Citation	Condition or Requirement

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of INDIANA enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii. - vii. below)

B. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)

1. The State will contract with an

_x_ i. MCO
____ ii. PCCM (including capitated PCCMs that qualify as PAHPs)
____ iii. Both

42 CFR 438.50(b)(2)
42 CFR 438.50(b)(3)

2. The payment method to the contracting entity will be:

____i. fee for service;
_x_ii. capitation;
____iii. a case management fee;
_x_iv. a bonus/incentive payment;
____ v. a supplemental payment, or
____vi. other. (Please provide a description below).

1905(t)
42 CFR 440.168
42 CFR 438.6(c)(5)(iii)(iv)

3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met.

Citation	Condition or Requirement

If applicable to this state plan, place a check mark to affirm the state has met ***all*** of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

____i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.

____ii. Incentives will be based upon specific activities and targets.

____iii. Incentives will be based upon a fixed period of time.

____iv. Incentives will not be renewed automatically.

____v. Incentives will be made available to both public and private PCCMs.

____vi. Incentives will not be conditioned on intergovernmental transfer agreements.

_x__vii. Not applicable to this 1932 state plan amendment.

CFR 438.50(b)(4)

4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)*

In early 1998, Indiana began outreach to Hoosiers seeking input on the new Children's Health Insurance Program (CHIP) option. Town halls were held throughout the state and the state seeking public input, advisory groups were formed to assist in the design of the program, and the state legislature passed necessary legislation to implement the new program. An extensive advertising campaign using television, radio and billboards was launched in 1998 to educate the public on the new program and encourage parents to enroll their children. The first phase CHIP, expanded the Hoosier Healthwise program to cover more uninsured Hoosier children by increasing the standard Medicaid eligibility for all children up to 150 percent of the federal poverty level.

Many legislative study committees and advisory groups have formed since the implementation of SCHIP in Indiana in 1998. These committees and groups provide a forum for the public and stakeholders to voice their opinions on the SCHIP.

Citation	Condition or Requirement

Presumptive Eligibility (PE) for pregnant women was legislatively mandated by the Indiana General Assembly during the 2007 legislative session. Public forums and presentations were held to gather feedback from providers and the public.

1932(a)(1)(A)

5. The state plan program will _x_ /will not ___ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory_____/ voluntary_____ enrollment will be implemented in the following county/area(s):

   i. county/counties (mandatory) _____

   ii. county/counties (voluntary)_____

   iii. area/areas (mandatory)_____

   iv. area/areas (voluntary)_____

C. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I)
1903(m)
42 CFR 438.50(c)(1)

1. __x_ The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.

1932(a)(1)(A)(i)(I)
1905(t)
42 CFR 438.50(c)(2)
1902(a)(23)(A)

2. ____The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.

1932(a)(1)(A)
42 CFR 438.50(c)(3)

3. __x_ The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.

1932(a)(1)(A
42 CFR 431.51
1905(a)(4)(C)

4. __x_ The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.

1932(a)(1)(A)

5. __x_ The state assures that all applicable managed care requirements of

Citation	Condition or Requirement
42 CFR 438 42 CFR 438.50(c)(4) 1903(m)	42 CFR Part 438 for MCOs and PCCMs will be met.
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	6. __x_ The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.
1932(a)(1)(A) 42 CFR 447.362 42 CFR 438.50(c)(6)	7. ____The state assures that all applicable requirements of 42 CFR 447.362 for payments under any nonrisk contracts will be met.
45 CFR 74.40	8. __x_ The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

D. Eligible groups

1932(a)(1)(A)(i)

1. List all eligible groups that will be enrolled on a mandatory basis.
Medicaid Expansion (MCHIP) – Children ages 1-19 up to 150% FPL
Presumptively Eligible Pregnant Women – Pregnant women up to 200% FPL

2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50.

Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.

1932(a)(2)(B)
42 CFR 438(d)(1)

i. ____Recipients who are also eligible for Medicare.

If enrollment is voluntary, describe the circumstances of enrollment. *(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)*

1932(a)(2)(C)
42 CFR 438(d)(2)

ii. ___Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with

Citation	Condition or Requirement
	the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.
1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)	iii. ____Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv. ____Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
1932(a)(2)(A)(v) 42 CFR 438.50(3)(iii)	v. ____Children under the age of 19 years who are in foster care or other out-of-the-home placement.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi. ____Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vii. ____Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.
	E. Identification of Mandatory Exempt Groups
1932(a)(2) 42 CFR 438.50(d)	1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. *(Examples: children receiving services at a specific clinic or enrolled in a particular program.)*
1932(a)(2) 42 CFR 438.50(d)	2. Place a check mark to affirm if the state's definition of title V children is determined by: ____i. program participation, ____ii. special health care needs, or ____iii. both
1932(a)(2) 42 CFR 438.50(d)	3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system. ____i. yes ____ii. no
1932(a)(2) 42 CFR 438.50 (d)	4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: *(Examples: eligibility database, self- identification)*

Citation	Condition or Requirement

i. Children under 19 years of age who are eligible for SSI under title XVI;

ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;

iii. Children under 19 years of age who are in foster care or other out-of-home placement;

iv. Children under 19 years of age who are receiving foster care or adoption assistance.

1932(a)(2)
42 CFR 438.50(d)

5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. *(Example: self-identification)*

1932(a)(2)
42 CFR 438.50(d)

6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: *(Examples: usage of aid codes in the eligibility system, self- identification)*

i. Recipients who are also eligible for Medicare.

The MMIS system contains information on which Medicaid recipients are also eligible for Medicare. Recipients with a Medicare filed in the MMIS system are automatically exempted from enrollment into managed care. The MMIS system checks Medicare eligibility status weekly for everyone in managed care and exempts recipients as new Medicare eligibility information is received.

ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

There are no federally recognized tribes in Indiana.

Citation	Condition or Requirement
42 CFR 438.50	F. List other eligible groups (not previously mentioned) who will be exempt from Mandatory enrollment Residing in a nursing facility or ICF/MR – Medicaid beneficiaries who reside in nursing facilities or intermediate care facilities for the mentally retarded Enrolled in another managed care program – Medicaid beneficiaries who are enrolled in another Medicaid managed care program Retroactive eligibility – Medicaid beneficiaries for the period of retroactive eligibility Members receiving services through a Home and Community Based Services Waiver Members residing in a State Operated Facility or Psychiatric Residential Treatment Facility
42 CFR 438.50	G. List all other eligible groups who will be permitted to enroll on a voluntary basis None.
	H. Enrollment process.
1932(a)(4) 42 CFR 438.50	1. Definitions i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient. ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.
1932(a)(4) 42 CFR 438.50	2. State process for enrollment by default. Describe how the state's default enrollment process will preserve: i. the existing provider-recipient relationship (as defined in H.1.i).

Citation	Condition or Requirement

MCHIP October 1, 2010-December 31, 2010: The first step of the default enrollment process is to search if the member was previously enrolled with a provider with the member's previous MCO or with a provider contracted with a different MCO. If so, the member will be enrolled with an MCO the provider is contracted with.

MCHIP January 1, 2011 and beyond: Default enrollment will be based on the member's prior relationship with an MCO. If a member does not select an MCO, the member will be assigned to an MCO based upon a previous relationship with an MCO in the past 12 months. If the member was not previously assigned to an MCO, the member will be assigned to an MCO based upon equitable distribution among the MCOs.

All three MCOs will assign a member to the member's current PMP if the member did not select a PMP.

Presumptively Eligible Pregnant Women October 1, 2010-December 31, 2010: A PE woman must select a primary medical provider while completing the PE process in the qualified provider's office. There is no default enrollment process.

Presumptively Eligible Pregnant Women January 1, 2011 and beyond: A PE woman must select a managed care entity while completing the PE process in the qualified provider's office. There is no default enrollment process.

ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).

MCHIP October 1, 2010-December 31, 2010: If a previous provider relationship or MCO relationship is not found, the default enrollment process will search for a family member's provider.

MCHIP January 1, 2011 and beyond: If a previous provider relationship is not found, all three MCOs will search for a family member's provider.

Presumptively Eligible Pregnant Women October 1, 2010-December 31, 2010: A PE woman must select a primary medical provider while completing the PE process in the qualified provider's office. There is no default enrollment process.

Citation	Condition or Requirement

Presumptively Eligible Pregnant Women January 1, 2011 and beyond: A PE woman must select a managed care entity while completing the PE process in the qualified provider's office. There is no default enrollment process.

iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)*

MCHIP October 1, 2010-December 31, 2010: If a previous provider relationship, MCO relationship or family member provider is not found, the default enrollment process will enroll the member with the MCO that has the fewest members.

MCHIP January 1, 2011 and beyond: If a member does not select an MCO, the State will assign the member to the MCO on a rotating basis.

Presumptively Eligible Pregnant Women October 1, 2010-December 31, 2010: A PE woman must select a primary medical provider while completing the PE process in the qualified provider's office. There is no default enrollment process.

Presumptively Eligible Pregnant Women January 1, 2011 and beyond: A PE woman must select a managed care entity while completing the PE process in the qualified provider's office. There is no default enrollment process.

1932(a)(4)
42 CFR 438.50

3. As part of the state's discussion on the default enrollment process, include the following information:

i. The state will__x__/ use a lock-in for MCHIP and will not use a lock-in for PE.

ii. The time frame for recipients to choose a health plan before being auto-assigned will be:

MCHIP October 1, 2010-December 31, 2010: 30 days.

Citation	Condition or Requirement

MCHIP January 1, 2011 and beyond: 14 days.

Presumptively Eligible Pregnant Women October 1, 2010-December 31, 2010: A PE woman must select a primary medical provider while completing the PE process in the qualified provider's office. There is no default enrollment process.

Presumptively Eligible Pregnant Women January 1, 2011 and beyond: A PE woman must select a managed care entity while completing the PE process in the qualified provider's office. There is no default enrollment process.

iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)*

MCHIP: Once a member is eligible for Medicaid, the member receives information from multiple sources. The Division of Family Resources (the State agency that determines Medicaid eligibility) provides initial information on Medicaid. Additionally, the member received mailed information from the State's enrollment broker. This information includes a basic overview of the Hoosier Healthwise program, the hotline toll-free number, and a comparison of the MCOs. The letter also informs the member that the member needs to contact the MCO or the member will be auto-assigned. If the member has not selected their MCO and PMP, the member receives a state generated letter to notify the member of their auto assignment.

Presumptively Eligible Pregnant Women October 1, 2010-December 31, 2010: A PE woman must select a primary medical provider while completing the PE process in the qualified provider's office. Thus, there is no auto-assignment.

Presumptively Eligible Pregnant Women January 1, 2011 and beyond: A PE woman must select a managed care entity while completing the PE process in the qualified provider's office. Thus, there is no auto-assignment.

iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*

Citation	Condition or Requirement

MCHIP: Members are notified of their auto-assignment via a letter. Information in the letter offers toll-free phone numbers should the member need to make a change. The open enrollment process is also outlined in the member enrollment packet and member handbook.

Presumptively Eligible Pregnant Women October 1, 2010-December 31, 2010: A PE woman must select a primary medical provider while completing the PE process in the qualified provider's office. Thus, there is no auto-assignment.

Presumptively Eligible Pregnant Women January 1, 2011 and beyond: A PE woman must select a managed care entity while completing the PE process in the qualified provider's office. Thus, there is no auto-assignment.

v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)*

MCHIP October 1, 2010-December 31, 2010: If the member does not select a primary medical provider, the State will assign the member a primary medical provider. The assignment algorithm first searches for a previous primary medical provider in the member's previous MCO. If no provider is found, the algorithm then searches for a previous primary medical provider in the other MCOs and then for a relationship with a previous MCO. If a match is not found, the algorithm then searches for a previous group primary medical provider. If no match is made, the member is assigned to an MCO on a rotating basis.

MCHIP January 1, 2011 and beyond: If the member does not select an MCO, the algorithm will check whether the member was assigned to an active MCO within the past 12 months. If no previous MCO assignment is found, the algorithm will check for other active relatives who are in the same case and program; or in another program and a different case. If no match is found, the algorithm will assign members to an MCO on a rotating basis.

There is not auto assignment process for PE women.

Citation	Condition or Requirement

vi. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)*

Auto-assignment rates will be reported to the State from the fiscal agent.

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

1. _x_ The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

2. _x_ The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

3. ____ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

   _x_ This provision is not applicable to this 1932 State Plan Amendment.

4. ____ The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)

   _x_ This provision is not applicable to this 1932 State Plan Amendment.

5. _x_ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

   ___ This provision is not applicable to this 1932 State Plan Amendment.

Citation	Condition or Requirement

1932(a)(4)
42 CFR 438.50

J. Disenrollment

1. The state will _x_ /will not _x_ use lock-in for managed care.

   The state will use lock-in for managed care for MCHIP. The state will not use lock-in for PE women.

2. The lock-in will apply for _9_ months (up to 12 months).

3. Place a check mark to affirm state compliance.

   _x_ The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

4. Describe any additional circumstances of "cause" for disenrollment (if any).

   Lack of access to medically necessary services covered under the MCO's contract with the state.

   The MCO does not, for moral or religious objections, cover the service the enrollee seeks.

   The enrollee needs related services to be performed at the same time; not all related services are available within the MCO's network; and the enrollee's primary care provider or another provider determines that receiving services separately would subject the enrollee to unnecessary risk.

   Lack of access to providers experienced in dealing with the enrollee's health care needs.

   Poor quality of care includes failure to comply with established standards of medical care administration and significant language or cultural barriers.

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)
42 CFR 438.50
42 CFR 438.10

_x_ The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)

Citation	Condition or Requirement

1932(a)(5)(D)
1905(t)

L. List all services that are excluded for each model (MCO & PCCM)

Medicaid Rehabilitation Option (MRO) services
Psychiatric Residential Treatment Facility (PRTF) services
Dental services
Individualized Family Services Plan (IFSP)
Pharmacy
Individualized Education Plan (IEP)
Long-Term Institutional Care
Hospice
Home and Community Based Services (HCBS) Waiver
Psychiatric Treatment in a State Hospital

1932 (a)(1)(A)(ii)

M. Selective contracting under a 1932 state plan option

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state will_____/will not__x__ intentionally limit the number of entities it contracts under a 1932 state plan option.

2. __x__ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*

4. __x__ The selective contracting provision in not applicable to this state plan.

CMS-10120 (exp. 01/31/2008)
1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

Citation	Condition or Requirement

The State of INDIANA enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii. - vii. below)

C. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)

1. The State will contract with an

____ i. MCO
__x__ ii. PCCM (including capitated PCCMs that qualify as PAHPs)
____ iii. Both

42 CFR 438.50(b)(2)
42 CFR 438.50(b)(3)

2. The payment method to the contracting entity will be:

____ i. fee for service;
____ ii. capitation;
__x__ iii. a case management fee;
__x__ iv. a bonus/incentive payment;
____ v. a supplemental payment, or
____ vi. other. (Please provide a description below).

A fee is paid to both the primary medical provider and disease management contractor for provision of case/disease management. During the 1st year of the contract (October 1, 2010 – September 30, 2011), no incentive payments will be available.

1905(t)
42 CFR 440.168

3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's

Citation	Condition or Requirement
42 CFR 438.6(c)(5)(iii)(iv)	case management fee, if certain conditions are met. If applicable to this state plan, place a check mark to affirm the state has met ***all*** of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)). _x_ i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered. _x_ ii. Incentives will be based upon specific activities and targets. _x_ iii. Incentives will be based upon a fixed period of time. _x_ iv. Incentives will not be renewed automatically. _x_ v. Incentives will be made available to both public and private PCCMs. _x_ vi. Incentives will not be conditioned on intergovernmental transfer agreements. ____ vii. Not applicable to this 1932 state plan amendment.
CFR 438.50(b)(4)	4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)* Care Select, an enhanced primary care case management (PCCM) program replacing Medicaid Select was phased in beginning October 1, 2007. Indiana Care Select Program is a care management program that provides comprehensive case management, care coordination and disease management services while ensuring that its members receive the appropriate care, at the appropriate time, in the appropriate setting. Beginning in 2006, the Office of Medicaid Policy and Planning (OMPP) began statewide public forums called community meetings. State staff first held a series of meetings in Central Indiana to gain public input. Prior to implementing the program, the OMPP held additional community meetings in each region of the state to provide detailed information on the new program.

Citation	Condition or Requirement

The State began the Care Select Advisory Group in 2006, which includes stakeholders from various state associations and advocacy groups. This group meets every other month. Additionally, many legislative study committees and Medicaid advisory groups exist and provide a forum for the public and stakeholders to voice their opinions on the Care Select and Traditional Medicaid programs.

In late summer of 2010, the State presented information on transitioning Care Select to a 1932 state plan amendment. Presentations were given during late summer and early fall to the state legislature and advisory groups. The Care Select Advisory Group, legislative study committees and other advisory groups continue to provide a forum for public comment on the Care Select and Traditional Medicaid programs.

1932(a)(1)(A)

5. The state plan program will_x__/will not___ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory_____/ voluntary_____ enrollment will be implemented in the following county/area(s):

Note from State: This program is being transitioned from a 1915(b) waiver effective October 1, 2010. Current (prior to October 1, 2010) and new enrollees will be automatically enrolled in the new program if disease management criteria are met. However, continued participation is voluntary and all members are allowed to opt out from the program at any time, including those that are automatically enrolled for transition (October 1, 2010). Members who meet the disease management criteria and are also eligible for Medicare or are also receiving services through an HCBS waiver will not be eligible for the Care Select Program.

ii. county/counties (mandatory) _____

v. county/counties (voluntary)_____

vi. area/areas (mandatory)_____

vii. area/areas (voluntary)_____

D. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

Citation		Condition or Requirement
1932(a)(1)(A)(i)(I) 1903(m) 42 CFR 438.50(c)(1)	1.	____The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.
1932(a)(1)(A)(i)(I) 1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)	2.	_x_The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.
1932(a)(1)(A) 42 CFR 438.50(c)(3)	3.	____The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.
1932(a)(1)(A 42 CFR 431.51 1905(a)(4)(C)	4.	__x__The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A) 42 CFR 438 42 CFR 438.50(c)(4) 1903(m)	5.	__x__The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	6.	____The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.
1932(a)(1)(A) for 42 CFR 447.362 42 CFR 438.50(c)(6)	7.	__x__The state assures that all applicable requirements of 42 CFR 447.362 payments under any nonrisk contracts will be met.
45 CFR 74.40	8.	__x__The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.
	E.	Eligible groups
1932(a)(1)(A)(i)	1.	List all eligible groups that will be enrolled on a voluntary basis.

Citation	Condition or Requirement

Aged, blind, disabled, foster children and wards of the State, and children receiving adoption assistance will be automatically enrolled in the Care Select Program if there is evidence (in claims) of one of the following conditions:

- Asthma
- Diabetes
- Chronic Heart Failure, Coronary Heart Disease, Hypertensive Heart Disease
- Chronic Kidney Disease
- Serious Mental Illness
- Severe Emotional Disturbance
- Depression

Individuals who are automatically enrolled may opt out by calling the enrollment broker and expressing that they are not interested in participating in the Care Select Program. Individuals that are in one of the above groups, but receiving coverage through Medicare or a Home and Community Based Services waiver will be excluded from automatic enrollment into the Care Select Program.

2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50.

Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.

1932(a)(2)(B)
42 CFR 438(d)(1)

i. ____Recipients who are also eligible for Medicare.

If enrollment is voluntary, describe the circumstances of enrollment. *(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)*

1932(a)(2)(C)
42 CFR 438(d)(2)

ii. ____Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

1932(a)(2)(A)(i)
42 CFR 438.50(d)(3)(i)

iii. ____Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.

Citation	Condition or Requirement
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv. _x_ Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
1932(a)(2)(A)(v) of- 42 CFR 438.50(3)(iii)	v. _x_ Children under the age of 19 years who are in foster care or other out- the-home placement.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi. _x_ Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vii. ____ Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.

E. Identification of Mandatory Exempt Groups

1932(a)(2)
42 CFR 438.50(d)

1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. *(Examples: children receiving services at a specific clinic or enrolled in a particular program.)*

1932(a)(2)
42 CFR 438.50(d)

2. Place a check mark to affirm if the state's definition of title V children is determined by:

____i. program participation,
____ii. special health care needs, or
____iii. both

1932(a)(2)
42 CFR 438.50(d)

3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system.

____i. yes
____ii. no

1932(a)(2)
42 CFR 438.50 (d)

4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: *(Examples: eligibility database, self- identification)*

Care Select is a voluntary program. All individuals automatically enrolled may opt out of the program at any time.

Citation	Condition or Requirement

v. Children under 19 years of age who are eligible for SSI under title XVI;

vi. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;

vii. Children under 19 years of age who are in foster care or other out-of-home placement;

viii. Children under 19 years of age who are receiving foster care or adoption assistance.

1932(a)(2)
42 CFR 438.50(d)

5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. *(Example: self-identification)*

Care Select is a voluntary program. All individuals automatically enrolled may opt out of the program at any time.

1932(a)(2)
42 CFR 438.50(d)

6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: *(Examples: usage of aid codes in the eligibility system, self- identification)*

iii. Recipients who are also eligible for Medicare.

Recipients who are also eligible for Medicare are identified through the usage of aid codes in the State's MMIS system.

iv. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

There are no Federally recognized Tribes within the state of Indiana.

42 CFR 438.50

F. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment

Care Select is a voluntary program, no groups are mandatorily enrolled.

Citation	Condition or Requirement
42 CFR 438.50	G. List all other eligible groups who will be permitted to enroll on a voluntary basis None.
	I. Enrollment process.
1932(a)(4) 42 CFR 438.50	1. Definitions iii. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient. iv. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.
1932(a)(4) 42 CFR 438.50	2. State process for enrollment by default. Describe how the state's default enrollment process will preserve: iv. the existing provider-recipient relationship (as defined in H.1.i). A Care Select member, who had previously been assigned to a PMP that is currently enrolled in the program, is reassigned to that PMP if the appropriate scope of practice and restrictions apply. Members not enrolled in the Care Select program may choose to see any Indiana Medicaid provider. v. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii). If there is not a previous PMP relationship, the auto-assignment logic looks for a previous relationship with a CMO. The system then attempts to assign the member to an appropriate PMP in the CMO by geographical order at each hierarchical level for look back period of 365 days. Members not enrolled in the Care Select program may choose to see any Indiana Medicaid provider.

Citation	Condition or Requirement

vi. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)*

In the event previous PMP and CMO auto-assignment logic attempts fail to make an appropriate PMP assignment, the default level of the auto-assignment logic looks for the neediest CMO and compares the member's geographical coordinates to PMPs in the neediest CMO in order of proximity.

Members not enrolled in the Care Select program are not enrolled with a PCCM, and may choose to see any Indiana Medicaid provider.

1932(a)(4)
42 CFR 438.50

3. As part of the state's discussion on the default enrollment process, include the following information:

vii. The state will____/will not_x_ use a lock-in for managed care.

viii. The time frame for recipients to choose a health plan before being auto-assigned will be 60 days.

ix. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)*

The State's MMIS system will notify members of their selections or when a member is auto-assigned via a mailing.

x. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*

Care Select Program participants may opt-out (disenroll) from the program at any time.

xi. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)*

Citation	Condition or Requirement

If the member does not select a PMP, the auto-assignment logic will search for a previous PMP the member's previous CMO. If the member does not have a previous PMP with a previous CMO, the auto-assignment logic will search for a previous PMP with a different CMO. If a match is not found, the auto-assignment logic then looks for a previous relationship with a CMO. If there is not a previous CMO relationship, the auto-assignment logic searches for a family member's PMP. If a match is still not made, the auto-assignment logic will then assign the member to the neediest CMO and compares the member's geographical coordinates to PMPs in the neediest CMO in order of proximity.

xii. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)*

Auto-assignment rates will be reported to the State from the fiscal agent.

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

1. _x_ The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

6. _x_ The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

7. ____ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

_x_ This provision is not applicable to this 1932 State Plan Amendment.

8. ____ The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of

Citation	Condition or Requirement

the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)

_x_ This provision is not applicable to this 1932 State Plan Amendment.

9. __x__ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

__This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4)
42 CFR 438.50

J. Disenrollment

5. The state will___/will not_x__ use lock-in for managed care.

6. The lock-in will apply for ____ months (up to 12 months).

7. Place a check mark to affirm state compliance.

_x___The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

8. Describe any additional circumstances of "cause" for disenrollment (if any).

No lock-in applies to the Care Select (PCCM) program.

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)
42 CFR 438.50
42 CFR 438.10

__x__The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)

1932(a)(5)(D)
1905(t)

L. List all services that are excluded for each model (MCO & PCCM)

Medicaid Rehabilitation Option (MRO) services
Psychiatric Residential Treatment Facility (PRTF) services
Dental services
Individualized Family Services Plan (IFSP)

Citation	Condition or Requirement

Pharmacy
Individualized Education Plan (IEP)
Long-Term Institutional Care
Hospice
Home and Community Based Services (HCBS) Waiver
Psychiatric Treatment in a State Hospital

1932 (a)(1)(A)(ii) M. Selective contracting under a 1932 state plan option

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

5. The state will_____/will not__x____ intentionally limit the number of entities it contracts under a 1932 state plan option.

6. _____ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

7. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*

8. __x__ The selective contracting provision in not applicable to this state plan.