively scheduled for January 2, 2017, providers will have the enhanced ability to view cost-sharing liability within the EVS.

■ Contracts with managed care organizations (MCOs) provide that any cost-sharing charges the MCO imposes on Medicaid enrollees are in accordance with the cost sharing specified in the state plan and the requirements set forth in 42 CFR 447.50 through 447.57.

Cost Sharing for Non-Emergency Services Provided in a Hospital Emergency Department

Medicaid Premiums and Cost Sharing

The state imposes cost sharing for non-emergency services provided in a hospital emergency department. Yes

☑ The state ensures that before providing non-emergency services and imposing cost sharing for such services, that the hospitals providing care:

- ■ Conduct an appropriate medical screening under 42 CFR 489.24, subpart G to determine that the individual does not need emergency services;
- ■ Inform the individual of the amount of his or her cost sharing obligation for non-emergency services provided in the emergency department;
- ■ Provide the individual with the name and location of an available and accessible alternative non-emergency services provider;
- ■ Determine that the alternative provider can provide services to the individual in a timely manner with the imposition of a lesser cost sharing amount or no cost sharing if the individual is otherwise exempt from cost sharing; and
- ■ Provide a referral to coordinate scheduling for treatment by the alternative provider.

☑ The state assures that it has a process in place to identify hospital emergency department services as non-emergency for purposes of imposing cost sharing. This process does not limit a hospital's obligations for screening and stabilizing treatment of an emergency medical condition under section 1867 of the Act; or modify any obligations under either state or federal standards relating to the application of a prudent-layperson standard for payment or coverage of emergency medical services by any managed care organization.

The process for identifying emergency department services as non-emergency for purposes of imposing cost sharing is:

Hospitals operationalize this process by performing the required EMTALA screening on the enrollee. The provider is reimbursed for the screening. If a non-emergency based on the prudent layperson standard is determined to exist, the hospital collects the co-payment. Cost sharing for non-emergency services provided in a hospital emergency department is only applicable to individuals in HIP 2.0 as authorized under the state's section 1115 demonstration waiver.

Cost Sharing for Drugs

The state charges cost sharing for drugs. Yes

The state has established differential cost sharing for preferred and non-preferred drugs. No

■ All drugs will be considered preferred drugs.

Beneficiary and Public Notice Requirements

☑ Consistent with 42 CFR 447.57, the state makes available a public schedule describing current cost sharing requirements in a manner that ensures that affected applicants, beneficiaries and providers are likely to have access to the notice. Prior to submitting a SPA which establishes or substantially modifies existing cost sharing amounts or policies, the state provides the public with advance notice of the SPA, specifying the amount of cost sharing and who is subject to the charges, and provides reasonable opportunity for stakeholder comment. Documentation demonstrating that the notice requirements have been met are submitted with the SPA. The state also provides opportunity for additional public notice if cost sharing is substantially modified during the SPA approval process.

Other Relevant Information

PRA Disclosure Statement

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V.20140415

Medicaid Premiums and Cost Sharing

State Name: Indiana

OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0004

Expiration date: 10/31/2014

Cost Sharing Amounts - Categorically Needy Individuals — G2a

1916
1916A
42 CFR 447.52 through 54

The state charges cost sharing to all categorically needy (Mandatory Coverage and Options for Coverage) individuals. Yes

Services or Items with the Same Cost Sharing Amount for All Incomes

	Service or Item	Amount	Dollars or Percentage	Unit	Explanation	
+						X

Services or Items with Cost Sharing Amounts that Vary by Income

Service or Item: Transportation - For which Medicaid pays $10 or less — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+	$27/month	FPL	0.50	$	Trip	Copayment amount charged is based on the reimbursement amount.	X

Service or Item: Transportation - For which Medicaid pays $10.01 to $50 — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+	$27/month	FPL	1.00	$	Trip	Copayment amount charged is based on the reimbursement amount.	X

Service or Item: Transportation - For which Medicaid pays $50.01 or more — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+	$27/month	FPL	2.00	$	Trip	Copayment amount charged is based on the reimbursement amount.	X

Service or Item: Pharmacy — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+	$27/month	FPL	3.00	$	Prescription	Copayment charged for each covered drug dispensed.	X

Medicaid Premiums and Cost Sharing

Add Service or Item

Cost Sharing for Non-preferred Drugs Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-preferred drugs (entered above), answer the following question:

The state charges cost sharing for non-preferred drugs to otherwise exempt individuals. No

Cost Sharing for Non-emergency Services Provided in the Hospital Emergency Department Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-emergency services provided in the hospital emergency department (entered above), answer the following question:

The state charges cost sharing for non-emergency services provided in the hospital emergency department to otherwise exempt individuals. No

PRA Disclosure Statement

V.20140415

Medicaid Premiums and Cost Sharing

State Name: Indiana

OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0004

Expiration date: 10/31/2014

Cost Sharing Amounts - Medically Needy Individuals	G2b
1916 1916A 42 CFR 447.52 through 54	
The state charges cost sharing to all medically needy individuals.	No

PRA Disclosure Statement

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V.20140415

Medicaid Premiums and Cost Sharing

State Name: Indiana

OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0004

Expiration date: 10/31/2014

Cost Sharing Amounts - Targeting	G2c
1916 1916A 42 CFR 447.52 through 54	
The state targets cost sharing to a specific group or groups of individuals.	No

PRA Disclosure Statement

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V.20140415

Medicaid Premiums and Cost Sharing

State Name: Indiana

OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0004

Expiration date: 10/31/2014

Cost Sharing Limitations — G3

42 CFR 447.56
1916
1916A

☑ The state administers cost sharing in accordance with the limitations described at 42 CFR 447.56, and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act, as follows:

Exemptions

Groups of Individuals - Mandatory Exemptions

The state may not impose cost sharing upon the following groups of individuals:

- ■ Individuals ages 1 and older, and under age 18 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118).
- ■ Infants under age 1 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118), whose income does not exceed the higher of:
  - ■ 133% FPL; and
  - ■ If applicable, the percent FPL described in section 1902(l)(2)(A)(iv) of the Act, up to 185 percent.
- ■ Disabled or blind individuals under age 18 eligible for the following eligibility groups:
  - ■ SSI Beneficiaries (42 CFR 435.120).
  - ■ Blind and Disabled Individuals in 209(b) States (42 CFR 435.121).
  - ■ Individuals Receiving Mandatory State Supplements (42 CFR 435.130).
- ■ Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age.
- ■ Disabled children eligible for Medicaid under the Family Opportunity Act (1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act).
- ■ Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends, except for cost sharing for services specified in the state plan as not pregnancy-related.
- ■ Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.
- ■ An individual receiving hospice care, as defined in section 1905(o) of the Act.
- ■ Indians who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services.
- ■ Individuals who are receiving Medicaid because of the state's election to extend coverage to the Certain Individuals Needing Treatment for Breast or Cervical Cancer eligibility group (42 CFR 435.213).

Groups of Individuals - Optional Exemptions

The state may elect to exempt the following groups of individuals from cost sharing:

The state elects to exempt individuals under age 19, 20 or 21, or any reasonable category of individuals 18 years of age or over. No

The state elects to exempt individuals whose medical assistance for services furnished in a home and community-based setting is reduced by amounts reflecting available income other than required for personal needs. No

Services - Mandatory Exemptions

The state may not impose cost sharing for the following services:

- ☑ Emergency services as defined at section 1932(b)(2) of the Act and 42 CFR 438.114(a).
- ☑ Family planning services and supplies described in section 1905(a)(4)(C) of the Act, including contraceptives and pharmaceuticals for which the state claims or could claim federal match at the enhanced rate under section 1903(a)(5) of the Act for family planning services and supplies.
- ☑ Preventive services, at a minimum the services specified at 42 CFR 457.520, provided to children under 18 years of age regardless of family income, which reflect the well-baby and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics.
- ☑ Pregnancy-related services, including those defined at 42 CFR 440.210(a)(2) and 440.250(p), and counseling and drugs for cessation of tobacco use. All services provided to pregnant women will be considered pregnancy-related, except those services specificially identified in the state plan as not being related to pregnancy.
- ☑ Provider-preventable services as defined in 42 CFR 447.26(b).

Enforceability of Exemptions

The procedures for implementing and enforcing the exemptions from cost sharing contained in 42 CFR 447.56 are (check all that apply):

- ☑ To identify that American Indians/Alaskan Natives (AI/AN) are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services in accordance with 42 CFR 447.56(a)(1)(x), the state uses the following procedures:
  - ☐ The state accepts self-attestation
  - ☐ The state runs periodic claims reviews
  - ☒ The state obtains an Active or Previous User Letter or other Indian Health Services (IHS) document
  - ☐ The Eligibility and Enrollment and MMIS systems flag exempt recipients
  - ☐ Other procedure

  Additional description of procedures used is provided below (optional):

- ☑ To identify all other individuals exempt from cost sharing, the state uses the following procedures (check all that apply):

☐ The MMIS system flags recipients who are exempt

☐ The Eligibility and Enrollment System flags recipients who are exempt

☐ The Medicaid card indicates if beneficiary is exempt

☐ The Eligibility Verification System notifies providers when a beneficiary is exempt

☒ Other procedure

Description:

The MMIS system does not deduct the co-payment for exempt populations. For example: (i) when a pregnancy diagnosis or family planning diagnosis is on the claim no co-payment is deducted; and (ii) the claims processing system compares the date of birth on the eligibility file to the date of service on the claim and if under 18 no co-payment is deducted. Providers are responsible for identifying exempt individuals utilizing information included in the provider manual. Core MMIS will be implemented by January 2, 2017 and that information will be in EVS once the Core MMIS is live.

Additional description of procedures used is provided below (optional):

For HIP 2.0 cost sharing, authorized under the State's Section 1115 Demonstration Waiver, the MMIS system flags recipients who are exempt and the Eligibility Verification system notifies providers when a beneficiary is exempt.

Payments to Providers

☑ The state reduces the payment it makes to a provider by the amount of a beneficiary's cost sharing obligation, regardless of whether the provider has collected the payment or waived the cost sharing, except as provided under 42 CFR 447.56(c).

Payments to Managed Care Organizations

The state contracts with one or more managed care organizations to deliver services under Medicaid. Yes

☑ The state calculates its payments to managed care organizations to include cost sharing established under the state plan for beneficiaries not exempt from cost sharing, regardless of whether the organization imposes the cost sharing on its recipient members or the cost sharing is collected.

Aggregate Limits

☑ Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household do not exceed an aggregate limit of 5 percent of the family's income applied on a quarterly or monthly basis.

■ The percentage of family income used for the aggregate limit is:

- (●) 5%
- ( ) 4%
- ( ) 3%
- ( ) 2%
- ( ) 1%
- ( ) Other: [ ] %

☑ The state calculates family income for the purpose of the aggregate limit on the following basis:

- (●) Quarterly
- ( ) Monthly

The state has a process to track each family's incurred premiums and cost sharing through a mechanism that does not rely on beneficiary documentation. Yes

☑ Describe the mechanism by which the state tracks each family's incurred premiums and cost sharing (check all that apply):

☐ As claims are submitted for dates of services within the family's current monthly or quarterly cap period, the state applies the incurred cost sharing for that service to the family's aggregate limit. Once the family reaches the aggregate limit, based on incurred cost sharing and any applicable premiums, the state notifies the family and providers that the family has reached their aggregate limit for the current monthly or quarterly cap period, and are no longer subject to premiums or cost sharing.

☒ Managed care organization(s) track each family's incurred cost sharing, as follows:

For Healthy Indiana Plan (HIP) cost sharing, for which the cost sharing amounts and procedures are authorized under the State's Section 1115 Demonstration Waiver, the managed care organizations (MCOs) receive family income data from the State's fiscal agent. This amount is updated and provided to the MCO whenever the member reports a change in income. The MCOs are contractually required to track the POWER Account contributions, premiums, co-payments and any other cost-sharing information against the total family income data provided by the State's fiscal agent. When a family's total cost-sharing expenditures approach the 5% quarterly family limit, the MCO is required to notify the State. Cost sharing is then suspended until a new quarterly cap period begins.

☒ Other process:

As an interim solution, until the launch of CoreMMIS is executed, the State does not currently charge cost sharing to Medicaid recipients with income less than $27/month. This protects the most high-risk demographics from incurring out-of-pocket costs and exceeding the 5% threshold. Upon the successful demonstration of CoreMMIS, the State will evaluate the interim methodology for efficiency and continue monitoring cost-sharing while making necessary adjustments for improvement. For all other fee-for-service members, the state is utilizing an interim tracking solution through which provider claims data is aggregated in the data warehouse and members are notified of their cost-sharing eligibility as they meet the 5% limit. Notification occurs via a letter being mailed by the State's fiscal agent.

☑ Describe how the state informs beneficiaries and providers of the beneficiaries' aggregate family limit and notifies beneficiaries and providers when a beneficiary has incurred premiums and cost sharing up to the aggregate family limit and individual family members are no longer subject to premiums or cost sharing for the remainder of the family's current monthly or quarterly cap period:

For HIP cost sharing, authorized under the State's Section 1115 Demonstration Waiver, beneficiaries are notified of the aggregate family limit through MCO welcome notices. MCOs are also contractually required to develop provider education, subject to state review and approval on the 5% cap on cost-sharing and the requirement to reduce or waive member co-payments when notified by the MCO or State that the member's family has exceeded the 5% cap on member cost-sharing.

Beneficiaries are notified in writing when the 5% limit has been reached, including the time period for which cost sharing will no longer apply. Providers are required to verify eligibility at every visit. Although not yet implemented until end of Q3, providers would be alerted if the cost sharing limit had been reached and cost sharing can no longer be applied. This will available through both the MCE call centers and State eligibility verification systems.

As result of the changes made to allow for the immediate implementation of the interim solution, providers are no longer receiving a letter from the State. The decision was made to send letters to the member directly in hopes of preventing communication from being sent to the wrong provider or the wrong address. Each Medicaid provider is required to submit four addresses for an enrollment: mail-to, service location, pay-to, and legal address. In lieu of notifying the provider by letter, providers were informed of the 5% cost-share requirement by a bulletin posted on IndianaMedicaid.com along with an email alert. The member notification instructs the member to present the letter to his or her provider and inform the office of the cost-share exemption. At this time, EVS does not have the ability to reflect the member's cost-sharing eligibility. The final solution to update the EVS, requiring CoreMMIS implementation, will work in tandem with the launch of a new Provider Healthcare Portal and allow real-time updates to a member's cost-sharing eligibility status.

The state has a documented appeals process for families that believe they have incurred premiums or cost sharing over the aggregate limit for the current monthly or quarterly cap period. Yes

Describe the appeals process used:

HIP MCOs are contractually required to operate a grievance and appeal process. HIP members have the opportunity to appeal to their MCO and if dissatisfied with the outcome of the MCO appeal process can file an appeal with the State.

Individuals enrolled in FFS can file an appeal directly with the State.

☑ Describe the process used to reimburse beneficiaries and/or providers if the family is identified as paying over the aggregate limit for the month/quarter:

For HIP enrollees, MCOs reimburse beneficiaries and adjust claims to providers in the event a family is identified as paying over the aggregate limit. For FFS enrollees, the State would direct the Fiscal Agent to process a manual reimbursement to the member and manual claims adjustment to the provider.

☑ Describe the process for beneficiaries to request a reassessment of their family aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a premium:

Individuals contact the Family and Social Services Administration (FSSA), Division of Family Resources (DFR) to request a reassessment. DFR then processes to determine if the family aggregate limit needs to be updated.

The state imposes additional aggregate limits, consistent with 42 CFR 447.56(f)(5). No

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V.20140415