Table of Contents

State/Territory Name: IN

State Plan Amendment (SPA) #: 15-0008

This file contains the following documents in the order listed:

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

May 5, 2015

Mr. Joseph Moser, Director of Medicaid
Office of Medicaid Policy and Planning
Indiana Family & Social Services Administration
402 West Washington Street, Room W461
Indianapolis, Indiana 46204-2739

ATTN: Amber Swartzell
RE: TN #15-0008

Dear Mr. Moser:

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

Transmittal #15-0008

- Addition of pregnant women eligible under 42 CFR 435.116, children eligible under 42 CFR 435.117 and 42 CFR 435.118, and presumptively eligible pregnant women to the State Plan 1932(a) managed care authority
- Effective Date: February 1, 2015

If you have any questions, please have a member of your staff contact Elizabeth Lewis at (312) 353-1756 or by email at Elizabeth.Lewis@cms.hhs.gov.

Sincerely,

/s/

Ruth A. Hughes
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 15-008

2. STATE: Indiana

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

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
February 1, 2015

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 435.116, 42 CFR 435.117, 42 CFR 435.118

7. FEDERAL BUDGET IMPACT:
a. FFY 2015 0
b. FFY 2016 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1-F, pages 1-14

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-F, pages 1-14

10. SUBJECT OF AMENDMENT:

This amendment aligns the populations authorized through the State Plan versus 1115 waiver to include: pregnant women eligible under 42 CFR 435.116, children eligible under 42 CFR 435.117 and 42 CFR 435.118, and presumptively eligible pregnant women.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME: Joseph Moser

14. TITLE: Medicaid Director

15. DATE SUBMITTED: 2/26/15

16. RETURN TO:
Joseph Moser
Medicaid Director
Indiana Office of Medicaid Policy and Planning
402 West Washington Street, Room W382
Indianapolis, IN 46204
ATTN: Amber Swartzell, State Plan Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 2/26/15

18. DATE APPROVED: 5/5/15

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 2/1/15

20. SIGNATURE OF REGIONAL OFFICIAL: /s/

21. TYPED NAME: Ruth A. Hughes

22. TITLE: Associate Regional Administrator

23. REMARKS:

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 described in 42 CFR 438.50(d).

Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 438 et seq., the state shall place check mark to affirm such compliance.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)-(2)

B. Managed Care Delivery System.

The State will contract with the entity(ies) below and reimburse them as noted under each entity type.

1. X MCO
   a. X Capitation

2. ☐PCCM (individual practitioners)
   a. ☐ Case management fee
   b. ☐ Bonus/incentive payments
   c. ☐ Other (please explain below)

3. ☐PCCM (entity based)
   a. ☐ Case management fee
   b. ☐ Bonus/incentive payments
   c. ☐ Other (please explain below)

Citation	Condition or Requirement

For states that elect to pay a PCCM a bonus/incentive payment as indicated in B.2.b. or B.3.b, place a check mark to affirm the state has met ***all*** of the following conditions (which are representative of the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

☐a. 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.

☐b. Incentives will be based upon a fixed period of time.

☐c. Incentives will not be renewed automatically.

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

☐e. Incentives will not be conditioned on intergovernmental transfer agreements.

☐f. Incentives will be based upon specific activities and targets.

CFR 438.50(b)(4) C. Public Process.

Describe the public process including tribal consultation, if applicable, 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 to seek 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.

Many legislative study committee and advisory groups have formed since the implementation of CHIP in Indiana in 1998. These committee and groups provide a

Citation	Condition or Requirement

forum for the public and stakeholders to voice their opinions on CHIP and Hoosier Healthwise.

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.

The Healthy Indiana Plan (HIP) is implemented through a Section 1115 Demonstration Waiver. The State undertook a comprehensive public input process in accordance with the 1115 waiver transparency and public notice requirements.

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.

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 Beneficiaries 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 it appropriately identifies individuals in the mandatory exempt groups identified in 1932(a)(1)(A)(i).
1932(a)(1)(A) 42 CFR 438	6. **X** The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.

Citation		Condition or Requirement
1903(m)		
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	7.	**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) CFR 447.362 42 CFR 438.50(c)(6)	8.	☐The state assures that all applicable requirements of 42 CFR 447.362 for 42 payments under any non-risk contracts will be met.
45 CFR 92.36	9.	**X** The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

Citation | Condition or Requirement

1932(a)(1)(A)
1932(a)(2)

E. Populations and Geographic Area

1. **Included Populations.** Please check which eligibility populations are included, if they are enrolled on a mandatory (M) or voluntary (V) basis, and the geographic scope of enrollment. Under the geography column, please indicate whether the nature of the population's enrollment is on a statewide basis, or if on less than a statewide basis, please list the applicable counties/regions.

Hoosier Healthwise

Population	**M**	**Geographic Area**	V	**Geographic Area**	**Excluded**
Section 1931 Children & Related Populations – 1905(a)(i)	**X**	**Statewide**			**X**
Section 1931 Adults & Related Populations1905(a)(ii)					**X**
Low-Income Adult Group					**X**
Former Foster Care Children under age 21					**X**
Former Foster Care Children age 21-25					**X**
Section 1925 Transitional Medicaid age 21 and older					**X**
SSI and SSI related Blind Adults, age 18 or older* - 1905(a)(iv)					**X**
Poverty Level Pregnant Women – 1905(a)(viii)	**X**	**Statewide**			
SSI and SSI related Blind Children, generally under age 18 – 1905(a)(iv)					**X**
SSI and SSI related Disabled children under age 18					**X**
SSI and SSI related Disabled adults age 18 and older – 1905(a)(v)					**X**
SSI and SSI Related Aged Populations age 65 or older- 1905(a)(iii)					**X**

Citation Condition or Requirement

Population	M	Geographic Area	V	Geographic Area	Excluded
SSI Related Groups Exempt from Mandatory Managed Care under 1932(a)(2)(B)					**X**
Recipients Eligible for Medicare					**X**
American Indian/Alaskan Natives			**X**	**Statewide**	
Children under 19 who are eligible for SSI					**X**
Children under 19 who are eligible under Section 1902(e)(3)					**X**
Children under 19 in foster care or other in-home placement					**X**
Children under 19 receiving services funded under section 501(a)(1)(D) of title V and in accordance with 42 CFR 438.50(d)(v)					**X**
Other	**X**	**PE Pregnant Women (Statewide)**			Reasonable Classifications of Children

Healthy Indiana Plan

Population	M	Geographic Area	V	Geographic Area	Excluded
Section 1931 Children & Related Populations – 1905(a)(i)					**X**
Section 1931 Adults & Related Populations1905(a)(ii)	**X**	**Statewide**			
Low-Income Adult Group	**X**	**Statewide**			
Former Foster Care Children under age 21					**X**
Former Foster Care Children age 21-25					**X**
Section 1925 Transitional Medicaid age 21 and older	**X**	**Statewide**			

Citation Condition or Requirement

Population	M	Geographic Area	V	Geographic Area	Excluded
SSI and SSI related Blind Adults, age 18 or older* - 1905(a)(iv)					**X**
Poverty Level Pregnant Women – 1905(a)(viii)					**X**
SSI and SSI related Blind Children, generally under age 18 – 1905(a)(iv)					**X**
SSI and SSI related Disabled children under age 18					**X**
SSI and SSI related Disabled adults age 18 and older – 1905(a)(v)					**X**
SSI and SSI Related Aged Populations age 65 or older- 1905(a)(iii)					**X**
SSI Related Groups Exempt from Mandatory Managed Care under 1932(a)(2)(B)					**X**
Recipients Eligible for Medicare					**X**
American Indian/Alaskan Natives			**X**	**Statewide**	
Children under 19 who are eligible for SSI					**X**
Children under 19 who are eligible under Section 1902(e)(3)					**X**
Children under 19 in foster care or other in-home placement					**X**
Children under 19 receiving services funded under section 501(a)(1)(D) of title V and in accordance with 42 CFR 438.50(d)(v)					**X**
Other					

Citation | Condition or Requirement

2. **Excluded Groups.** Within the populations identified above as Mandatory or Voluntary, there may be certain groups of individuals who are excluded from the managed care program. Please indicate if any of the following groups are excluded from participating in the program:

☐ Other Insurance--Medicaid beneficiaries who have other health insurance.

X Reside in Nursing Facility or ICF/MR--Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

X Enrolled in Another Managed Care Program--Medicaid beneficiaries who are enrolled in another Medicaid managed care program

☐ Eligibility Less Than 3 Months--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

X Participate in HCBS Waiver--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).

X Retroactive Eligibility–Medicaid beneficiaries for the period of retroactive eligibility.

X Other (Please define): Residing in a State Operated Facility or Psychiatric Residential Facility (Hoosier Healthwise).

1932(a)(4) F. Enrollment Process.

1. Definitions.

   a. Auto Assignment- assignment of a beneficiary to a health plan when the beneficiary has not had an opportunity to select their health plan.

   b. Default Assignment- assignment of a beneficiary to a health plan when the beneficiary has had an opportunity to select their health plan.

2. Please describe how the state effectuates the enrollment process. Select an enrollment methodology from the following options and describe the elements listed beneath it:

   a. **X** The applicant is permitted to select a health plan at the time of application.

Citation | Condition or Requirement

i. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).

ii. What action the state takes if the applicant does not indicate a plan selection on the application.

iii. If action includes making a default assignment, describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).

iv. The state's process for notifying the beneficiary of the default assignment. (Example: *state generated correspondence*.)

Applicants have access to Enrollment Broker choice counseling. If an MCO is not selected on the application, default assignment to an MCO is based on the member's prior relationship with an MCO, or a family member's previous or current MCO assignment. If there is no prior relationship or family member assignment, the member is assigned based on rotating assignment. The MCO assigns a PMP based on past relationship if the member does not self-select one. PE for pregnant women in the Hoosier Healthwise program has no default enrollment. MCO generated correspondence provides notice of auto-assignment.

b. ☐ The beneficiary has an active choice period following the eligibility determination.

i. How the beneficiary is notified of their initial choice period, including its duration.

ii. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).

iii. Describe the algorithm used for default assignment and describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).

iv. The state's process for notifying the beneficiary of the default assignment.

c. ☐ The beneficiary is auto-assigned to a health plan immediately upon being determined eligible.

Citation	Condition or Requirement

i. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).

ii. The state's process for notifying the beneficiary of the auto-assignment. (*Example: state generated correspondence*.)

iii. Describe the algorithm used for auto-assignment and describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).

1932(a)(4)
42 CFR 438.50

3. 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.

a. **X** The state assures it has an enrollment system that allows Beneficiaries 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.

b. **X** The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid Beneficiaries 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).

c. ☐ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs in accordance with 42 CFR 438.52(b). Please list the impacted rural counties:

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

d. **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 438.56

G. Disenrollment.

1. The state will **X**/will not **X** limit disenrollment for managed care.

Citation | Condition or Requirement

NOTE: The policies described in Section G apply to Hoosier Healthwise. HIP disenrollment policies are governed by the HIP 1115 Demonstration Waiver.

The State does not use disenrollment limitations for presumptively eligible pregnant women. Lock-in applies to the remainder of the enrolled populations.

2. The disenrollment limitation will apply for **9** months (up to 12 months).

3. **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 the state's process for notifying the Medicaid Beneficiaries of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*

   MCO Enrollment Packets

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

   The following are the just cause reasons for disenrollment from Hoosier Healthwise:
   - Receiving poor quality of care;
   - Failure of the MCO to provide covered services;
   - Failure of the MCO to comply with established standards of medical care administration;
   - Significant language or cultural barriers;
   - Corrective action levied against the MCO by FSSA;
   - Limited access to a primary care clinic or other health services within reasonable proximity to a member's residence;
   - A determination that another MCO's formulary is more consistent with a new member's existing health care needs;
   - Lack of access to medically necessary services covered under MCO's contract with the State;
   - A service is not covered by the MCO for moral or religious objections;
   - Related services are required to be performed at the same time and not all related services are available within the MCO's network, and the member's provider determines that receiving the services separately will subject the member to unnecessary risk;

Citation	Condition or Requirement

- Lack of access to providers experienced in dealing with the member's healthcare needs;
- The member's primary healthcare provider disenrolls from the member's current MCO and re-enrolls with another Hoosier Healthwise MCO; or
- Other circumstances determined by FSSA or its designee to constitute poor quality of health care coverage.

H. Information Requirements for Beneficiaries

1932(a)(5)(c)
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(e) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments.

1932(a)(5)(D)(b)
1903(m)
1905(t)(3)

I. List all benefits for which the MCO is responsible.

Hoosier Healthwise: All State Plan except MRO, 1915(i), dental, Individualized Family Services Plan, Pharmacy, Individualized Education Plan. Disenrolled for: Long-Term Institutional, Hospice, HCBS waiver, psychiatric treatment in State hospital, PRTF.

HIP: Benefits are defined in the HIP 1115 Demonstration Waiver.

1932(a)(5)(D)(b)(4)
42 CFR 438.228

J. **X** The state assures that each managed care organization has established an internal grievance procedure for enrollees.

1932(a)(5)(D)(b)(5)
42 CFR 438.206
42 CFR 438.207

K. Describe how the state has assured adequate capacity and services.

The MCO contracts delineate a series of requirements related to network adequacy. For example, the MCOs must demonstrate compliance with: (i) primary medical provider availability within 30 miles of the member's residence; (ii) behavioral health providers within 30 miles (urban) or 45 miles (rural); and (iii) specialty providers within 60 or 90 miles (distance standard varies by provider type). The State monitors for compliance through geo-access reporting.

1932(a)(5)(D)(c)(1)(A)
42 CFR 438.240

L. **X** The state assures that a quality assessment and improvement strategy has been developed and implemented.

1932(a)(5)(D)(c)(2)(A)
42 CFR 438.350

M. **X** The state assures that an external independent review conducted by a qualified independent entity will be performed yearly.

Citation	Condition or Requirement

1932 (a)(1)(A)(ii) N. 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.

Citation	Condition or Requirement

RESERVED FOR FUTURE USE

CMS-10120 (exp. 01/31/2008)
1932(a)(J)(A) A. Section 1932(a)(l)(A) of the Social Security Act.