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State/Territory Name: Indiana

State Plan Amendment (SPA) #: IN-17-0000-003

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) Approved State Plan

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, Maryland 21244-1850



Children and Adults Health Programs Group

JUL 20 2017

Mr. Gary Parker
State CHIP Director
Office of Medicaid Policy and Planning
Family and Social Services Administration
402 West Washington Street, W372
Indianapolis, IN 46204-2739

Dear Mr. Parker:

I am writing to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA) number IN-17-0000-003, submitted on June 22, 2017, with a retroactive effective date of July 1, 2016.

SPA IN-17-0000-003 updates Indiana's state plan to reflect that the state provides coverage for over-the-counter medications based on the coverage options available at section 2110(a)(7) of the Social Security Act and 42 CFR §457.490.

Your title XXI project officer is Ms. Michelle Wojcicki. She is available to answer questions concerning these amendments and other CHIP-related issues. Ms. Wojcicki's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-0306
Facsimile: (410) 786-5882
E-mail: Michelle.Wojcicki1@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Wojcicki and to Ms. Ruth Hughes, Associate Regional Administrator (ARA) in our Chicago Regional Office. Ms. Hughes' address is:

Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health Operations
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

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If you have additional questions or concerns, please contact Ms. Amy Lutzky, Director, Division of State Coverage Programs, at (410) 786-0721.

We look forward to continuing to work with you and your staff.

Sincerely,

/Anne Marie Costello/

Anne Marie Costello
Director

cc:

Ms. Ruth Hughes, ARA, CMS Region V, Chicago

TEMPLATE FOR CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: Indiana

(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR, 457.40(b))

(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following Child Health Plan for the Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following State officials are responsible for program administration and financial oversight (42 CFR 457.40(c)):

Name: Gary Parker
Name: Allison Taylor
Name: Jen Walthall

Position/Title: Director, CHIP
Position/Title: Director, OMPP
Position/Title: Secretary, FSSA

*Disclosure. 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 0938-0707. The time required to complete this information collection is estimated to average 80 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, write to: CMS, 7500 Security Blvd., Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Introduction: Section 4901 of the Balanced Budget Act of 1997 (BBA), public law 105-33 amended the Social Security Act (the Act) by adding a new title XXI, the Children’s Health Insurance Program (CHIP). In February 2009, the Children’s Health Insurance Program Reauthorization Act (CHIPRA) renewed the program. The Patient Protection and Affordable Care Act of 2010 further modified the program.

This template outlines the information that must be included in the state plans and the state plan amendments (SPAs). It reflects the regulatory requirements at 42 CFR Part 457 as well as the previously approved SPA templates that accompanied guidance issued to States through State Health Official (SHO) letters. Where applicable, we indicate the SHO number and the date it was issued for your reference. The CHIP SPA template includes the following changes:

- Combined the instruction document with the CHIP SPA template to have a single document. Any modifications to previous instructions are for clarification only and do not reflect new policy guidance.
- Incorporated the previously issued guidance and templates (see the Key following the template for information on the newly added templates), including:
 - Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
 - Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
 - Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
 - Dental and supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
 - Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
 - Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
 - Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)
- Moved sections 2.2 and 2.3 into section 5 to eliminate redundancies between sections 2 and 5.
- Removed crowd-out language that had been added by the August 17 letter that later was repealed.

The Centers for Medicare & Medicaid Services (CMS) is developing regulations to implement the CHIPRA requirements. When final regulations are published in the Federal Register, this template will be modified to reflect those rules and States will be required to submit SPAs illustrating compliance with the new regulations. States are not required to resubmit their State plans based on the updated template. However, States must use the updated template when submitting a State Plan Amendment.

Federal Requirements for Submission and Review of a Proposed SPA. (42 CFR Part 457 Subpart A)

In order to be eligible for payment under this statute, each State must submit a Title XXI plan for approval by the Secretary that details how the State intends to use the funds and fulfill other requirements under the law and regulations at 42 CFR Part 457. A SPA is approved in 90 days unless the Secretary notifies the State in writing that the plan is disapproved or that specified additional information is needed. Unlike Medicaid SPAs, there is only one 90 day review period, or clock for CHIP SPAs, that may be stopped by a request for additional information and restarted after a complete response is received. More information on the SPA review process is found at 42 CFR 457 Subpart A.

When submitting a State plan amendment, states should redline the changes that are being made to the existing State plan and provide a “clean” copy including changes that are being made to the existing state plan.

The template includes the following sections:

1. **General Description and Purpose of the Children’s Health Insurance Plans and the Requirements-** This section should describe how the State has designed their program. It also is the place in the template that a State updates to insert a short description and the proposed effective date of the SPA, and the proposed implementation date(s) if different from the effective date. (Section 2101); (42 CFR, 457.70)
2. **General Background and Description of State Approach to Child Health Coverage and Coordination-** This section should provide general information related to the special characteristics of each state’s program. The information should include the extent and manner to which children in the State currently have creditable health coverage, current State efforts to provide or obtain creditable health coverage for uninsured children and how the plan is designed to be coordinated with current health insurance, public health efforts, or other enrollment initiatives. This information provides a health insurance baseline in terms of the status of the children in a given State and the State programs currently in place. (Section 2103); (42 CFR 457.410(A))
3. **Methods of Delivery and Utilization Controls-** This section requires a description that must include both proposed methods of delivery and proposed utilization control systems. This section should fully describe the delivery system of the Title XXI program including the proposed contracting standards, the proposed delivery systems and the plans for enrolling providers. (Section 2103); (42 CFR 457.410(A))
4. **Eligibility Standards and Methodology-** The plan must include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. This section includes a list of potential eligibility standards the State can check off and provide a short description of how those standards will be applied. All eligibility standards must be consistent with the provisions of Title XXI and may not discriminate on the basis of diagnosis. In addition, if the standards vary within the state, the State should describe how they will be applied and under what circumstances they will be applied. In addition, this section provides information on income eligibility for Medicaid expansion programs (which are exempt from Section 4 of the State plan template) if applicable. (Section 2102(b)); (42 CFR 457.305 and 457.320)
5. **Outreach-** This section is designed for the State to fully explain its outreach activities. Outreach is defined in law as outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs. The purpose is to inform these families of the availability of, and to assist them in enrolling their children in, such a program. (Section 2102(c)(1)); (42CFR, 457.90)
6. **Coverage Requirements for Children’s Health Insurance-** Regarding the required scope of health insurance coverage in a State plan, the child health assistance provided must consist of any of the four types of coverage outlined in Section 2103(a) (specifically, benchmark coverage;

benchmark-equivalent coverage; existing comprehensive state-based coverage; and/or Secretary-approved coverage). In this section States identify the scope of coverage and benefits offered under the plan including the categories under which that coverage is offered. The amount, scope, and duration of each offered service should be fully explained, as well as any corresponding limitations or exclusions. (Section 2103); (42 CFR 457.410(A))

7. **Quality and Appropriateness of Care-** This section includes a description of the methods (including monitoring) to be used to assure the quality and appropriateness of care and to assure access to covered services. A variety of methods are available for State's use in monitoring and evaluating the quality and appropriateness of care in its child health assistance program. The section lists some of the methods which states may consider using. In addition to methods, there are a variety of tools available for State adaptation and use with this program. The section lists some of these tools. States also have the option to choose who will conduct these activities. As an alternative to using staff of the State agency administering the program, states have the option to contract out with other organizations for this quality of care function. (Section 2107); (42 CFR 457.495)
8. **Cost Sharing and Payment-** This section addresses the requirement of a State child health plan to include a description of its proposed cost sharing for enrollees. Cost sharing is the amount (if any) of premiums, deductibles, coinsurance and other cost sharing imposed. The cost-sharing requirements provide protection for lower income children, ban cost sharing for preventive services, address the limitations on premiums and cost-sharing and address the treatment of pre-existing medical conditions. (Section 2103(e)); (42 CFR 457, Subpart E)
9. **Strategic Objectives and Performance Goals and Plan Administration-** The section addresses the strategic objectives, the performance goals, and the performance measures the State has established for providing child health assistance to targeted low income children under the plan for maximizing health benefits coverage for other low income children and children generally in the state. (Section 2107); (42 CFR 457.710)
10. **Annual Reports and Evaluations-** Section 2108(a) requires the State to assess the operation of the Children's Health Insurance Program plan and submit to the Secretary an annual report which includes the progress made in reducing the number of uninsured low income children. The report is due by January 1, following the end of the Federal fiscal year and should cover that Federal Fiscal Year. In this section, states are asked to assure that they will comply with these requirements, indicated by checking the box. (Section 2108); (42 CFR 457.750)
11. **Program Integrity-** In this section, the State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Sections 2101(a) and 2107(e); (42 CFR 457, subpart I)
12. **Applicant and Enrollee Protections-** This section addresses the review process for eligibility and enrollment matters, health services matters (i.e., grievances), and for states that use premium assistance a description of how it will assure that applicants and enrollees are given the opportunity at initial enrollment and at each redetermination of eligibility to obtain health benefits coverage other than through that group health plan. (Section 2101(a)); (42 CFR 457.1120)

Program Options. As mentioned above, the law allows States to expand coverage for children through a separate child health insurance program, through a Medicaid expansion program, or through a combination of these programs. These options are described further below:

- **Option to Create a Separate Program-** States may elect to establish a separate child health program that are in compliance with title XXI and applicable rules. These states must establish enrollment systems that are coordinated with Medicaid and other sources of health coverage for children and also must screen children during the application process to determine if they are eligible for Medicaid and, if they are, enroll these children promptly in Medicaid.
- **Option to Expand Medicaid-** States may elect to expand coverage through Medicaid. This option for states would be available for children who do not qualify for Medicaid under State rules in effect as of March 31, 1997. Under this option, current Medicaid rules would apply.

Medicaid Expansion- CHIP SPA Requirements

In order to expedite the SPA process, states choosing to expand coverage only through an expansion of Medicaid eligibility would be required to complete sections:

- 1 (General Description)
- 2 (General Background)

They will also be required to complete the appropriate program sections, including:

- 4 (Eligibility Standards and Methodology)
- 5 (Outreach)
- 9 (Strategic Objectives and Performance Goals and Plan Administration including the budget)
- 10 (Annual Reports and Evaluations).

Medicaid Expansion- Medicaid SPA Requirements

States expanding through Medicaid-only will also be required to submit a Medicaid State Plan Amendment to modify their Title XIX State plans. These states may complete the first check-off and indicate that the description of the requirements for these sections are incorporated by reference through their State Medicaid plans for sections:

- 3 (Methods of Delivery and Utilization Controls)
- 4 (Eligibility Standards and Methodology)
- 6 (Coverage Requirements for Children's Health Insurance)
- 7 (Quality and Appropriateness of Care)
- 8 (Cost Sharing and Payment)
- 11 (Program Integrity)
- 12 (Applicant and Enrollee Protections)

- **Combination of Options-** CHIP allows states to elect to use a combination of the Medicaid program and a separate child health program to increase health coverage for children. For example, a State may cover optional targeted-low income children in families with incomes of up to 133 percent of poverty through Medicaid and a targeted group of children above that level through a separate child

health program. For the children the State chooses to cover under an expansion of Medicaid, the description provided under “Option to Expand Medicaid” would apply. Similarly, for children the State chooses to cover under a separate program, the provisions outlined above in “Option to Create a Separate Program” would apply. States wishing to use a combination of approaches will be required to complete the Title XXI State plan and the necessary State plan amendment under Title XIX.

Proposed State plan amendments should be submitted electronically and one signed hard copy to the Centers for Medicare & Medicaid Services at the following address:

Name of Project Officer
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, Maryland 21244
Attn: Children and Adults Health Programs Group
Center for Medicaid and CHIP Services
Mail Stop - S2-01-16

Section 1. General Description and Purpose of the Children’s Health Insurance Plans and the Requirements

1.1. The state will use funds provided under Title XXI primarily for (Check appropriate box) (Section 2101)(a)(1)); (42 CFR 457.70):

Guidance: Check below if child health assistance shall be provided primarily through the development of a separate program that meets the requirements of Section 2101, which details coverage requirements and the other applicable requirements of Title XXI.

1.1.1. Obtaining coverage that meets the requirements for a separate child health program (Sections 2101(a)(1) and 2103); OR

Guidance: Check below if child health assistance shall be provided primarily through providing expanded eligibility under the State’s Medicaid program (Title XIX). Note that if this is selected the State must also submit a corresponding Medicaid SPA to CMS for review and approval.

1.1.2. Providing expanded benefits under the State’s Medicaid plan (Title XIX) (Section 2101(a)(2)); OR

Guidance: Check below if child health assistance shall be provided through a combination of both 1.1.1. and 1.1.2. (Coverage that meets the requirements of Title XXI, in conjunction with an expansion in the State’s Medicaid program). Note that if this is selected the state must also submit a corresponding Medicaid state plan amendment to CMS for review and approval.

1.1.3. A combination of both of the above. (Section 2101(a)(2))
Medicaid expansion under Phase I of the CHIP program was approved June 26, 1998.
State-designed child health program under Phase II of the program was approved December 22, 1999.

1.1-DS The State will provide dental-only supplemental coverage. Only States operating a separate CHIP program are eligible for this option. States choosing this option must also complete sections 4.1-DS, 4.2-DS, 6.2-DS, 8.2-DS, and 9.10 of this SPA template. (Section 2110(b)(5))

1.2. Check to provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))

1.3. Check to provide an assurance that the State complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42CFR 457.130)

Guidance: The effective date as specified below is defined as the date on which the State begins to incur costs to implement its State plan or amendment. (42 CFR 457.65) The implementation date is defined as the date the State begins to provide services; or, the date on which the State puts into practice the new policy described in the State plan or amendment. For example, in a State that has increased eligibility, this is the date on which the State begins to provide coverage to enrollees (and not the date the State begins outreach or accepting applications).

- 1.4.** Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

Original Plan

Effective Date: October 1, 1997

Implementation Date: July 1, 1998

SPA #11 Purpose of SPA: Health Services Initiative: Poison Treatment, Advice, and Prevention.

Proposed effective date: July 1, 2016

Proposed implementation date: July 1, 2016

- 1.4- TC** **Tribal Consultation** (Section 2107(e)(1)(C)) Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

TN No: Approval Date Effective Date

Section 2. General Background and Description of Approach to Children’s Health Insurance Coverage and Coordination

Guidance: The demographic information requested in 2.1. can be used for State planning and will be used strictly for informational purposes. **THESE NUMBERS WILL NOT BE USED AS A BASIS FOR THE ALLOTMENT.**

Factors that the State may consider in the provision of this information are age breakouts, income brackets, definitions of insurability, and geographic location, as well as race and ethnicity. The State should describe its information sources and the assumptions it uses for the development of its description.

- Population

- Number of uninsured
- Race demographics
- Age Demographics
- Info per region/Geographic information

2.1. Describe the extent to which, and manner in which, children in the State (including targeted low-income children and other groups of children specified) identified, by income level and other relevant factors, such as race, ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, distinguish between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (Section 2102(a)(1)); (42 CFR 457.80(a))

The table below provides information from the Kaiser State Health Facts website regarding general population characteristics. This information can be used to establish a general understanding of the current environment in the State of Indiana.

Kaiser State Health Facts (2015) for State of Indiana

Description:	Number
Total Children 0-18:	1,663,800
Total Children 0-18 w/o Health Insurance	83,100

The table below provides information from Kids Count Data Center (2015) website regarding how many children in the state would qualify for either CHIP or Medicaid.

Total Children 0-18 Below 250% FPL	833,000
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The table below provides information from the State of Indiana regarding the populations currently being served by Indiana Medicaid. It should be noted that MCHIP refers to the portion of the Medicaid population funded via CHIP funding and SCHIP refers to the CHIP population not funded via Medicaid funding. It should also be noted that many of the State's children are served in non-CHIP program areas. The information below can be used to establish a general understanding of the current environment in the State of Indiana.

State of Indiana (January 2017)

Description:	Number
Total Children 0-18 Enrolled in Medicaid or CHIP	671,898
Total Children 0-18 Enrolled in Hoosier Healthwise	581,121
Total Children 0-18 Enrolled in MCHIP (Enrolled in Hoosier Healthwise)	65,849
Total Children 0-18 Enrolled in SCHIP (Enrolled in Hoosier Healthwise)	27,487

Guidance: Section 2.2 allows states to request to use the funds available under the 10 percent limit on administrative expenditures in order to fund services not otherwise allowable. The health services initiatives must meet the requirements of 42 CFR 457.10.

2.2. Health Services Initiatives- Describe if the State will use the health services initiative

option as allowed at 42 CFR 457.10. If so, describe what services or programs the State is proposing to cover with administrative funds, including the cost of each program, and how it is currently funded (if applicable), also update the budget accordingly. (Section 2105(a)(1)(D)(ii)); (42 CFR 457.10)

Poison Treatment Advice And Prevention. Indiana will use CHIP funds, within the 10 percent federal administrative expenditures cap allowed for states, to support the Indiana Poison Center (IPC). IPC provides daily, 24-hour emergency telephone treatment advice, referral assistance, and information to manage exposure to poisonous and hazardous substances. The IPC answers poisoning emergency calls from the general public 24 hours a day, 365 days each year at no charge. At all times, a Specialist in Poison Information (SPI) is available to manage cases and Certified Specialists in Poison Information (CSPI) manage cases and direct Poison Information Providers. The service is provided to all communities, including underserved and indigent populations, in over 150 languages and via telecommunications devices for the deaf and hearing impaired (TDD).

Approximately 50,000 exposures from Indiana are received annually by the IPC. Children under 19 represented 59% of all reports in calendar year 2014 with 48% of reported exposures for children under age 6. An estimated 33% of all calls relate to children age 0-18 with annual household incomes of \$60,000 or less (250% FPL for a family of 4), which is based on The Kids Count Data Center 2014 statistic, which states 56% of Hoosier children are living in a household with incomes less than 250% FPL. Children under the age of 5 account for nearly half of all poison exposures.

For every \$1 spent on poison control efforts, there is a return on investment of \$18. Over 90% of phone calls received by IPC are from the home, and results in an average savings of \$1,581 in avoided emergency department charges per case. There is a decreased length of hospital stay by 1.2 – 3 days, which is estimated to save \$7,948 per day saved, and results in approximately \$25 million per year in savings.

IPC public education programs on poisoning response and prevention direct attention and resources to at-risk children, adolescents and adults living in poverty, including minority and immigrant communities, where materials appear in multiple languages beyond English including Spanish and Burmese. IPC works closely with schools, healthcare organizations, parenting groups, and childcare providers throughout Indiana to promote poison awareness. The toxicologists in the center have worked closely with the Indiana State Department of Health (ISDH) on emerging patterns of drug abuse in locales throughout the state. IPC has published education materials focused on poison prevention and disseminates hard copies throughout the state and on social media sites like Facebook and Twitter. In addition to public education focused on prevention, IPC educates providers in management of poisonings and drug overdoses, and furthers knowledge in the field of clinical toxicology by research and contribution to the medical literature. The IPC website will have a link to allow members of the public to be able apply for health coverage for Medicaid and CHIP.

The IPC public toll-free number is listed in all Indiana telephone directories. It is also the first result on Google and Bing search engines for “poison center number” or “poison control.”

Funding under this HSI will not supplant or match CHIP federal funds with other Federal funds, nor will it allow other Federal funds to supplant or match CHIP Federal funds.

Funding under this HSI is dedicated to children 18 years of age or younger.

2.3-TC

Tribal Consultation Requirements- (Sections 1902(a)(73) and 2107(e)(1)(C)); (ARRA #2, CHIPRA #3, issued May 28, 2009) Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(1)(C) of the Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

Describe the process the State uses to seek advice on a regular, ongoing basis from federally-recognized tribes, Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS. Include information about the frequency, inclusiveness and process for seeking such advice.

Section 3. Methods of Delivery and Utilization Controls

Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 4.

Guidance: In Section 3.1., discussion may include, but is not limited to: contracts with managed health care plans (including fully and partially capitated plans); contracts with indemnity health insurance plans; and other arrangements for health care delivery. The State should describe any variations based upon geography, as well as the State methods for establishing and defining the delivery systems.

Should the State choose to cover unborn children under the Title XXI State plan, the State must describe how services are paid. For example, some states make a global payment for all unborn children while other states pay for services on fee-for-services basis. The State's payment mechanism and delivery mechanism should be briefly described here.

Section 2103(f)(3) of the Act, as amended by section 403 of CHIPRA, requires separate or combination CHIP programs that operate a managed care delivery system to apply several provisions of section 1932 of the Act in the same manner as these provisions apply under title XIX of the Act. Specific provisions include: section 1932(a)(4), Process for Enrollment and Termination and Change of Enrollment; section 1932(a)(5), Provision of Information; section 1932(b), Beneficiary Protections; section 1932(c), Quality Assurance Standards; section 1932(d), Protections Against Fraud and Abuse; and section 1932(e), Sanctions for Noncompliance. If the State CHIP program operates a managed

care delivery system, provide an assurance that the State CHIP managed care contract(s) complies with the relevant sections of section 1932 of the Act. States must submit the managed care contract(s) to the CMS Regional Office servicing them for review and approval.

In addition, states may use up to 10 percent of actual or estimated Federal expenditures for targeted low-income children to fund other forms of child health assistance, including contracts with providers for a limited range of direct services; other health services initiatives to improve children's health; outreach expenditures; and administrative costs (See 2105(c)(2)(A)). Describe which, if any, of these methods will be used.

Examples of the above may include, but are not limited to: direct contracting with school-based health services; direct contracting to provide enabling services; contracts with health centers receiving funds under section 330 of the Public Health Service Act; contracts with hospitals such as those that receive disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923 of the Act; contracts with other hospitals; and contracts with public health clinics receiving Title V funding. If applicable, address how the new arrangements under Title XXI will work with existing service delivery methods, such as regional networks for chronic illness and disability; neonatal care units, or early-intervention programs for at-risk infants, in the delivery and utilization of services. (42CFR 457.490(a))

- 3.1. Delivery Standards** Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102)(a)(4) (42CFR 457.490(a))

Public health insurance in Indiana is provided via the Medicaid program. CHIP enrollees are enrolled in the Hoosier Healthwise program (risk-based capitated managed care program). Children eligible for the Medicaid expansion component (referred to specifically as MCHIP) are enrolled in Hoosier Healthwise under Benefit Package A. Those eligible for the State-designed component of Indiana's CHIP program (referred to as the SCHIP population) are enrolled in Hoosier Healthwise under Benefit Package C. The Hoosier Healthwise program is governed by Section 1932. The SCHIP population is only governed by the state plan.

Indiana will use administrative funds for a comprehensive study with the goal of developing a strategy to improve access to specialty care for low-income children.

Like many regions, northwest Indiana is struggling to provide access to care for low-income populations. The problem is particularly acute in the northwest region of Lake County, and especially with regard to access to pediatric specialty care. This has led to two sets of unacceptable outcomes. On the one hand, when children do not receive needed services, the result is avoidable hospitalizations and emergency department visits. On the other hand, when access is provided it is often through visits to

out-of-state providers at a higher cost to both to the SCHIP program and to families in terms of increased travel time and inconvenience. In order to develop a strategy to increase access in this region, it is necessary to conduct a comprehensive study. Indiana has tentatively identified a partnership with Indiana University to conduct this study.

The steps in this study will include:

- Baseline and needs assessment. This step would involve utilizing Family and Social Services Administration and health plan data to examine access to and utilization of pediatric specialty services in the northern Lake County region compared to the rest of the state. To the greatest extent possible, public health data (including chronic disease incidence rates and ambulatory care sensitive condition admission rates specific to the region) will be utilized in this analysis.
- Interviews with providers and other key stakeholders. The data analysis will be supplemented with information gathered in interviews with local providers, health plans and state officials regarding access to services. Some of the specific information gathered will be how primary care providers access specialty care for their patients, which specialties are most difficult to access, wait times for specialty appointments, and perceived barriers to improving access.
- Identification of collaborative solutions. The goal of the above analysis is to objectively identify issues related to neonatal and pediatric specialty access in northern Lake County. Based on this analysis, the contractor for the study will work with community providers to determine potential solutions to the issues identified. The contractor will also be expected to research and share successful models that have been implemented elsewhere.
- Implementation assistance. The contractor will be expected to work in an ongoing role with community providers and other key stakeholders to establish systems that will assure ongoing access to care for underserved SCHIP and other low-income children in northern Lake County.
- Determination of need for HITECH collaboration. The contractor will work with key stakeholders to identify the need for and interest in developing an electronic health record collaborative within the meaningful use guidelines that will support the implementation of systems that secure greater access.

The overarching goal of this initiative is to improve access, and therefore health outcomes, for children in the SCHIP program, as well as other low-income children.

- Check here if the State child health program delivers services using a managed care delivery model. The State provides an assurance that its managed care contract(s) complies with the relevant provisions of section 1932 of the Act, including section 1932(a)(4), Process for Enrollment and Termination and Change of Enrollment; section 1932(a)(5), Provision of Information; section 1932(b), Beneficiary Protections; section 1932(c), Quality Assurance Standards; section 1932(d), Protections Against Fraud and Abuse; and section 1932(e), Sanctions for Noncompliance. The State also assures that it

will submit the contract(s) to the CMS Regional Office for review and approval. (Section 2103(f)(3))

The State assures that its managed care contracts complies with all relevant sections of section 1932 of the Act, and the State will submit the contracts to the CMS Regional Office for review and approval.

Guidance: In Section 3.2., note that utilization control systems are those administrative mechanisms that are designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package.

Examples of utilization control systems include, but are not limited to: requirements for referrals to specialty care; requirements that clinicians use clinical practice guidelines; or demand management systems (e.g., use of an 800 number for after-hours and urgent care). In addition, the State should describe its plans for review, coordination, and implementation of utilization controls, addressing both procedures and State developed standards for review, in order to assure that necessary care is delivered in a cost-effective and efficient manner. (42CFR, 457.490(b))

- 3.2.** Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved State plan. (Section 2102)(a)(4) (42CFR 457.490(b))

Hoosier Healthwise has a number of utilization control mechanisms in place that are designed to ensure that health care use is appropriate and medically necessary.

Medicaid Management Information System (MMIS): The MMIS contains a Surveillance and Utilization Review (SUR) subsystem that provides a comprehensive method for conducting utilization review and program management. Under this system, computerized reports are generated that provide a statistical profile of provider practices and recipient utilization. The system allows for the flagging of areas where there is deviation from peers. Rankings are created or identified to indicate which individuals have the greatest amount of deviation. SUR analysts take action where warranted. The objective is for misuse of health services to be identified, investigated, and corrected. Provider desk reviews are conducted based upon Federal and State requirements, and prepayment review and other action is taken where warranted. Recipient restricted card procedures are implemented in cases of recipient over utilization.

Programmatic (CHIP): Specific mechanisms designed to prevent over utilization are also built into the Phase II CHIP program. Limitations are placed on the benefit package and nominal copayments will be imposed for certain services. A more detailed discussion regarding benefits can be found in Section 6; and a more detailed discussion regarding copayments can be found in Section 8.

Programmatic (Hoosier Healthwise): The managed care system established under Hoosier Healthwise also has some built in utilization controls. The Primary Medical Provider (PMP), serves as a gatekeeper who provides or authorizes primary care services and makes referrals for specialty care (except those which may be self-referred) where appropriate. Referrals must be documented in the patient's medical record. In addition, MCOs are required to have written utilization review (UR) programs in place. The program must include a utilization review committee directed by the Medical Director of the MCO; utilization management practices that conform to industry standards; and resources for evaluating, and, if necessary, modifying the UR process. In order for the State to track expenditures and service utilization in the Risk Based Managed Care (RBMC) program, shadow claims are required to be reported for patient encounters. The shadow claims provide details regarding diagnoses, procedures, place of services, billed amounts and providers.

Section 4. Eligibility Standards and Methodology

Guidance: States electing to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan or combination plan should check the appropriate box and provide the ages and income level for each eligibility group. If the State is electing to take up the option to expand Medicaid eligibility as allowed under section 214 of CHIPRA regarding lawfully residing, complete section 4.1-LR as well as update the budget to reflect the additional costs if the state will claim title XXI match for these children until and if the time comes that the children are eligible for Medicaid.

4.0. Medicaid Expansion

4.0.1. Ages of each eligibility group and the income standard for that group:
Refer to CS 3.

4.1. Separate Program Check all standards that will apply to the State plan. (42CFR 457.305(a) and 457.320(a))

4.1.0 Describe how the State meets the citizenship verification requirements.
Include whether or not State has opted to use SSA verification option.

Refer to CS 18

4.1.1 Geographic area served by the Plan if less than Statewide:
Statewide

4.1.2 Ages of each eligibility group, including unborn children and pregnant women (if applicable) and the income standard for that group:
0-18 (less than 19 years of age)

4.1.2.1-PC Age: through birth (SHO #02-004, issued November 12, 2002)

4.1.3 Income of each separate eligibility group (if applicable):
Refer to CS 7.

4.1.3.1-PC 0% of the FPL (and not eligible for Medicaid) through %
of the FPL (SHO #02-004, issued November 12, 2002)

4.1.4 Resources of each separate eligibility group (including any standards relating to spend downs and disposition of resources):

4.1.5 Residency (so long as residency requirement is not based on length of time in state):

Refer to CS 17.

4.1.6 Disability Status (so long as any standard relating to disability status does not restrict eligibility):

4.1.7 Access to or coverage under other health coverage:

- Children cannot have other creditable health care coverage. A three-month waiting period from the date the child was last covered will be imposed.
- Exceptions to the waiting period will be provided if the coverage was lost involuntarily (such as through the loss of employment, divorce, etc.), if the child was previously covered by Medicaid, the premium paid by the family for the child for other insurance in a group health plan exceeded 5 percent of the household income, the cost of family coverage that includes the child exceeds 9.5% of the household

income, or the child has special health care needs.

4.1.8 Duration of eligibility, not to exceed 12 months:

- All children have 12 months as the duration of eligibility. Families are required to notify DFR if their income increases or if health insurance coverage is obtained during the eligibility period.
- Children age 3 through 18 remain eligible only as long as they meet income and other program requirements.
- Children under age 3 receive continuous eligibility for 12 months, regardless of changes in income.
- An exception to this is allowed if an individual reports a change in income which would qualify the individual for Medicaid.

4.1.9 Other Standards- Identify and describe other standards for or affecting eligibility, including those standards in 457.310 and 457.320 that are not addressed above. For instance:

Refer to CS 19.

Guidance: States may only require the SSN of the child who is applying for coverage. If SSNs are required and the State covers unborn children, indicate that the unborn children are exempt from providing a SSN. Other standards include, but are not limited to presumptive eligibility and deemed newborns.

4.1.9.1 States should specify whether Social Security Numbers (SSN) are required.

Refer to CS 19

Guidance: States should describe their continuous eligibility process and populations that can be continuously eligible.

4.1.9.2 Continuous eligibility

Children under age 3 receive continuous eligibility for 12 months, regardless of changes in income.

4.1-PW

Pregnant Women Option (section 2112)- The State includes eligibility for one or more populations of targeted low-income pregnant women under the plan. Describe the population of pregnant women that the State proposes to cover in this section. Include all eligibility criteria, such as those described in the above categories (for instance, income and resources) that will be applied to this population. Use the same reference number system for those criteria (for example, 4.1.1-P for a geographic restriction). Please remember to update sections 8.1.1-PW, 8.1.2-PW, and 9.10 when electing this option.

Guidance: States have the option to cover groups of “lawfully residing” children and/or pregnant women. States may elect to cover (1) “lawfully residing” children described at section 2107(e)(1)(J) of the Act; (2) “lawfully residing” pregnant women described at section 2107(e)(1)(J) of the Act; or (3) both. A state electing to cover children and/or pregnant women who are considered lawfully residing in the U.S. must offer coverage to all such individuals who meet the definition of lawfully residing, and may not cover a subgroup or only certain groups. In addition, states may not cover these new groups only in CHIP, but must also extend the coverage option to Medicaid. States will need to update their budget to reflect the additional costs for coverage of these children. If a State has been covering these children with State only funds, it is helpful to indicate that so CMS understands the basis for the enrollment estimates and the projected cost of providing coverage. Please remember to update section 9.10 when electing this option.

4.1- LR

Lawfully Residing Option (Sections 2107(e)(1)(J) and 1903(v)(4)(A); (CHIPRA # 17, SHO # 10-006 issued July 1, 2010) Check if the State is electing the option under section 214 of the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) regarding lawfully residing to provide coverage to the following otherwise eligible pregnant women and children as specified below who are lawfully residing in the United States including the following:

A child or pregnant woman shall be considered lawfully present if he or she is:

- (1) A qualified alien as defined in section 431 of PRWORA (8 U.S.C. §1641);
- (2) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;
- (3) An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. §1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;
- (4) An alien who belongs to one of the following classes:
 - (i) Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);
 - (ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;
 - (iii) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);
 - (iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;
 - (v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;
 - (vi) Aliens currently in deferred action status; or
 - (vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;

- (5) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days;
- (6) An alien who has been granted withholding of removal under the Convention Against Torture;
- (7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. § 1101(a)(27)(J));
- (8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or
- (9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

- Elected for pregnant women.
- Elected for children under age

4.1.1-LR The State provides assurance that for an individual whom it enrolls in Medicaid under the CHIPRA Lawfully Residing option, it has verified, at the time of the individual's initial eligibility determination and at the time of the eligibility redetermination, that the individual continues to be lawfully residing in the United States. The State must first attempt to verify this status using information provided at the time of initial application. If the State cannot do so from the information readily available, it must require the individual to provide documentation or further evidence to verify satisfactory immigration status in the same manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the Act.

4.1-DS **Supplemental Dental** (Section 2103(c)(5) - A child who is eligible to enroll in dental-only supplemental coverage, effective January 1, 2009. Eligibility is limited to only targeted low-income children who are otherwise eligible for CHIP but for the fact that they are enrolled in a group health plan or health insurance offered through an employer. The State's CHIP plan income eligibility level is at least the highest income eligibility standard under its approved State child health plan (or under a waiver) as of January 1, 2009. All who meet the eligibility standards and apply for dental-only supplemental coverage shall be provided benefits. States choosing this option must report these children separately in SEDS. Please update sections 1.1-DS, 4.2-DS, and 9.10 when electing this option.

4.2. **Assurances** The State assures by checking the box below that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102(b)(1)(B) and 42

CFR 457.320(b))

4.2.1. These standards do not discriminate on the basis of diagnosis.

4.2.2. Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income. This applies to pregnant women included in the State plan as well as targeted low-income children.

4.2.3. These standards do not deny eligibility based on a child having a pre-existing medical condition. This applies to pregnant women as well as targeted low-income children.

4.2-DS

Supplemental Dental - Please update sections 1.1-DS, 4.1-DS, and 9.10 when electing this option. For dental-only supplemental coverage, the State assures that it has made the following findings with standards in its plan: (Section 2102(b)(1)(B) and 42 CFR 457.320(b))

4.2.1-DS These standards do not discriminate on the basis of diagnosis.

4.2.2-DS Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.

4.2.3-DS These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3.

Methodology. Describe the methods of establishing and continuing eligibility and enrollment. The description should address the procedures for applying the eligibility standards, the organization and infrastructure responsible for making and reviewing eligibility determinations, and the process for enrollment of individuals receiving covered services, and whether the State uses the same application form for Medicaid and/or other public benefit programs. (Section 2102)(b)(2)) (42CFR, 457.350)

The application process and eligibility determination process for the CHIP program is integrated into the application and eligibility determination process for Hoosier Healthwise. Eligibility determinations for MCHIP (Title XIX) and SCHIP (XXI) are made by the DFR. Applicants are first screened for eligibility under Title XIX, and if found ineligible, they will be screened for eligibility under Title XXI. Before an application will be approved, income of a parent or guardian must be verified by supporting documentation from the payer. Acceptable items for verifying earnings include: pay stubs, statements from employers, or a wage verification form that is completed by employers. Indiana will conduct follow-up screening to identify when coverage is available through another plan. SCHIP will be discontinued beginning the day the child receives other creditable coverage.

Families who apply for benefits will be advised of the cost sharing requirements under SCHIP, and, to be considered for eligibility under SCHIP, they must agree to meet the cost-sharing requirements if the child is found eligible. In addition a conditional approval notice will be sent to the family and a record will be sent to the premium collection vendor. Once the first premium payment is made, the child becomes enrolled in the program.

Guidance: The box below should be checked as related to children and pregnant women.
Please note: A State providing dental-only supplemental coverage may not have a waiting list or limit eligibility in any way.

4.3.1. Limitation on Enrollment Describe the processes, if any, that a State will use for instituting enrollment caps, establishing waiting lists, and deciding which children will be given priority for enrollment. If this section does not apply to your state, check the box below. (Section 2102(b)(2)) (42CFR, 457.305(b))

The following procedures will be used to determine when the State might need to consider options for containing enrollment and expenditures to ensure that Indiana's budget or annual appropriation is not exceeded. This process was approved by the Children's Health Policy Board in the spring of 2000.

The CHIP office will analyze current and past MCHIP and SCHIP enrollment in order to determine future enrollment trends and projected enrollment levels. CHIP expenditures will be estimated for MCHIP and SCHIP based on previous expenditures and will monitor projected expenses to determine their impact on the budget.

Enrollment and expenditure projections will be utilized to develop an estimate of how many enrollees the State can afford to cover in CHIP and then when to consider implementing mechanisms to ensure that the budget or annual appropriation is not exceeded. Budget limitations may be the result of the state appropriation or the annual federal allocation. If either the state appropriation or the federal allocation is exceeded, the state could choose to:

Allocate additional funds from another source or limit enrollment or expenditures to remain within the original state appropriation or federal allocation by pursuing one of the following options:

- Cover SCHIP at the Medicaid match rate once Title XXI funds are exhausted
- Establish a waiting list for SCHIP
- Change the benefit package for SCHIP
- Implement cost-sharing for SCHIP to a maximum of 5% of a family's income.

Check here if this section does not apply to your State.

Guidance: Note that for purposes of presumptive eligibility, States do not need to verify the citizenship status of the child. States electing this option should indicate so in the State plan. (42 CFR 457.355)

4.3.2. Check if the State elects to provide presumptive eligibility for children that meets the requirements of section 1920A of the Act. (Section 2107(e)(1)(L)); (42 CFR 457.355)

Guidance: Describe how the State intends to implement the Express Lane option. Include

information on the identified Express Lane agency or agencies, and whether the State will be using the Express Lane eligibility option for the initial eligibility determinations, redeterminations, or both.

4.3.3-EL Express Lane Eligibility Check here if the state elects the option to rely on a finding from an Express Lane agency when determining whether a child satisfies one or more components of CHIP eligibility. The state agrees to comply with the requirements of sections 2107(e)(1)(E) and 1902(e)(13) of the Act for this option. Please update sections 4.4-EL, 5.2-EL, 9.10, and 12.1 when electing this option. This authority may not apply to eligibility determinations made before February 4, 2009, or after September 30, 2013. (Section 2107(e)(1)(E))

4.3.3.1-EL Also indicate whether the Express Lane option is applied to (1) initial eligibility determination, (2) redetermination, or (3) both.

4.3.3.2-EL List the public agencies approved by the State as Express Lane agencies.

4.3.3.3-EL List the components/components of CHIP eligibility that are determined under the Express Lane. In this section, specify any differences in budget unit, deeming, income exclusions, income disregards, or other methodology between CHIP eligibility determinations for such children and the determination under the Express Lane option.

4.3.3.3-EL List the component/components of CHIP eligibility that are determined under the Express Lane.

4.3.3.4-EL Describe the option used to satisfy the screen and enrollment requirements before a child may be enrolled under title XXI.

Guidance: States should describe the process they use to screen and enroll children required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 457.80(c). Describe the screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by an Express Lane agency and those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated. Describe whether the State is temporarily enrolling children in CHIP, based on the income finding from an Express Lane agency, pending the completion of the screen and enroll process.

In this section, states should describe their eligibility screening process in a way that addresses the five assurances specified below. The State should consider including important definitions, the relationship with affected Federal, State and local agencies, and other applicable criteria that will describe the State's ability to make assurances. (Sections 2102(b)(3)(A) and 2110(b)(2)(B)), (42 CFR 457.310(b)(2), 42CFR 457.350(a)(1) and 457.80(c)(3))

4.4. Eligibility screening and coordination with other health coverage programs

States must describe how they will assure that:

4.4.1. only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance (including access to a State health benefits plan) are furnished child health assistance under the plan. (Sections 2102(b)(3)(A), 2110(b)(2)(B)) (42 CFR 457.310(b), 42 CFR 457.350(a)(1) and 42 CFR 457.80(c)(3)) Confirm that the State does not apply a waiting period for pregnant women.

Eligibility determinations for MCHIP (Title XIX) and SCHIP (XXI) are made by the DFR. Applicants are first screened for eligibility under Title XIX, and if found ineligible, they will be screened for eligibility under Title XXI. The ICES system has a systematic approach to screening and enrolling an enrollee into the appropriate aid category.

Before an application will be approved, income of a parent or guardian must be verified by supporting documentation from the payer. Acceptable items for verifying earnings include: pay stubs, statements from employers, or a wage verification form that is completed by employers. Indiana will conduct follow-up screening to identify when coverage is available through another plan. SCHIP will be discontinued beginning the day the child receives other creditable coverage. Three primary methods of third party liability policy gathering will be utilized:

- Absent parent data match using data from the State Wage Information Collection Agency
- Match with data from the Department of Defense that shows CHAMPUS coverage for dependents
- Match through Health Management Systems which matches claims information from the IndianaAIM system with insurance information from private insurance policies.
- The State will utilize the employment section of the application form to identify children who are eligible for dependent coverage under the state employees' health plan

4.4.2. children found through the screening process to be potentially eligible for medical assistance under the State Medicaid plan are enrolled for assistance under such plan; (Section 2102(b)(3)(B)) (42CFR, 457.350(a)(2))

Eligibility determinations for MCHIP (Title XIX) and SCHIP (XXI) are made by the

DFR. Applicants are first screened for eligibility under Title XIX, and if found ineligible, they will be screened for eligibility under Title XXI. The ICES system has a systematic approach to screening and enrolling an enrollee into the appropriate aid category.

4.4.3. children found through the screening process to be ineligible for Medicaid are enrolled in CHIP; (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))

Children who are found not eligible for Medicaid under Title XIX, are enrolled in MCHIP if they are up to 158% FPL and do not have other insurance. Title XIX, rather than Title XXI, is used to provide services for children who are under 158% FPL but who have other health insurance. The enhanced match does not apply for these children since they do not fall under the targeted low-income definition due to their other insurance coverage. Children who are above 158% but not more than 250% FPL, who do not have other health coverage and who meet the other CHIP eligibility requirements are enrolled in SCHIP if the parent/guardian agrees to the cost sharing obligation.

4.4.4. the insurance provided under the State child health plan does not substitute for coverage under group health plans. (Section 2102(b)(3)(C)) (42CFR, 457.805) Indiana has instituted a number of mechanisms designed to address crowd out. To ensure that CHIP enrollees do not have other health insurance, the State requires that all CHIP recipients attest to the lack of current health care coverage and specify the date of last coverage.

Since the MCHIP program limits family income to 158% of poverty, crowd out is not a significant issue because many of the lower income families do not have the option of employer-based health insurance.

Crowd out is of greater concern under SCHIP due to the higher income threshold. As such, Indiana has instituted three-month waiting periods and monthly premiums as crowd out deterrents under the SCHIP program. Also provisions included in Public Law 273-1999 prohibit insurers from knowingly or intentionally referring children covered under their dependent coverage policies to the CHIP program.

The Hoosier Healthwise application asks "Did any applicants who do not have health insurance lose their coverage in the last three months? Please tell us why coverage was lost." The choices are:

- Loss of employment
- Could not afford
- Coverage limit reached
- Company ended coverage
- Non-custodial parent dropped coverage
- Divorce
- Other

This information (for both approved and denied children) is entered into the ICES and monitored for signs of crowd-out among applicants. Applicants who lose coverage involuntarily are not subjected to the three-month waiting period. Denial reasons are tracked, resulting in:

Count of applicants who were denied because they voluntarily dropped coverage but did not wait the required three months before applying

Count of applicants who were denied because they currently carry private insurance

Count of currently enrolled children who are denied because they gained private coverage rendering them ineligible for CHIP. This information is monitored using our data warehouse.

4.4.4.1. (formerly 4.4.4.4) If the State provides coverage under a premium assistance program, describe: 1) the minimum period without coverage under a group health plan. This should include any allowable exceptions to the waiting period; 2) the expected minimum level of contribution employers will make; and 3) how cost-effectiveness is determined. (42CFR 457.810(a)-(c))

4.4.5. Child health assistance is provided to targeted low-income children in the State who are American Indian and Alaska Native. (Section 2102(b)(3)(D)) (42 CFR 457.125(a))

Targeted low-income children of American Indian and Alaskan Native families are allowed to enroll in CHIP. The eligibility system has been modified to allow a manual system override procedure to exempt any of these individuals from cost-sharing once they have been deemed eligible.

Guidance: When the State is using an income finding from an Express Lane agency, the State must still comply with screen and enroll requirements before enrolling children in CHIP. The State may either continue its current screen and enroll process, or elect one of two new options to fulfill these requirements.

4.4-EL The State should designate the option it will be using to carry out screen and enroll requirements:

The State will continue to use the screen and enroll procedures required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 42 CFR 457.80(c). Describe this process.

The State is establishing a screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any

differences between the income calculation methodologies used by the Express Lane agency and those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated.

- The State is temporarily enrolling children in CHIP, based on the income finding from the Express Lane agency, pending the completion of the screen and enroll process.

Section 5. Outreach and Coordination

- 5.1.** (formerly 2.2) Describe the current State efforts to provide or obtain creditable health coverage for uninsured children by addressing sections 5.1.1 and 5.1.2. (Section 2102)(a)(2) (42CFR 457.80(b))

Guidance: The information below may include whether the state elects express lane eligibility a description of the State's outreach efforts through Medicaid and state-only programs.

- 5.1.1.** (formerly 2.2.1.) The steps the State is currently taking to identify and enroll all uninsured children who are eligible to participate in public health insurance programs (i.e., Medicaid and state-only child health insurance):

Program: Purpose

Division of Family Resources (DFR) Enrollment Centers: Individuals currently apply for Hoosier Healthwise at one of more than 300 enrollment centers or through the offices of the Division of Family Resources (DFR) located in all 92 counties throughout the State. These enrollment centers can provide information on the programs under Medicaid.

Eligibility Modernization Project: Beginning October 29, 2007 the State of Indiana is modernizing its eligibility process. There is a uniform call center for questions regarding eligibility, enrollment, and Medicaid Programs.

Free and Reduced Lunch Program: Literature regarding the Medicaid program is distributed to all children that participate in the free and reduced lunch program.

Children's Special Health Care Services (CSHSC) Program: Insurance program that provides medical assistance to approximately 8,000 families of children who have certain chronic medical conditions and who also meet medical and financial eligibility requirements. Children are referred to the CSHCS program by providers and by other programs throughout the State. CSHCS requires that children who

apply for the program also apply for Medicaid.

MOMS Helpline: Provides health care information and referrals through a toll free telephone number. The MOMS Helpline staff screen all clients for Hoosier Healthwise eligibility and provide appropriate referrals.

Local Health Departments: Local Health Departments (LHDs) provide immunizations, lead screenings and other direct services to individuals throughout Indiana. Some LHDs have special staff dedicated specifically to outreach activities.

First Steps: Indiana's early intervention system for infants and toddlers, who have developmental delays, brings together federal, state, local, and private funding sources in order to create a coordinated, community-based system of services. In each community, a "child find" system is developed and is utilized to identify, locate and evaluate children who are eligible for early intervention services. First Steps collaborates with the DFR by distributing information about the Hoosier Healthwise program.

Community Health Centers (CHC): These centers design their services around needs identified in their particular communities. Many of the CHCs engage in significant outreach activities and some serve as Hoosier Healthwise enrollment centers.

Indiana Minority Health Coalition: Used to promote healthy lifestyles through disease prevention and health awareness; and to provide referrals, information services, community outreach, and program services. The agency also collaborates with these coalitions on outreach activities for the immunization program and other programs administered by the agency. In addition, Indiana has developed statewide enrollment partnerships with Indiana Black Expo, the Wishard Hospital Hispanic Health Project and the Indiana Primary Health Care Association (IPHCA).

Guidance: The State may address the coordination between the public-private outreach and the public health programs that is occurring statewide. This section will provide a historic record of the steps the State is taking to identify and enroll all uninsured children from the time the State's plan was initially approved. States do not have to rewrite his section but may instead update this section as appropriate.

5.1.2. (formerly 2.2.2.) The steps the State is currently taking to identify and enroll all uninsured children who are eligible to participate in health insurance programs that involve a public-private partnership:

ISDH and the IPHCA Through a collaborative arrangement between the ISDH and the IPHCA, health care services are provided to children and other individuals throughout the State. This arrangement was designed to improve access to primary health care programs for the medically underserved; individuals at poverty level; working poor; migrant and seasonal farm workers; the homeless; and individuals who lack health care due to geographic, financial and/or cultural barriers.

DMHA: The DMH has undertaken a collaborative effort with mental health providers throughout the

state. The providers act as mini-HMOs in that they receive a payment up-front from the DMH, and, in return, provide a full array of mental health services to seriously emotionally disturbed children who are at 200% of poverty or below. The DMH is also involved in the Dawn Project, a collaborative effort with the Department of Education (DOE), Division of Special Education, the Marion County Office of Family and Children, the Marion County Superior Court Juvenile Division and the Marion County Mental Health Association. The goal of this pilot project is to provide community-based services to children and youth in Marion County who are seriously emotionally disturbed and who are at imminent risk of long-term inpatient psychiatric hospitalization or residential care. Families are assigned a service coordinator who works with the family to design an array of services that meet the individual needs of the child and family. Referrals to the program come primarily from the Office of Family and Children, the DOE and the Juvenile Court.

Guidance: The State should describe below how it's Title XXI program will closely coordinate the enrollment with Medicaid because under Title XXI, children identified as Medicaid-eligible are required to be enrolled in Medicaid. Specific information related to Medicaid screen and enroll procedures is requested in Section 4.4. (42CFR 457.80(c))

5.2. (formerly 2.3) Describe how CHIP coordinates with other public and private health insurance programs, other sources of health benefits coverage for children, other relevant child health programs, (such as title V), that provide health care services for low-income children to increase the number of children with creditable health coverage. (Section 2102(a)(3), 2102(b)(3)(E) and 2102(c)(2)) (42CFR 457.80(c)). This item requires a brief overview of how Title XXI efforts – particularly new enrollment outreach efforts – will be coordinated with and improve upon existing State efforts.

The SCHIP program, the MCHIP Medicaid expansion, and the Title XIX Medicaid program are all closely coordinated. Individuals who apply for benefits will be considered for each of the programs. Since the CHIP program is a component of Hoosier Healthwise, the CHIP program utilizes the same delivery system as is already in place for Medicaid. The goal is to provide a medical home for each child, and to establish a seamless system of care. This ensures that the programs are coordinated not only for the benefit it provides to enrollees, but also for the purpose of administrative simplification and efficiency. For example, Family and Social Services Administration (FSSA) has modified Indiana Client Eligibility System (ICES), CORE MMIS, FSSA's cost allocation plan, and other related systems to correctly reflect expenditures eligible for reimbursement from Indiana's federal CHIP allocation.

5.2-EL The State should include a description of its election of the Express Lane eligibility option to provide a simplified eligibility determination process and expedited enrollment of eligible children into Medicaid or CHIP.

Guidance: Outreach strategies may include, but are not limited to, community outreach workers, outstationed eligibility workers, translation and transportation services, assistance with enrollment forms, case management and other targeting activities to inform families of low-income children of the availability of the health insurance program under the plan or other private or public health coverage.

The description should include information on how the State will inform the target of the availability of the programs, including American Indians and Alaska Natives, and assist them in enrolling in the appropriate program.

- 5.3. Strategies** Describe the procedures used by the State to accomplish outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program. (Section 2102(c)(1)) (42CFR 457.90)

The outreach initiatives are listed below.

Central Office Activities:

The steps the central DFR office took are:

- Issuing a new policy directive regarding enhancing outreach and enrollment
- Analyzing the number of uninsured children per county
- Reviewing equipment specifications and technical needs so that local providers and agencies who want to partner with the State can purchase compatible equipment
- Developing a simplified shortened or joint Hoosier Healthwise application form
- Developing program outreach materials and campaigns
- Delinking Hoosier Healthwise from TANF in the computer system
- Redesigning the membership card so that no stigma is attached to carrying the card
- Creating a new training curriculum for caseworkers and other individuals
- Developing relationships with hospitals, schools, health centers and social service agencies to create enrollment centers statewide

Local Efforts:

Local DFR agency efforts include:

- Each office is given a county-specific enrollment target and are furnished a list of names of individuals and entities that they were required to contact
- Each office is responsible for working with partners in the individual communities and develop local enrollment centers
- Each office is required to develop local outreach plans geared to the specific communities.

State and Local Collaborations:

The State worked with eight community coalitions on a three year Robert Wood Johnson (RWJ) Covering Kids outreach grant which targeted hard to reach populations.

Public Law 273-1999 provides that the CHIP program may contract with community entities for services such as outreach and enrollment, and consumer education.

In addition to the collaborations with external coalitions, OMPP has determined that it is effective to employ local health care partners in eligibility intake efforts for the CHIP program. Toward this end, the state has contracted with Health and Hospital Corporation of Marion County (HHC), which operates

Wishard Hospital, for CHIP eligibility intake services (including appropriate proportioned costs for facilities to carry out these services). These services enhance and complement other services provided by HHC, which include eligibility outstation services for both Medicaid and CHIP. HHC conducts eligibility intake to potentially eligible targeted low income children at the hospital, at other health care facilities owned by HHC, and at health fairs, schools, and other local community organizations.

Special Populations:

The State appears at eve Black Expo, the IMHC, and the Wishard Hospital Hispanic Health Access Initiative to develop culturally sensitive materials and to implement outreach initiatives.

Section 6. Coverage Requirements for Children’s Health Insurance

Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State’s Medicaid plan and proceed to Section 7 since children covered under a Medicaid expansion program will receive all Medicaid covered services including EPSDT.

6.1. The State elects to provide the following forms of coverage to children: (Check all that apply.) (Section 2103(c)); (42CFR 457.410(a))

Guidance: Benchmark coverage is substantially equal to the benefits coverage in a benchmark benefit package (FEHBP-equivalent coverage, State employee coverage, and/or the HMO coverage plan that has the largest insured commercial, non-Medicaid enrollment in the state). If box below is checked, either 6.1.1.1., 6.1.1.2., or 6.1.1.3. must also be checked. (Section 2103(a)(1))

6.1.1. Benchmark coverage; (Section 2103(a)(1) and 42 CFR 457.420)

Guidance: Check box below if the benchmark benefit package to be offered by the State is the standard Blue Cross/Blue Shield preferred provider option service benefit plan, as described in and offered under Section 8903(1) of Title 5, United States Code. (Section 2103(b)(1) (42 CFR 457.420(b))

6.1.1.1. FEHBP-equivalent coverage; (Section 2103(b)(1) (42 CFR 457.420(a)) (If checked, attach copy of the plan.)

Guidance: Check box below if the benchmark benefit package to be offered by the State is State employee coverage, meaning a coverage plan that is offered and generally available to State employees in the state. (Section 2103(b)(2))

6.1.1.2. State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)

Guidance: Check box below if the benchmark benefit package to be offered by the State is offered by a health maintenance organization (as defined in Section 2791(b)(3) of the Public Health Services Act) and has the largest insured commercial, non-Medicaid enrollment of covered lives of such coverage plans offered by an HMO in the state. (Section 2103(b)(3) (42 CFR 457.420(c)))

6.1.1.3. HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)

Guidance: States choosing Benchmark-equivalent coverage must check the box below and ensure that the coverage meets the following requirements:

- the coverage includes benefits for items and services within each of the categories of basic services described in 42 CFR 457.430:
 - dental services
 - inpatient and outpatient hospital services,
 - physicians' services,
 - surgical and medical services,
 - laboratory and x-ray services,
 - well-baby and well-child care, including age-appropriate immunizations, and
 - emergency services;
- the coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages (FEHBP-equivalent coverage, State employee coverage, or coverage offered through an HMO coverage plan that has the largest insured commercial enrollment in the state); and
- the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the additional categories in such package, if offered, as described in 42 CFR 457.430:
 - coverage of prescription drugs,
 - mental health services,
 - vision services and
 - hearing services.

If 6.1.2. is checked, a signed actuarial memorandum must be attached. The actuary who prepares the opinion must select and specify the standardized set and population to be used under paragraphs (b)(3) and (b)(4) of 42 CFR 457.431. The State must provide sufficient detail to explain the basis of the methodologies used to estimate the actuarial value or, if requested by CMS, to replicate the State results.

The actuarial report must be prepared by an individual who is a member of the

American Academy of Actuaries. This report must be prepared in accordance with the principles and standards of the American Academy of Actuaries. In preparing the report, the actuary must use generally accepted actuarial principles and methodologies, use a standardized set of utilization and price factors, use a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan, apply the same principles and factors in comparing the value of different coverage (or categories of services), without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used, and take into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the State child health plan that results from the limitations on cost sharing under such coverage. (Section 2103(a)(2))

- 6.1.2. Benchmark-equivalent coverage; (Section 2103(a)(2) and 42 CFR 457.430) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431.

See instructions. (See Attachment A, benefits package, and Attachment B, actuarial opinion memo)

Guidance: A State approved under the provision below, may modify its program from time to time so long as it continues to provide coverage at least equal to the lower of the actuarial value of the coverage under the program as of August 5, 1997, or one of the benchmark programs. If “existing comprehensive state-based coverage” is modified, an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997, or one of the benchmark plans must be attached. Also, the fiscal year 1996 State expenditures for “existing comprehensive state-based coverage” must be described in the space provided for all states. (Section 2103(a)(3))

- 6.1.3. Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) This option is only applicable to New York, Florida, and Pennsylvania. Attach a description of the benefits package, administration, and date of enactment. If existing comprehensive State-based coverage is modified, provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997 or one of the benchmark plans. Describe the fiscal year 1996 State expenditures for existing comprehensive state-based coverage.

Guidance: Secretary-approved coverage refers to any other health benefits coverage deemed appropriate and acceptable by the Secretary upon application by a state. (Section 2103(a)(4)) (42 CFR 457.250)

6.1.4. Secretary-approved Coverage. (Section 2103(a)(4)) (42 CFR 457.450)

6.1.4.1. Coverage the same as Medicaid State plan

6.1.4.2. Comprehensive coverage for children under a Medicaid Section 1115 demonstration waiver

6.1.4.3. Coverage that either includes the full EPSDT benefit or that the State has extended to the entire Medicaid population

Guidance: Check below if the coverage offered includes benchmark coverage, as specified in Under 457.420, specify the State must clearly demonstrate that the coverage it provides includes the same coverage as the benchmark package, and also describes the services that are being added to the benchmark package.

6.1.4.4. Coverage that includes benchmark coverage plus additional coverage

6.1.4.5. Coverage that is the same as defined by existing comprehensive state-based coverage applicable only New York, Pennsylvania, or Florida (under 457.440)

Guidance: Check below if the State is purchasing coverage through a group health plan, and intends to demonstrate that the group health plan is substantially equivalent to or greater than to coverage under one of the benchmark plans specified in 457.420, through use of a benefit-by-benefit comparison of the coverage. Provide a sample of the comparison format that will be used. Under this option, if coverage for any benefit does not meet or exceed the coverage for that benefit under the benchmark, the State must provide an actuarial analysis as described in 457.431 to determine actuarial equivalence.

6.1.4.6. Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Provide a sample of how the comparison will be done)

Guidance: Check below if the State elects to provide a source of coverage that is not described above. Describe the coverage that will be offered, including any benefit limitations or exclusions.

6.1.4.7. Other (Describe)

Guidance: All forms of coverage that the State elects to provide to children in its plan must be

checked. The State should also describe the scope, amount and duration of services covered under its plan, as well as any exclusions or limitations. States that choose to cover unborn children under the State plan should include a separate section 6.2 that specifies benefits for the unborn child population. (Section 2110(a)) (42CFR, 457.490)

If the state elects to cover the new option of targeted low income pregnant women, but chooses to provide a different benefit package for these pregnant women under the CHIP plan, the state must include a separate section 6.2 describing the benefit package for pregnant women. (Section 2112)

6.2. The State elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a)) (42CFR 457.490)

- 6.2.1. Inpatient services (Section 2110(a)(1))
- 6.2.2. Outpatient services (Section 2110(a)(2))
- 6.2.3. Physician services (Section 2110(a)(3))
- 6.2.4. Surgical services (Section 2110(a)(4))
- 6.2.5. Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))
- 6.2.6. Prescription drugs (Section 2110(a)(6))
- 6.2.7. Over-the-counter medications (Section 2110(a)(7))
- 6.2.8. Laboratory and radiological services (Section 2110(a)(8))
- 6.2.9. Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))
- 6.2.10. Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))
- 6.2.11. Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11))

- 6.2.12.** Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))
- 6.2.13.** Disposable medical supplies (Section 2110(a)(13))
Coverage subject to limitations
Guidance: Home and community based services may include supportive services such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home.
- 6.2.14.** Home and community-based health care services (Section 2110(a)(14))
Guidance: Nursing services may include nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services in a home, school or other setting.
- 6.2.15.** Nursing care services (Section 2110(a)(15))
- 6.2.16.** Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16))
- 6.2.17.** Dental services (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)
- 6.2.18.** Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))
- 6.2.19.** Outpatient substance abuse treatment services (Section 2110(a)(19))
- 6.2.20.** Case management services (Section 2110(a)(20))
- 6.2.21.** Care coordination services (Section 2110(a)(21))
- 6.2.22.** Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
- 6.2.23.** Hospice care (Section 2110(a)(23))
Guidance: Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic or rehabilitative service may be provided, whether in a facility, home, school, or other setting, if recognized by State law and only if the service is: 1) prescribed by or furnished by a physician or other licensed or registered

practitioner within the scope of practice as prescribed by State law; 2) performed under the general supervision or at the direction of a physician; or 3) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

6.2.24. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (Section 2110(a)(24))

6.2.25. Premiums for private health care insurance coverage (Section 2110(a)(25))

6.2.26. Medical transportation (Section 2110(a)(26))

Guidance: Enabling services, such as transportation, translation, and outreach services, may be offered only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

6.2.27. Enabling services (such as transportation, translation, and outreach services) (Section 2110(a)(27))

6.2.28. Any other health care services or items specified by the Secretary and not included under this Section (Section 2110(a)(28))

6.2-DC **Dental Coverage** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) The State will provide dental coverage to children through one of the following. Please update Sections 9.10 and 10.3-DC when electing this option. Dental services provided to children eligible for dental-only supplemental services must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5)):

6.2.1-DC State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT¹) codes are included in the dental benefits:

1. Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (must follow periodicity schedule)
2. Preventive (i.e., dental prophylaxis, topical fluoride treatments, sealants) (CDT codes: D1000-D1999) (must follow periodicity schedule)
3. Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999)
4. Endodontic (i.e., root canals) (CDT codes: D3000-D3999)
5. Periodontic (treatment of gum disease) (CDT codes: D4000-D4999)
6. Prosthodontic (dentures) (CDT codes: D5000-D5899, D5900-D5999, and D6200-D6999)
7. Oral and Maxillofacial Surgery (i.e., extractions of teeth and other oral surgical procedures) (CDT codes: D7000-D7999)

- 8. Orthodontics (i.e., braces) (CDT codes: D8000-D8999)
- 9. Emergency Dental Services

6.2.1.1-DC Periodicity Schedule. The State has adopted the following periodicity schedule:

- State-developed Medicaid-specific
- American Academy of Pediatric Dentistry
- Other Nationally recognized periodicity schedule
- Other (description attached)

6.2.2-DC Benchmark coverage; (Section 2103(c)(5), 42 CFR 457.410, and 42 CFR 457.420)

6.2.2.1-DC FEHBP-equivalent coverage; (Section 2103(c)(5)(C)(i)) (If checked, attach copy of the dental supplemental plan benefits description and the applicable CDT² codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2.2.2-DC State employee coverage; (Section 2103(c)(5)(C)(ii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2.2.3-DC HMO with largest insured commercial enrollment (Section 2103(c)(5)(C)(iii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2-DS **Supplemental Dental Coverage-** The State will provide dental coverage to children eligible for dental-only supplemental services. Children eligible for this option must receive the same dental services as provided to otherwise eligible CHIP children (Section 2110(b)(5)(C)(ii)). Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, and 9.10 when electing this option.

Guidance: Under Title XXI, pre-existing condition exclusions are not allowed, with the only exception being in relation to another law in existence (HIPAA/ERISA). Indicate that the plan adheres to this requirement by checking the applicable description.

In the event that the State provides benefits through a group health plan or group health

coverage, or provides family coverage through a group health plan under a waiver (see Section 6.4.2.), pre-existing condition limits are allowed to the extent permitted by HIPAA/ERISA. If the State is contracting with a group health plan or provides benefits through group health coverage, describe briefly any limitations on pre-existing conditions. (Formerly 8.6.)

6.3. The State assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: (42CFR 457.480)

- 6.3.1.** The State shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); OR
- 6.3.2.** The State contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.6.2. (formerly 6.4.2) of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA. (Formerly 8.6.) (Section 2103(f)) Describe:

Guidance: States may request two additional purchase options in Title XXI: cost effective coverage through a community-based health delivery system and for the purchase of family coverage. (Section 2105(c)(2) and (3)) (457.1005 and 457.1010)

6.4. **Additional Purchase Options-** If the State wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the State must address the following: (Section 2105(c)(2) and (3)) (42 CFR 457.1005 and 457.1010)

6.4.1. **Cost Effective Coverage-** Payment may be made to a State in excess of the 10 percent limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in Section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the State to administer the plan, if it demonstrates the following (42CFR 457.1005(a)):

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; Describe the coverage provided by the alternative delivery system. The State may cross reference Section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the

coverage described above; Describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))

Guidance: Check below if the State is requesting to provide cost-effective coverage through a community-based health delivery system. This allows the State to waive the 10 percent limitation on expenditures not used for Medicaid or health insurance assistance if coverage provided to targeted low-income children through such expenditures meets the requirements of Section 2103; the cost of such coverage is not greater, on an average per child basis, than the cost of coverage that would otherwise be provided under Section 2103; and such coverage is provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under Section 330 of the Public Health Services Act or with hospitals such as those that receive disproportionate share payment adjustments under Section 1886(c)(5)(F) or 1923.

If the cost-effective alternative waiver is requested, the State must demonstrate that payments in excess of the 10 percent limitation will be used for other child health assistance for targeted low-income children; expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); expenditures for outreach activities as provided in Section 2102(c)(1) under the plan; and other reasonable costs incurred by the State to administer the plan. (42CFR, 457.1005(a))

6.4.1.3. The coverage must be provided through the use of a community based health delivery system, such as through contracts with health centers receiving funds under Section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under Section 1886(c)(5)(F) or 1923 of the Social Security Act. Describe the community-based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))

Guidance: Check 6.4.2.if the State is requesting to purchase family coverage. Any State requesting to purchase such coverage will need to include information that establishes to the Secretary's satisfaction that: 1) when compared to the amount of money that would have been paid to cover only the children involved with a comparable package, the purchase of family coverage is cost effective; and 2) the purchase of family coverage is not a substitution for coverage already being provided to the child. (Section 2105(c)(3)) (42CFR 457.1010)

6.4.2. **Purchase of Family Coverage-** Describe the plan to purchase family coverage. Payment may be made to a State for the purpose of family coverage under a group

health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: (Section 2105(c)(3)) (42CFR 457.1010)

- 6.4.2.1.** Purchase of family coverage is cost-effective. The State’s cost of purchasing family coverage, including administrative expenditures, that includes coverage for the targeted low-income children involved or the family involved (as applicable) under premium assistance programs must not be greater than the cost of obtaining coverage under the State plan for all eligible targeted low-income children or families involved; and (2) The State may base its demonstration of cost effectiveness on an assessment of the cost of coverage, including administrative costs, for children or families under premium assistance programs to the cost of other CHIP coverage for these children or families, done on a case-by-case basis, or on the cost of premium assisted coverage in the aggregate.
- 6.4.2.2.** The State assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B)) (42CFR 457.1010(b))
- 6.4.2.3.** The State assures that the coverage for the family otherwise meets title XXI requirements. (42CFR 457.1010(c))

6.4.3-PA: Additional State Options for Providing Premium Assistance (CHIPRA # 13, SHO # 10-002 issued February, 2, 2010) A State may elect to offer a premium assistance subsidy for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(B), to all targeted low-income children who are eligible for child health assistance under the plan and have access to such coverage. No subsidy shall be provided to a targeted low-income child (or the child’s parent) unless the child voluntarily elects to receive such a subsidy. (Section 2105(c)(10)(A)). Please remember to update section 9.10 when electing this option. Does the State provide this option to targeted low-income children?

- Yes
- No

6.4.3.1-PA Qualified Employer-Sponsored Coverage and Premium Assistance Subsidy

6.4.3.1.1-PA Provide an assurance that the qualified employer-sponsored insurance meets the definition of qualified employer-sponsored coverage as defined in Section 2105(c)(10)(B), and that the premium assistance subsidy meets the definition of premium assistance subsidy as defined in 2105(c)(10)(C).

6.4.3.1.2-PA Describe whether the State is providing the premium assistance subsidy as reimbursement to an employee or for out-of-pocket expenditures or directly to the employee's employer.

6.4.3.2-PA: Supplemental Coverage for Benefits and Cost Sharing Protections Provided under the Child Health Plan.

6.4.3.2.1-PA If the State is providing premium assistance for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(E)(i), provide an assurance that the State is providing for each targeted low-income child enrolled in such coverage, supplemental coverage consisting of all items or services that are not covered or are only partially covered, under the qualified employer-sponsored coverage consistent with 2103(a) and cost sharing protections consistent with Section 2103(e).

6.4.3.2.2-PA Describe whether these benefits are being provided through the employer or by the State providing wraparound benefits.

6.4.3.2.3-PA If the State is providing premium assistance for benchmark or benchmark-equivalent coverage, the State ensures that such group health plans or health insurance coverage offered through an employer will be certified by an actuary as coverage that is equivalent to a benchmark benefit package described in Section 2103(b) or benchmark equivalent coverage that meets the requirements of Section 2103(a)(2).

6.4.3.3-PA: Application of Waiting Period Imposed Under State Plan: States are required to apply the same waiting period to premium assistance as is applied to direct coverage for children under their CHIP State plan, as specified in Section 2105(c)(10)(F).

6.4.3.3.1-PA Provide an assurance that the waiting period for children in premium assistance is the same as for those children in direct coverage (if State has a waiting period in place for children in direct CHIP coverage).

6.4.3.4-PA: Opt-Out and Outreach, Education, and Enrollment Assistance

6.4.3.4.1-PA Describe the State's process for ensuring parents are permitted to disenroll their child from qualified employer-sponsored coverage and to enroll in CHIP effective on the first day of any month for which the child is eligible for such assistance and in a manner that ensures continuity of coverage for the child (Section 2105(c)(10)(G)).

6.4.3.4.2-PA Describe the State’s outreach, education, and enrollment efforts related to premium assistance programs, as required under Section 2102(c)(3). How does the State inform families of the availability of premium assistance, and assist them in obtaining such subsidies? What are the specific significant resources the State intends to apply to educate employers about the availability of premium assistance subsidies under the State child health plan? (Section 2102(c))

6.4.3.5-PA Purchasing Pool- A State may establish an employer-family premium assistance purchasing pool and may provide a premium assistance subsidy for enrollment in coverage made available through this pool (Section 2105(c)(10)(I)). Does the State provide this option?

Yes
 No

6.6.3.5.1-PA Describe the plan to establish an employer-family premium assistance purchasing pool.

6.6.3.5.2-PA Provide an assurance that employers who are eligible to participate: 1) have less than 250 employees; 2) have at least one employee who is a pregnant woman eligible for CHIP or a member of a family that has at least one child eligible under the State’s CHIP plan.

6.6.3.5.3-PA Provide an assurance that the State will not claim for any administrative expenditures attributable to the establishment or operation of such a pool except to the extent such payment would otherwise be permitted under this title.

6.4.3.6-PA Notice of Availability of Premium Assistance- Describe the procedures that assure that if a State provides premium assistance subsidies under this Section, it must: 1) provide as part of the application and enrollment process, information describing the availability of premium assistance and how to elect to obtain a subsidy; and 2) establish other procedures to ensure that parents are fully informed of the choices for child health assistance or through the receipt of premium assistance subsidies (Section 2105(c)(10)(K)).

6.4.3.6.1-PA Provide an assurance that the State includes information about premium assistance on the CHIP application or enrollment form.

Section 7. Quality and Appropriateness of Care

Guidance: Methods for Evaluating and Monitoring Quality- Methods to assure quality include the application of performance measures, quality standards consumer information

strategies, and other quality improvement strategies.

Performance measurement strategies could include using measurements for external reporting either to the State or to consumers and for internal quality improvement purposes. They could be based on existing measurement sets that have undergone rigorous evaluation for their appropriateness (e.g., HEDIS). They may include the use of standardized member satisfaction surveys (e.g., CAHPS) to assess members' experience of care along key dimensions such as access, satisfaction, and system performance.

Quality standards are often used to assure the presence of structural and process measures that promote quality and could include such approaches as: the use of external and periodic review of health plans by groups such as the National Committee for Quality Assurance; the establishment of standards related to consumer protection and quality such as those developed by the National Association of Insurance Commissioners; and the formation of an advisory group to the State or plan to facilitate consumer and community participation in the plan.

Information strategies could include: the disclosure of information to beneficiaries about their benefits under the plan and their rights and responsibilities; the provision of comparative information to consumers on the performance of available health plans and providers; and consumer education strategies on how to access and effectively use health insurance coverage to maximize quality of care.

Quality improvement strategies should include the establishment of quantified quality improvement goals for the plan or the State and provider education. Other strategies include specific purchasing specifications, ongoing contract monitoring mechanisms, focus groups, etc.

Where States use managed care organizations to deliver CHIP care, recent legal changes require the State to use managed care quality standards and quality strategies similar to those used in Medicaid managed care.

Tools for Evaluating and Monitoring Quality- Tools and types of information available include, HEDIS (Health Employer Data Information Set) measures, CAHPS (Consumer Assessments of Health Plans Study) measures, vital statistics data, and State health registries (e.g., immunization registries).

Quality monitoring may be done by external quality review organizations, or, if the State wishes, internally by a State board or agency independent of the State CHIP Agency. Establishing grievance measures is also an important aspect of monitoring.

Check here if the State elects to use funds provided under Title XXI only to provide expanded

eligibility under the State's Medicaid plan, and continue on to Section 8.

Guidance: The State must specify the qualifications of entities that will provide coverage and the conditions of participation. States should also define the quality standard they are using, for example, NCQA Standards or other professional standards. Any description of the information strategies used should be linked to Section 9. (Section 2102(a)(7)(A)) (42CFR, 457.495)

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (Section 2102(a)(7)(A)) (42CFR 457.495(a)) Will the State utilize any of the following tools to assure quality? (Check all that apply and describe the activities for any categories utilized.)

External Quality Review

The State contracts with an evaluation consultant who develops and updates performance criteria, and also provides assistance in producing the evaluation and annual reports. The performance criteria are an important tool for measuring quality of care, particularly with respect to well-baby care, well-child care, and immunizations. Hoosier Healthwise uses NCQA's HEDIS measures to monitor quality.

Quality Improvement Programs

Quality assurance requirements are imposed on MCOs that contract with the State under Hoosier Healthwise. MCOs must have quality improvement (QI) programs in place that meet the federal requirements (42 CFR 438 Subpart D) and the National Committee for Quality Assurance (NCQA) standards. The QI programs must be based on annual plans that are approved by the OMPP. In addition, MCOs must meet a number of other QI requirements, including: establishing a QI Committee overseen by the MCO Medical Director; submitting Quarterly QI reports; conducting focused studies, including medical data abstraction and data entry, in areas of clinical priority for the Indiana Medicaid population; establishing internal systems for monitoring services; conducting a quality of care chart audit of providers of services; attending monthly Hoosier Healthwise Quality Improvement Committee (QIC) meetings; submitting QI data to the State; and taking other steps to improve quality of services.

7.1.1. Quality standards

MCOs that provide services under Hoosier Healthwise must have Quality Improvement (QI) programs in place that meet the National Committee for Quality Assurance (NCQA) standards.

PMPs will be required to comply with universally accepted standards for preventive care, as endorsed by the American Academy of Pediatrics, the Academy of Family Physicians, the American College of Obstetrics and Gynecology, and the American Society of Internal Medicine. Specifically, these standards apply to the following areas: childhood immunizations, pregnancy, lead toxicity, comprehensive well child periodic health assessment, HIV status, asthma, diabetes, alcohol and drug abuse, sexually transmitted diseases, motor vehicle accidents, pregnancy prevention, prevention of influenza, smoking prevention and cessation, and others. Clinical practice guidelines from the Agency for Healthcare Research and Quality and the Indiana Medicaid Coordinated Care Technical Assistance

Group (TAG) may also recommend standards.

- Through the Clinical Advisory Committee, providers provide the OMPP with input on Hoosier Healthwise policies affecting quality, accessibility, appropriateness and cost effectiveness of care.
- The Hoosier Healthwise QIC oversees quality of care and appropriateness of care and integrates the quality improvement process. The Quality Integrity Committee (QIC) membership consists of MCO medical directors, MCO QI staff representatives, and the OMPP staff members
- Requests to disenroll are documented, tracked and monitored

7.1.2. Performance measurement

- MCOs must conduct annual member satisfaction surveys, and present this information to the OMPP, recipients and providers.
- MCOs must provide the Health Plan Employer Data Information Set (HEDIS) measures to OMPP on an annual basis.
- The evaluation consultant will develop performance criteria to measure the quality of services provided under CHIP. These measures will include health status indicators and EPSDT compliance.

7.1.2 (a) CHIPRA Quality Core Set
Child Core Quality Data

7.1.2 (b) Other

7.1.3. Information strategies

- Hoosier Healthwise applicants are provided with materials regarding managed care; PMPs; MCOs; preventive services; 1-800 telephone hotline; emergency room usage; grievance procedures; recipients' rights and responsibilities; coverage, cost and claims; and a summary of program activities.
- The State conducts provider training and benefit advocate training. Indiana has implemented an enhanced outreach campaign

7.1.4. Quality improvement strategies

- The State has a toll free telephone number for recipients and providers. Staff investigates inquires and complaints received through this phone line.
- The Hoosier Healthwise MCOs monitor PMPs 24-hour accessibility by making random calls to PMPs during regular business hours and after hours.
- The State monitors several key indicators to assure that access problems do not arise. These indicators include: waiting periods; access to care after hours; referrals to specialists; and access to emergency or family planning services.
- MCOs must conduct focus studies on areas of clinical priority including preventive care, behavioral health, prenatal outcomes, and disease management (e.g. asthma and diabetes care)

Guidance: Provide a brief description of methods to be used to assure access to covered services, including a description of how the State will assure the quality and appropriateness of the

care provided. The State should consider whether there are sufficient providers of care for the newly enrolled populations and whether there is reasonable access to care. (Section 2102(a)(7)(B))

7.2. Describe the methods used, including monitoring, to assure: (Section 2102(a)(7)(B)) (42CFR 457.495)

7.2.1. Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. (Section 2102(a)(7)) (42CFR 457.495(a))

The State employs an External Quality Review Organization (EQRO) that monitors and assesses the quality of and access to health care enabled by Hoosier Healthwise. Advising the monitoring process is a Quality Improvement Committee, a Clinical Advisory Committee, and Focused Study Workgroups. The Focused Study Workgroups include neonatal outcomes, management of members with complex needs, and behavioral health. The HEDIS is being utilized for tracking health plan performance on an annual basis. Several quarterly reports based on HEDIS specifications are also provided to OMPP by the Hoosier Healthwise MCOs. The State's EQRO is also the CHIP's independent evaluation consultant. Data collected by the vendor for the EQR are refined for the purpose of assessing CHIP's programmatic effectiveness in this area.

CHIP monitors the size of Primary Physician panels at least annually.

7.2.2. Access to covered services, including emergency services as defined in 42 CFR 457.10. (Section 2102(a)(7)) 42CFR 457.495(b))

The evaluation consultant is responsible for updating and developing tools to measure the utilization of health services. The measure set will be intended to assess how often, how effectively and how appropriately enrollees are utilizing services under the program

7.2.3. Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102(a)(7)) (42CFR 457.495(c))

All Hoosier Healthwise members are allowed to select a Primary Medical Provider. If one is not selected within 30 days, a PMP will be assigned to them. By ensuring that all members have a medical home, chronic, complex, or serious medical conditions can be closely monitored and appropriate referrals can be made when necessary. In addition, when the network is not adequate for the enrollee's medical condition, managed care organizations are required to allow members to access to out-of-network providers.

7.2.4. Decisions related to the prior authorization of health services are completed in accordance with State law or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42CFR 457.495(d)) Exigent medical circumstances may require more rapid response according to the medical needs of the patient.

Decisions related to the prior authorization of health services are completed in accordance with the CHIP administrative rules, found in Title 405 of the Indiana Administrative Code,

Section 13-2-1.

Section 8. Cost-Sharing and Payment

Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State’s Medicaid plan, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan? (42CFR 457.505) Indicate if this also applies for pregnant women. (CHIPRA #2, SHO # 09-006, issued May 11, 2009)

8.1.1. Yes

8.1.2. No, skip to question 8.8.

8.1.1-PW Yes

8.1.2-PW No, skip to question 8.8.

Guidance: It is important to note that for families below 150 percent of poverty, the same limitations on cost sharing that are under the Medicaid program apply. (These cost-sharing limitations have been set forth in Section 1916 of the Social Security Act, as implemented by regulations at 42 CFR 447.50 - 447.59). For families with incomes of 150 percent of poverty and above, cost sharing for all children in the family cannot exceed 5 percent of a family's income per year. Include a statement that no cost sharing will be charged for pregnancy-related services. (CHIPRA #2, SHO # 09-006, issued May 11, 2009) (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge by age and income (if applicable) and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

8.2.1. Premiums:

Sliding scale premiums (see chart below) will be imposed on families of children eligible for the Title XXI SCHIP program. Cost-sharing for these families (with incomes above 150% of FPL), will not exceed five percent of the family’s yearly income. Individuals eligible under MCHIP (with incomes up to 150% of FPL) will continue to comply with cost-sharing limitations established under Medicaid. SCHIP individuals pay premiums monthly.

If an applicant is determined to be eligible for SCHIP (Hoosier Healthwise Package C), ICES issues a notice to the applicant informing him or her of the premium payment responsibility for enrollment, and holds the account in suspense. Information regarding the eligibility status and cost-sharing responsibilities is transferred to the premium-collection vendor. The premium-collection vendor issues

a premium statement and provides detailed information regarding the cost-sharing requirements. If the premium is paid by the due date, the premium-collection vendor transfers this information to ICES and the applicant's account is changed from suspended status to enrolled. The applicant becomes retroactively eligible for SCHIP coverage beginning the first day of the month the application was submitted to the DFR.

If the premium is not paid by the due date (the 12th day of the month following eligibility determination), the applicant's ICES account will remain in suspense and a second premium notice will be sent. If the premium has not been paid by the last day of the month following eligibility determination, the applicant will be notified that the application has been denied.

In situations where a child is enrolled in the program, but the family later fails to make a payment by the due date, a 60-day grace period will be provided. If fees are not paid by the end of the 60-day grace period, the child will be disenrolled from the program. Families that have been disenrolled due to non-payment of premiums may re-apply for coverage immediately. After meeting eligibility requirements, including the payment of all delinquent and current premiums due, the disenrolled child (ren) may be re-enrolled in the program.

PREMIUMS

Income (As a percent of FPL)	One Child	Two or More Children
Over 150 to 175 percent	\$22.00	\$33.00
Over 175 to 200 percent	\$33.00	\$50.00
Over 200 to 225 percent	\$42.00	\$53.00
Over 225 to 250 percent	\$53.00	\$70.00

8.2.2. Deductibles:
Not applicable.

8.2.3. Coinsurance or copayments:

Prescription Drugs — Generic, Compound and Sole-Source: \$3

Prescription Drugs — Brand Name: \$10

Emergency Ambulance Transportation: \$10

8.2.4. Other:

8.2-DS **Supplemental Dental** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) For children enrolled in the dental-only supplemental coverage, describe the amount of cost-sharing, specifying any sliding scale based on income. Also describe how the State will track that the cost sharing does not exceed 5 percent of gross family income. The 5 percent of income calculation shall include all cost-sharing for health insurance and dental insurance. (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b), and (c), 457.515(a) and (c), and 457.560(a)) Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, 6.2-DS, and 9.10 when electing this option.

8.2.1-DS Premiums:

8.2.2-DS Deductibles:

8.2.3-DS Coinsurance or copayments:

8.2.4-DS Other:

8.3. Describe how the public will be notified, including the public schedule, of this cost sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. (Section 2103(e)(1)(A)) (42CFR 457.505(b))

- Notice in the Hoosier Healthwise brochure;
- Notice in the application form (if the family does not agree to the cost-sharing requirements under SCHIP, the child will be considered only for Medicaid or MCHIP and will not be considered for SCHIP);
- Notice in the conditional approval form which is sent to the family after the child is found conditionally eligible for SCHIP before the family has received the premium notice;
- Notice in the first premium voucher which is sent to the family by the premium collection vendor;

- Notice in the members' handbooks which are sent once the first premium has been paid and the child has been enrolled;
- Public hearings are held regarding state statute rule changes including those defining cost sharing requirements;
- Publication in the Indiana Register; and
- Publication in the Indiana Administrative Code.
- Enrollees are sent a notice generated from the eligibility system that informs them of their cost-sharing maximum

Guidance: The State should be able to demonstrate upon request its rationale and justification regarding these assurances. This section also addresses limitations on payments for certain expenditures and requirements for maintenance of effort.

8.4. The State assures that it has made the following findings with respect to the cost sharing in its plan: (Section 2103(e))

- 8.4.1.** Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42CFR 457.530)
- 8.4.2.** No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42CFR 457.520)
- 8.4.3** No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42CFR 457.515(f))

- 8.5.** Describe how the State will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family’s income for the length of the child’s eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the State for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))

Indiana will utilize a “shoe box” approach, similar to that used by the Massachusetts CHIP program.

In an enrollment notice, automatically generated from the eligibility system, families are informed of their cost sharing limit based on their individual income, and instructed to keep records of their payments. They are further instructed to contact the Hoosier Healthwise Package C payment line for instructions about future payments if they believe their premium plus co-payments (if applicable) have reached the amount on the enrollment notice.

To ensure that no eligible children are charged cost sharing in excess of the cumulative cost-sharing maximum the office will obtain monthly reports from ICES that will reflect cost-sharing limits at the case level. Monthly, these reports will be compared to premium payment reports provided by the premium collection vendor. We will monitor MCOs for co-payment activity to confirm none are made or to track amounts per enrollee. Using this information the office will be able to determine which enrollees are within range, yet under the cost-sharing maximum. Those enrollees who have accumulated premium payment and co-payment liability within 4% of their annual income will be notified of their status and advised to stop premium payments and co pays, and to submit their records for review and confirmation of non-payment status. After payment record review and non-payment status confirmation, the office will notify:

- a) The premium vendor to waive premiums/suspend invoicing through the remainder of the benefit period, and
- b) The MCO (who will then notify their pharmacy and ambulance transportation vendors) to waive co-payments through the specified date.

A letter will be sent to each family who meets their 5% cap that may be used to confirm their cost-share-free status to vendors as needed with instructions to the vendor on how to verify.

- 8.6.** Describe the procedures the State will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. (Section 2103(b)(3)(D)) (42CFR 457.535)

Targeted low-income children of American Indian and Alaskan Native families are excluded from the cost-sharing requirements. The ICES system has been modified to allow a manual system override procedure to exempt these individuals from cost-sharing once they have been deemed eligible.

- 8.7.** Provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(c))

If the premium is not paid by the due date (the 12th day of the month following eligibility

determination), the applicant’s ICES account will remain in suspense and a second premium notice will be sent. If the premium has not been paid by the last day of the month following eligibility determination, the applicant will be notified that the application has been denied.

In situations where a child is enrolled in the program, but the family later fails to make a payment by the due date, a 60-day grace period will be provided. If fees are not paid by the end of the 60-day grace period, the child will be disenrolled from the program.

In both situations above, the applicant or enrollee will receive an ICES notice that provides for appeal of the closure or denial decision. The notice states in part:

“You have the right to appeal and have a fair hearing. An appeal will be accepted if it is received within 30 days of this notice or within 30 days of the effective date of the action,, whichever is later. We will allow 3 extra days for mailing.

If you wish to appeal, send a signed letter to your local Division of Family Resources office at the address at the top of this Notice. If you prefer, you can send your appeal to the Indiana Family and Social Services Administration, Division of Family Resources, Hearings and Appeals, room W392, Indianapolis IN 46204. If you have questions, please contact your caseworker.

You will be notified in writing of the date, time and place for the hearing. You can represent yourself, or have someone represent you such as attorney, friend, or relative. If your wish to have legal representation and cannot afford it, you may call the Legal Services Organization serving your area at (800) 892-2776.”

Guidance: Section 8.7.1 is based on Section 2101(a) of the Act provides that the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.

8.7.1. Provide an assurance that the following disenrollment protections are being applied:

Guidance: Provide a description below of the State’s premium grace period process and how the State notifies families of their rights and responsibilities with respect to payment of premiums. (Section 2103(e)(3)(C))

- 8.7.1.1.** State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))
- 8.7.1.2.** The disenrollment process affords the enrollee an opportunity to show that the enrollee’s family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b))

8.7.1.3. In the instance mentioned above, that the State will facilitate enrolling the child in Medicaid or adjust the child’s cost-sharing category as appropriate. (42CFR 457.570(b))

8.7.1.4 The State provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))

8.8. The State assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))

8.8.1. No Federal funds will be used toward State matching requirements. (Section 2105(c)(4)) (42CFR 457.220)

8.8.2. No cost-sharing (including premiums, deductibles, copayments, coinsurance and all other types) will be used toward State matching requirements. (Section 2105(c)(5) (42CFR 457.224) (Previously 8.4.5)

8.8.3. No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))

8.8.4. Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))

8.8.5. No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42CFR 457.475)

8.8.6. No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A)) (42CFR 457.475)

Section 9. Strategic Objectives and Performance Goals and Plan Administration

Guidance: States should consider aligning its strategic objectives with those discussed in Section II of the CHIP Annual Report.

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2)) (42CFR 457.710(b))

9.1.1 Reduce Uninsured Previously uninsured low-income children will have health insurance through Indiana’s Title XXI program

9.1.2 Enrollment

Targeted low-income children will have health insurance through Indiana's Title XXI program

9.1.3 Access to Care

Children enrolled in Indiana's Title XXI Program will have access to appropriate behavioral health care

9.1.4 Preventive Care

Immunizations-children will receive the recommended immunizations

9.1.5 Adolescent Well Care

Adolescents aged 12-21 will receive recommended well care visits

9.1.6 Well-Child Visits First 15 months of life, six or more visits.

9.1.7 Well-Child Visits, ages 3-6 years

Guidance: Goals should be measurable, quantifiable and convey a target the State is working towards.

9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3)) (42CFR 457.710(c))

Maintain state's uninsured rate for population at or below 200% FPL below the 25th percentile of states nationally

Enrollment of approximately 13,500 children between 200% and 250% FPL by 9/30/2012

The rate at which children prescribed ADHD medication will have the appropriate follow up visits with a behavioral health provider will exceed the HEDIS 50th percentile for Medicaid

The rate at which children receive immunizations will exceed the Medicaid HEDIS 50th percentile available at the time of HEDIS Report Submission (July of each year)

The rate at which adolescents aged 12-21 will receive the recommended well care visits will exceed the Medicaid HEDIS 50th percentile available at the time of HEDIS report submission (July of each year)

The rate at which children 0-15 months of age receive at least six well care visits will exceed the Medicaid HEDIS 50th percentile available at the time of HEDIS report submission (July of each year).

The rate at which children 3-6 years of age receive at least one preventive exam will exceed the HEDIS 50th percentile at the time of HEDIS report submission (July of each year).

Guidance: The State should include data sources to be used to assess each performance goal. In addition, check all appropriate measures from 9.3.1 to 9.3.8 that the State will be utilizing to measure performance, even if doing so duplicates what the State has already discussed in Section 9.

It is acceptable for the State to include performance measures for population subgroups chosen by the State for special emphasis, such as racial or ethnic minorities, particular high-risk or hard to reach populations, children with special needs, etc.

HEDIS (Health Employer Data and Information Set) 2008 contains performance measures relevant to children and adolescents younger than 19. In addition, HEDIS 3.0 contains measures for the general population, for which breakouts by children's age bands (e.g., ages < 1, 1-9, 10-19) are required. Full definitions, explanations of data sources, and other important guidance on the use of HEDIS measures can be found in the HEDIS 2008 manual published by the National Committee on Quality Assurance. So that State HEDIS results are consistent and comparable with national and regional data, states

should check the HEDIS 2008 manual for detailed definitions of each measure, including definitions of the numerator and denominator to be used. For states that do not plan to offer managed care plans, HEDIS measures may also be able to be adapted to organizations of care other than managed care.

- 9.3.** Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the State's performance, taking into account suggested performance indicators as specified below or other indicators the State develops: (Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

US Census CPS 3 year average uninsured rate for children under age 19 at or below 200% FPL

Hoosier Healthwise enrollment in the 200-250% FPL bracket

HEDIS measure for follow up care for ADHD medications (ADD), initiation phase

HEDIS (CIS), Combo Three

HEDIS (AWS) for ages 12-21 years

HEDIS (W15) for children ages 0-15 months

HEDIS (W34) for children 3-6 years of age

Check the applicable suggested performance measurements listed below that the State plans to use: (Section 2107(a)(4))

9.3.1. The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.

9.3.2. The reduction in the percentage of uninsured children.

9.3.3. The increase in the percentage of children with a usual source of care.

9.3.4. The extent to which outcome measures show progress on one or more of the health problems identified by the state.

9.3.5. HEDIS Measurement Set relevant to children and adolescents younger than 19.

9.3.6. Other child appropriate measurement set. List or describe the set used.

9.3.7. If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:

9.3.7.1. Immunizations

9.3.7.2. Well childcare

9.3.7.3. Adolescent well visits

9.3.7.4. Satisfaction with care

9.3.7.5. Mental health

9.3.7.6. Dental care

9.3.7.7. Other, list:

9.3.8. Performance measures for special targeted populations.

- 9.4.** The State assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1)) (42CFR 457.720)

Guidance: The State should include an assurance of compliance with the annual reporting requirements, including an assessment of reducing the number of low-income uninsured children. The State should also discuss any annual activities to be undertaken that relate to assessment and evaluation of the program.

9.5. The State assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the State’s plan for these annual assessments and reports. (Section 2107(b)(2)) (42CFR 457.750)

The State assures that it will submit the evaluation required under Section 10 by January 1st of each year. The State also assures that it will complete an annual assessment of the progress made in reducing the number of uncovered low-income children, and report to the Secretary on the result of the assessment.

The assessments will be based largely upon the strategic objectives set forth in Section 9 and program evaluation criteria designed by the evaluation consultant. The strategic objectives focus on enrolling children, establishing usual sources of care, measuring enrollee and provider satisfaction, and improving health status. The data used to measure performance and assess the quality of care provided to Hoosier Healthwise children will be compiled from existing databases and the audited health plan-reported HEDIS results for child-relevant measures.

9.6. The State assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review or audit. (Section 2107(b)(3)) (42CFR 457.720)

Guidance: The State should verify that they will participate in the collection and evaluation of data as new measures are developed or existing measures are revised as deemed necessary by CMS, the states, advocates, and other interested parties.

9.7. The State assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. (42CFR 457.710(e))

9.8. The State assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a State under Title XIX: (Section 2107(e)) (42CFR 457.135)

9.8.1. Section 1902(a)(4)(C) (relating to conflict of interest standards)

9.8.2. Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)

9.8.3. Section 1903(w) (relating to limitations on provider donations and taxes)

9.8.4. Section 1132 (relating to periods within which claims must be filed)

Guidance: Section 9.9 can include discussion of community-based providers and consumer representatives in the design and implementation of the plan and the method for ensuring ongoing public involvement. Issues to address include a listing of public meetings or announcements made to the public concerning the development of the children's health insurance program or public forums used to discuss changes to the State plan.

9.9. Describe the process used by the State to accomplish involvement of the public in the design and implementation of the plan and the method for ensuring ongoing public involvement. (Section 2107(c)) (42CFR 457.120(a) and (b))

Public Input on Plan Design:

In designing the first and second phases of the CHIP program, Indiana developed a public input plan that included several different levels of discussion, and which capitalized on the expertise and experience of a myriad of individuals and entities within the state. This input included:

- A twenty-one member bi-partisan Governor's Advisory Panel representing a cross-section of Indiana experts was appointed to develop a blueprint on implementation of the CHIP program. Members on the panel included: hospital representatives, physicians, insurance executives, parents, advocates, school officials, health clinic representatives, and members of the Indiana General Assembly. Numerous press releases were utilized to publicize the work of the Advisory Panel. All meetings were publicized and covered by the news media. Further, there was significant news coverage during the General Assembly's deliberations on the Governor's CHIP proposal.
- Five subcommittees were established to provide a broader range of input and allow for in-depth discussion and analysis on key areas of importance. Membership on the subcommittees included: hospitals, physicians, nurses, pharmacists, local health department representatives, optometrists, mental health providers, economists, academics, numerous community and social services programs, migrant farmworkers and homeless parents, and various other experts. The subcommittees focused on the following key topics: Coordination/Infrastructure/Provider Supply/Community Systems; Benefits and Cost Sharing; Eligibility and Crowd Out; Outreach and Education; and Data, Evaluation and Outcomes. The subcommittees' reports were submitted to the Advisory Panel for consideration.
- A series of eight public forums were held across the state in order to allow for a wide range of input from individuals and entities within individual communities. The forums provided opportunities for citizens to share their concerns regarding methods for improving and for building upon the state's current health care system, and mechanisms for encouraging parents to access health services. In order to maximize awareness and participation, the forums were held at a number of different sites and at varying times. The local social service and health promotion agencies helped select the most appropriate time and location for each hearing. To promote the forums, the organizers worked closely with numerous individuals and entities. Assistance was provided by the local WIC sites, local Maternal and Child Health (MCH) agencies, local immunization sites, local Medicaid providers, community health centers, local DFR offices, the LHDs, and the Indiana Coalition on Housing and Homeless Issues. In order to make it easier for parents to attend, child care was provided during the forums. Individuals who were not able to attend were encouraged to submit written comments. State and local news media were notified in advance of all public forums through a myriad of sources. News releases, media

advisories and telephone calls were all utilized in an effort to maximize press coverage.

- Numerous focus groups were established to draw upon the expertise, experience, and perspectives of homogeneous groups of individuals. The focus groups consisted of groups of providers, advocates, parents and adolescents. The groups met in various locations throughout the State and discussed key issues from their own specific perspectives.
- The Phase II benefits package was sent to stakeholders with requests for comments.
- Discussion of plan design was also possible during the rulemaking process. A public hearing was held during this process.
- As part of its CHIP oversight responsibility, the Policy Board established broad based committees in the areas of: children with special health care needs, data, and program coordination.
- Legislative oversight of the CHIP program will be provided by the Select Joint Committee on Medicaid Oversight.

Promotion of Plan Implementation:

The Chair of the Governor's Advisory Panel appeared before various editorial boards as a means of increasing awareness of the CHIP program. A CHIP website was developed to provide information regarding the CHIP program. This website (<http://www.in.gov/fssa/ompp/2545.htm>) is updated regularly and also includes a link to the Hoosier Healthwise website for families. Radio and television public service announcements were aired throughout the State. A radio blitz that included information about Hoosier Healthwise in a "Back to School" message was run throughout the State. Billboards, bus placards, and newspaper ads have also been used to promote the program. And, with the assistance of local DFR offices, local newspapers have run articles informing families about Hoosier Healthwise.

- 9.9.1.** Describe the process used by the State to ensure interaction with Indian Tribes and organizations in the State on the development and implementation of the procedures required in 42 CFR 457.125. States should provide notice and consultation with Tribes on proposed pregnant women expansions. (Section 2107(c)) (42CFR 457.120(c)) Indiana contracted with the Indiana Minority Health Coalition (IMHC) and Wishard Hispanic Health Project during the design, implementation, and early stages of the CHIP program to develop culturally sensitive materials targeting a Native American audience and to assure that Native American children who are eligible for the program received assistance. Currently, the Coordinator of the American Indian Center is available in an advisory role to the State regarding this population.
- 9.9.2.** For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), describe how and when prior public notice was provided as required in 42 CFR 457.65(b) through (d).

In the 2002 Indiana legislative session, state law (P.L. 107-2002) was passed to eliminate continuous eligibility from Hoosier Healthwise. As a result, it was necessary to amend our MCHIP administrative rules. As required by Indiana's rulemaking statute (IC 4-22-2), the agency provided public notice of the change before the rule was adopted. The proposed rule was published in the Indiana Register on June 1, 2002. Notice of the public hearing concerning the proposed change was published in the Indianapolis Star newspaper on May 24, 2002. A public hearing was held June 24, 2002. The agency complied with

the public notice requirements prior to the July 1, 2002 effective date of the change in eligibility.

In addition to the public notice required by the rulemaking process, the agency provided notice of the change to all Hoosier Healthwise members. All Hoosier Healthwise members were sent a notice between June 17, 2002 and June 21, 2002 advising them of the change in law and how it would affect them. In addition, the CHIP premium collection vendor also sent flyers out with members' invoices in order to provide them with an additional reminder of the change in eligibility. These flyers were included with the June, July, and August 2002 invoices.

In the 2007 Indiana legislative session, state law (P.L. 218-2007) was passed to increase the income eligibility up to 250% FPL, and create continuous eligibility for children until three (3) years of age. The statute gives authority to the Office of Medicaid Policy and Planning to adjust eligibility based on available program resources and further gives rulemaking authority to establish premiums. The rulemaking process with all notice and comment requirements will be followed as described above.

9.9.3. Describe the State's interaction, consultation, and coordination with any Indian tribes and organizations in the State regarding implementation of the Express Lane eligibility option.

9.10. Provide a 1-year projected budget. A suggested financial form for the budget is below. The budget must describe: (Section 2107(d)) (42CFR 457.140)

- Planned use of funds, including:
 - Projected amount to be spent on health services;
 - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
 - Assumptions on which the budget is based, including cost per child and expected enrollment.
 - Projected expenditures for the separate child health plan, including but not limited to expenditures for targeted low income children, the optional coverage of the unborn, lawfully residing eligibles, dental services, etc.
 - All cost sharing, benefit, payment, eligibility need to be reflected in the budget.
- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.
- Include a separate budget line to indicate the cost of providing coverage to pregnant women.
- States must include a separate budget line item to indicate the cost of providing coverage to premium assistance children.
- Include a separate budget line to indicate the cost of providing dental-only supplemental coverage.

- Include a separate budget line to indicate the cost of implementing Express Lane Eligibility.
- Provide a 1-year projected budget for all targeted low-income children covered under the state plan using the attached form. Additionally, provide the following:
 - Total 1-year cost of adding prenatal coverage
 - Estimate of unborn children covered in year 1

CHIP Budget

STATE: IN	FFY Budget
Federal Fiscal Year	2017
State's enhanced FMAP rate	
Benefit Costs	
Insurance payments	
Managed care	121,762,593
<u>per member/per month rate</u>	
Fee for Service	56,142,158
Total Benefit Costs	177,904,751
(Offsetting beneficiary cost sharing payments)	-7,776,999
Net Benefit Costs	170,127,752
Cost of Proposed SPA Changes – Benefit	
Administration Costs	
Personnel	378,174
General administration	140,681
Contractors/Brokers	405,583
Claims Processing	1,350,000
Outreach/marketing costs	1,924,319
Health Services Initiatives	651,825
Other	4,835,040
Total Administration Costs	9,685,825
10% Administrative Cap	18,903,084
Cost of Proposed SPA Changes	651,825
Federal Share	179,309,897
State Share	503,477
Total Costs of Approved CHIP Plan	179,813,374

**NOTE: Include the costs associated with the current SPA.
\$0**

STATE: IN	FFY Budget
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The Source of State Share Funds: The state portion of the expenditures will be generated from the State's tobacco settlement money. State general revenues will be used as a supplement, if needed.

Section 10. Annual Reports and Evaluations

Guidance: The National Academy for State Health Policy (NASHP), CMS and the states developed framework for the annual report that states have the option to use to complete the required evaluation report. The framework recognizes the diversity in State approaches to implementing CHIP and provides consistency across states in the structure, content, and format of the evaluation report. Use of the framework and submission of this information will allow comparisons to be made between states and on a nationwide basis. The framework for the annual report can be obtained from NASHP's website at <http://www.nashp.org>. Per the title XXI statute at Section 2108(a), states must submit reports by January 1st to be compliant with requirements.

10.1. Annual Reports. The State assures that it will assess the operation of the State plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2)) (42CFR 457.750)

10.1.1. The progress made in reducing the number of uninsured low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. The State assures it will comply with future reporting requirements as they are developed. (42CFR 457.710(e))

10.3. The State assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

10.3-DC The State agrees to submit yearly the approved dental benefit package and to submit quarterly current and accurate information on enrolled dental providers in the State to the Health Resources and Services Administration for posting on the Insure Kids Now! Website. Please update Sections 6.2-DC and 9.10 when electing this option.

Section 11. Program Integrity (Section 2101(a))

Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue to Section 12.

11.1. The State assures that services are provided in an effective and efficient manner through

free and open competition or through basing rates on other public and private rates that are actuarially sound. (Section 2101(a)) (42CFR 457.940(b))

11.2. The State assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a State under Title XIX: (Section 2107(e)) (42CFR 457.935(b)) (The items below were moved from section 9.8. Previously 9.8.6. - 9.8.9.)

- 11.2.1.** 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
- 11.2.2.** Section 1124 (relating to disclosure of ownership and related information)
- 11.2.3.** Section 1126 (relating to disclosure of information about certain convicted individuals)
- 11.2.4.** Section 1128A (relating to civil monetary penalties)
- 11.2.5.** Section 1128B (relating to criminal penalties for certain additional charges)
- 11.2.6.** Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and Enrollee Protections (Sections 2101(a))

Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State’s Medicaid plan.

12.1. Eligibility and Enrollment Matters- Describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120. Describe any special processes and procedures that are unique to the applicant’s rights when the State is using the Express Lane option when determining eligibility.

Guidance: “Health services matters” refers to grievances relating to the provision of health care.

12.2. Health Services Matters- Describe the review process for health services matters that complies with 42 CFR 457.1120.

12.3. Premium Assistance Programs- If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, describe how the State will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

Key for Newly Incorporated Templates

The newly incorporated templates are indicated with the following letters after the numerical section throughout the template.

- PC- Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
- PW- Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
- TC- Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
- DC- Dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- DS- Supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- PA- Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
- EL- Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
- LR- Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)

CMS Regional Offices

CMS Regional Offices	States		Associate Regional Administrator	Regional Office Address
Region 1- Boston	Connecticut Massachusetts Maine	New Hampshire Rhode Island Vermont	Richard R. McGreal richard.mcgreal@cms.hhs.gov	John F. Kennedy Federal Bldg. Room 2275 Boston, MA 02203-0003
Region 2- New York	New York Virgin Islands	New Jersey Puerto Rico	Michael Melendez michael.melendez@cms.hhs.gov	26 Federal Plaza Room 3811 New York, NY 10278-0063
Region 3- Philadelphia	Delaware District of Columbia Maryland	Pennsylvania Virginia West Virginia	Ted Gallagher ted.gallagher@cms.hhs.gov	The Public Ledger Building 150 South Independence Mall West Suite 216 Philadelphia, PA 19106
Region 4- Atlanta	Alabama Florida Georgia Kentucky	Mississippi North Carolina South Carolina Tennessee	Jackie Glaze jackie.glaze@cms.hhs.gov	Atlanta Federal Center 4 th Floor 61 Forsyth Street, S.W. Suite 4T20 Atlanta, GA 30303-8909
Region 5- Chicago	Illinois Indiana Michigan	Minnesota Ohio Wisconsin	Verlon Johnson verlon.johnson@cms.hhs.gov	233 North Michigan Avenue, Suite 600 Chicago, IL 60601
Region 6- Dallas	Arkansas Louisiana New Mexico	Oklahoma Texas	Bill Brooks bill.brooks@cms.hhs.gov	1301 Young Street, 8th Floor Dallas, TX 75202
Region 7- Kansas City	Iowa Kansas	Missouri Nebraska	James G. Scott james.scott1@cms.hhs.gov	Richard Bulling Federal Bldg. 601 East 12 Street, Room 235 Kansas City, MO 64106-2808
Region 8- Denver	Colorado Montana North Dakota Dakota	South Dakota Utah Wyoming	Richard Allen richard.allen@cms.hhs.gov	Federal Office Building, Room 522 1961 Stout Street Denver, CO 80294-3538
Region 9- San Francisco	Arizona California Hawaii Nevada	American Samoa Guam Northern Mariana Islands	Gloria Nagle gloria.nagle@cms.hhs.gov	90 Seventh Street Suite 5-300 San Francisco Federal Building San Francisco, CA 94103

Region 10- Seattle	Idaho Washington	Alaska Oregon	Carol Peverly carol.peverly@cms.hhs.gov	2001 Sixth Avenue MS RX-43 Seattle, WA 98121
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GLOSSARY

Adapted directly from Sec. 2110. DEFINITIONS.

CHILD HEALTH ASSISTANCE- For purposes of this title, the term ‘child health assistance’ means payment for part or all of the cost of health benefits coverage for targeted low-income children that includes any of the following (and includes, in the case described in Section 2105(a)(2)(A), payment for part or all of the cost of providing any of the following), as specified under the State plan:

1. Inpatient hospital services.
2. Outpatient hospital services.
3. Physician services.
4. Surgical services.
5. Clinic services (including health center services) and other ambulatory health care services.
6. Prescription drugs and biologicals and the administration of such drugs and biologicals, only if such drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.
7. Over-the-counter medications.
8. Laboratory and radiological services.
9. Prenatal care and prepregnancy family planning services and supplies.
10. Inpatient mental health services, other than services described in paragraph (18) but including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services.
11. Outpatient mental health services, other than services described in paragraph (19) but including services furnished in a State-operated mental hospital and including community-based services.
12. Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices).
13. Disposable medical supplies.
14. Home and community-based health care services and related supportive services (such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home).
15. Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services) in a home, school, or other setting.
16. Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.
17. Dental services.
18. Inpatient substance abuse treatment services and residential substance abuse treatment services.
19. Outpatient substance abuse treatment services.
20. Case management services.
21. Care coordination services.
22. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

23. Hospice care.
24. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is--
 - a. prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law,
 - b. performed under the general supervision or at the direction of a physician, or
 - c. furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.
25. Premiums for private health care insurance coverage.
26. Medical transportation.
27. Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.
28. Any other health care services or items specified by the Secretary and not excluded under this section.

TARGETED LOW-INCOME CHILD DEFINED- For purposes of this title--

1. **IN GENERAL-** Subject to paragraph (2), the term ‘targeted low-income child’ means a child--
 - a. who has been determined eligible by the State for child health assistance under the State plan;
 - b. (i) who is a low-income child, or
(ii) is a child whose family income (as determined under the State child health plan) exceeds the Medicaid applicable income level (as defined in paragraph (4)), but does not exceed 50 percentage points above the Medicaid applicable income level; and
 - c. who is not found to be eligible for medical assistance under title XIX or covered under a group health plan or under health insurance coverage (as such terms are defined in Section 2791 of the Public Health Service Act).
2. **CHILDREN EXCLUDED-** Such term does not include--
 - a. a child who is a resident of a public institution or a patient in an institution for mental diseases; or
 - b. a child who is a member of a family that is eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State.
3. **SPECIAL RULE-** A child shall not be considered to be described in paragraph (1)(C) notwithstanding that the child is covered under a health insurance coverage program that has been in operation since before July 1, 1997, and that is offered by a State which receives no Federal funds for the program's operation.
4. **MEDICAID APPLICABLE INCOME LEVEL-** The term ‘Medicaid applicable income level’ means, with respect to a child, the effective income level (expressed as a percent of the poverty line) that has been specified under the State plan under title XIX (including under a waiver authorized by the Secretary or under Section 1902(r)(2)), as of June 1, 1997, for the child to be eligible for medical

assistance under Section 1902(1)(2) for the age of such child.

5. **TARGETED LOW-INCOME PREGNANT WOMAN.**—The term ‘targeted low-income pregnant woman’ means an individual— (A) during pregnancy and through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends; (B) whose family income exceeds 185 percent (or, if higher, the percent applied under subsection (b)(1)(A)) of the poverty line applicable to a family of the size involved, but does not exceed the income eligibility level established under the State child health plan under this title for a targeted low-income child; and (C) who satisfies the requirements of paragraphs (1)(A), (1)(C), (2), and (3) of Section 2110(b) in the same manner as a child applying for child health assistance would have to satisfy such requirements.

ADDITIONAL DEFINITIONS- For purposes of this title:

1. **CHILD-** The term ‘child’ means an individual under 19 years of age.
2. **CREDITABLE HEALTH COVERAGE-** The term ‘creditable health coverage’ has the meaning given the term ‘creditable coverage’ under Section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)) and includes coverage that meets the requirements of section 2103 provided to a targeted low-income child under this title or under a waiver approved under section 2105(c)(2)(B) (relating to a direct service waiver).
3. **GROUP HEALTH PLAN; HEALTH INSURANCE COVERAGE; ETC-** The terms ‘group health plan’, ‘group health insurance coverage’, and ‘health insurance coverage’ have the meanings given such terms in Section 2191 of the Public Health Service Act.
4. **LOW-INCOME CHILD -** The term ‘low-income child’ means a child whose family income is at or below 200 percent of the poverty line for a family of the size involved.
5. **POVERTY LINE DEFINED-** The term ‘poverty line’ has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.
6. **PREEXISTING CONDITION EXCLUSION-** The term ‘preexisting condition exclusion’ has the meaning given such term in section 2701(b)(1)(A) of the Public Health Service Act (42 U.S.C. 300gg(b)(1)(A)).
7. **STATE CHILD HEALTH PLAN; PLAN-** Unless the context otherwise requires, the terms ‘State child health plan’ and ‘plan’ mean a State child health plan approved under Section 2106.
8. **UNINSURED CHILD-** The term ‘uninsured child’ means a child that does not have creditable health coverage.