Medicaid Eligibility

State Name: Indiana

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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.

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☒ 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:

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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:

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	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

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.

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