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.

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Citation	3.1(a) (6)	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.

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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.