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State/Territory: Indiana

State Plan Amendment (SPA)#: 20-001

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

November 17, 2020

Allison Taylor, Medicaid Director
Family and Social Services Administration
402 W. Washington, Room W374
Indianapolis, IN 46204

RE: Transmittal Number (TN) 20-001

Dear Ms. Taylor:

Enclosed for your records is an approved copy of the following State Plan Amendment (SPA):

SPA TN 20-001: - Tobacco Cessation

- Effective Date: February 1, 2020
- Approval date: November 16, 2020

If you have any questions, please have a member of your staff contact Mai Le-Yuen at (312) 353-2853 or by email at mai.le-yuen@cms.hhs.gov.

Sincerely,

[redacted] Digitally signed by James G. Scott -S
Date: 2020.11.17 18:30:43 06'00'

James G. Scott, Director
Division of Program Operations

Enclosure

cc: Sara Albertson, FSSA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 20-001

2. STATE: Indiana

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
February 1, 2020

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
42 C.F.R 447.53(b)

7. FEDERAL BUDGET IMPACT (*in thousands*) :
a. FFY 2020 $ 17,419
b. FFY 2021 $ 17,416

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
G2a, G3

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
4.18 Page 54, 55, 56(a-f); 4.18-A Page 1-3a; 4.18-C

SUBJECT OF AMENDMENT: This State Plan Amendment makes conforming changes to the Medicaid State Plan to add tobacco cessation drugs to the list of exclusions from cost sharing requirements. The changes were effective February 1, 2020.

10. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED

Indiana's Medicaid State Plan does not require the Governor's review. See Section 7.4 of the State Plan.

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME: Allison Taylor

14. TITLE: Medicaid Director

15. DATE SUBMITTED: 3/31/2020

16. RETURN TO:
Allison Taylor
Medicaid Director
Indiana Office of Medicaid Policy and Planning
402 West Washington Street, Room W461
Indianapolis, IN 46204
ATTN: Amy Owens, Federal Relations Lead

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
March 31, 2020

18. DATE APPROVED
November 16, 2020

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
February 1, 2020

20. SIGNATURE OF REGIONAL OFFICIAL
[redacted]
Digitally signed by James G. Scott -S
Date: 2020.11.17 18:31:26 -06'00'

21. TYPED NAME
James G. Scott

22. TITLE
Director, Division of Program Operations

23. REMARKS

FORM CMS-179 (07/92)

Instructions on Back

Medicaid Premiums and Cost Sharing

State Name: Indiana

OMB Control Number: 0938-1148

Transmittal Number: IN - 20 - 0001

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

Add	Service or Item	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	Tobacco Cessation Products	0.00	$	Prescription	Tobacco cessation products are exempt from copays.	Remove

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.

Add	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	$27/month	FPL	0.50	$	Trip	Copayment amount charged is based on the reimbursement amount.	Remove

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.

Add	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	$27/month	FPL	1.00	$	Trip	Copayment amount charged is based on the reimbursement amount.	Remove

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.

Add	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	$27/month	FPL	2.00	$	Trip	Copayment amount charged is based on the reimbursement amount.	Remove

Service or Item: Pharmacy — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

Add	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	$27/month	FPL	3.00	$	Prescription	Copayment amount charged is based on the reimbursement amount.	Remove

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.20181119

Medicaid Premiums and Cost Sharing

State Name: Indiana

OMB Control Number: 0938-1148

Transmittal Number: IN - 20 - 0001

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

TN: 20:001
Supersedes
TN: 85-14, 03-031, 94-009

Approval Date: _11/16/2020_____

Effective Date: 2/1/20

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:

- [x] Emergency services as defined at section 1932(b)(2) of the Act and 42 CFR 438.114(a).
- [x] 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.
- [x] 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.
- [x] 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.
- [x] 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):

- [x] 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
  - [x] 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):

- [x] 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 copayment is deducted. Providers are responsible for identifying exempt individuals utilizing information included in the provider manual.

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 MMlS 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:

Fee-For-Service members, cost-share eligibility is aggregated using provider claim data. This is completed by the data warehouse. 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. Providers are alerted if the cost sharing limit has been reached and cost sharing can no longer be applied. This is available through the State Eligibility Verification System (EVS). EVS allows real-time member cost-sharing eligibility status.

☑ 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. Providers are alerted if the cost sharing limit had been reached and cost sharing can no longer be applied. This is available through both the MCE call centers and State eligibility verification systems (EVS) . EVS allow real-time member 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 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

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.

V.20160722

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Revision: HCFA-AT-91-4 (BPD)

AUGUST 1991

OMB No.: 0938-

State/Territory: Indiana

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Revision: HCFA-AT-91-4 (BPD)

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