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**State/Territory Name:** Indiana

**State Plan Amendment (SPA) #:** IN-20-0002-CHIP

This file contains the following documents in the order listed:

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**

August 2, 2023

Allison Taylor
Director of Medicaid
Indiana Family and Social Services Administration
402 West Washington Street, Room W4611, MS-25
Indianapolis, IN 46204

Dear Allison Taylor:

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendment (SPA) IN-20-0002, submitted on June 30, 2020, with additional information received on June 26, 2023, has been approved. Through this SPA, Indiana has demonstrated compliance with section 5022 of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act, which requires child health and pregnancy related assistance to include coverage of services necessary to prevent, diagnose, and treat a broad range of behavioral health symptoms and disorders. This SPA has an effective date of October 24, 2019.

As part of this SPA, in order to comply with Section 2103(c)(5) of the Act, effective July 1, 2021, Indiana also removed the utilization limit on Tobacco Cessation Counseling. Additionally, Section 2103(c)(5)(B) of the Act requires that these behavioral health services be delivered in a culturally and linguistically appropriate manner. Indiana demonstrated compliance by providing the necessary assurances and benefit descriptions that the state covers a range of behavioral health services in a culturally and linguistically appropriate manner.

Your Project Officer is Chanelle Parkar. She is available to answer your questions concerning this amendment and other CHIP-related matters. Her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850
Telephone: (667) 290-8798
E-mail: chanelle.parkar@cms.hhs.gov

If you have additional questions, please contact Meg Barry, Division Director, Division of State Coverage Programs, at (410) 786-1536. We look forward to continuing to work with you and your staff.

Sincerely,
/Signed by Sarah deLone/

Sarah DeLone
Deputy Director

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**

August 15, 2023

Allison Taylor, Director of Medicaid
Indiana Family and Social Services Administration
402 West Washington Street, Room W4611, MS-25
Indianapolis, IN 46204

Dear Allison Taylor:

A technical correction has been made related to your title XXI Children's Health Insurance Program (CHIP) State plan amendment (SPA), IN-20-0000-0002, approved on August 2, 2023. The SPA approval also includes the exclusion of copayments and premiums for pregnant individuals during their pregnancy and 12 months of continuous postpartum coverage, effective April 1, 2022.

Your Project Officer is Chanelle Parkar. She is available to answer your questions concerning this amendment and other CHIP-related matters. Her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850
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If you have additional questions, please contact Meg Barry, Division Director, Division of State Coverage Programs, at (410) 786-1536. We look forward to continuing to work with you and your staff.

Sincerely,
/Signed by Sarah deLone/

Sarah DeLone
Deputy Director

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: Rachael Foster — Position/Title: CHIP Manager, OMPP
Name: Allison Taylor — Position/Title: Medicaid Director, OMPP
Name: Dr. Daniel Rusyniak — Position/Title: Secretary, FSSA

*Disclosure. In accordance with the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #34). 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 1005-33 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, as amended by the Health Care and Education Reconciliation Act of 2010, further modified the program. The HEALTHY KIDS Act

and The Bipartisan Budget Act of 2018 together resulted in an extension of funding for CHIP through federal fiscal year 2027.

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.
- Added new provisions related to delivery methods, including managed care, to section 3 (81 FR 27498, issued May 6, 2016)

States are not required to resubmit existing State plans using this current updated template. However, States must use this updated template when submitting a new 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 the State to specify its proposed method of delivery. If the State proposes to use managed care, the State must describe and attest to certain requirements of a managed care delivery system, including contracting standards; enrollee enrollment processes; enrollee notification and grievance processes; and plans for enrolling providers, among others. (Section 2103); (42 CFR Part 457. Subpart L)
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)); (42 CFR 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.

Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 457 et seq., the state shall place a check mark to affirm that it will be in compliance no later than the applicable compliance date.

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

Chanelle Parkar
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 #20-0002 Purpose of SPA: SUPPORT Act Compliance SPA
Proposed effective date: October 24th, 2019
effective date for removal of 10-unit limit on Tobacco Cessation Counseling: July 1st, 2021.

Proposed implementation date: October 24th, 2019
Implementation date for removal of 10-unit limit on Tobacco Cessation Counseling was: July 1st, 2021.

Effective April 1, 2022 removes copayments and premiums for individuals eligible for extended postpartum coverage.

**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.

Tribal Notice is not required for CHIP State Plan Amendments in the State of Indiana. Indiana does not have any I/T/Us located in the state.

Guidance: See guidance for section 6.1.4.1 for a guidance on the statutory requirements for EPSDT under sections 1905(r) and 1902(a)(43) of the Act. If the benefit being

provided does not meet the EPSDT statutory requirements, do not check this box.

**6.2.22**. ☒ EPSDT consistent with requirements of sections 1905(r) and 1902(a)(43) of the Act

**6.2.22.1** ☒☐ The state assures that any limitations applied to the amount, duration, and scope of benefits described in Sections 6.2 and 6.3- BH of the CHIP state plan can be exceeded as medically necessary.

**6.2-BH Behavioral Health Coverage** Section 2103(c)(5) requires that states provide coverage to prevent, diagnose, and treat a broad range of mental health and substance use disorders in a culturally and linguistically appropriate manner for all CHIP enrollees, including pregnant women and unborn children.

Guidance: Please attach a copy of the state's periodicity schedule. For pregnancy-related coverage, please describe the recommendations being followed for those services.

**6.2.1- BH Periodicity Schedule** The state has adopted the following periodicity schedule for behavioral health screenings and assessments. Please specify any differences between any covered CHIP populations:

☐ State-developed schedule
☒ American Academy of Pediatrics/ Bright Futures
☐ Other Nationally recognized periodicity schedule (please specify: )
☐ Other (please describe: )

**6.3- BH Covered Benefits** Please check off the behavioral health services that are provided to the state's CHIP populations, and provide a description of the amount, duration, and scope of each benefit. For each benefit, please also indicate whether the benefit is available for mental health and/or substance use disorders. If there are differences in benefits based on the population or type of condition being treated, please specify those differences.

If EPSDT is provided, as described at Section 6.2.22 and 6.2.22.1, the state should only check off the applicable benefits. It does not have to provide additional information regarding the amount, duration, and scope of each covered behavioral health benefit.

Guidance: Please include a description of the services provided in addition to the behavioral health screenings and assessments described in the assurance below at 6.3.1.1-BH.

**6.3.1- BH** ☒ Behavioral health screenings and assessments. (Section 2103(c)(6)(A))

**6.3.1.1- BH** ☒ The state assures that all developmental and behavioral health recommendations outlined in the AAP Bright Futures periodicity schedule and United States Public Preventive Services Task Force (USPSTF) recommendations graded as A and B are covered as a part of the CHIP benefit package, as appropriate for the covered populations.

Guidance: Examples of facilitation efforts include requiring managed care organizations and their networks to use such tools in primary care practice, providing education, training, and technical resources, and covering the costs of administering or purchasing the tools.

**6.3.1.2- BH** ☒ The state assures that it will implement a strategy to facilitate the use of age-appropriate validated behavioral health screening tools in primary care settings. Please describe how the state will facilitate the use of validated screening tools.
As part of the State's facilitation efforts, currently contractually obligates each Managed Care Entity and their networks to follow the latest guidance from the American Academy of Pediatrics.

At this time, the State disseminates information through the use of provider manuals with information on how to access the latest public tools from the American Academy of Pediatrics. Policy changes that lead to a manual update or edit are also communicated with providers through bulletins which are electronic notices sent to all providers to sign up for the service.

**6.3.2- BH** ☒ Outpatient services (Sections 2110(a)(11) and 2110(a)(19))

Guidance: Psychosocial treatment includes services such as psychotherapy, group therapy, family therapy and other types of counseling services.

**6.3.2.1- BH** ☒ Psychosocial treatment
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Direct reimbursement is allowed for psychosocial treatment provided by licensed physicians, psychologists endorsed as a health service provider in psychology (HSPP), outpatient mental health facilities, psychiatric hospitals, and psychiatric wings of acute care hospitals.

Current state regulation requires prior authorization (PA) for mental health services

provided in an outpatient or office setting that exceed 20 units per member, per provider, per rolling 12-month period.

**6.3.2.2- BH** ☒ Tobacco cessation
Provided for: ☒ Substance Use Disorder

Tobacco dependence treatments are reimbursable pursuant to State regulation 405 Indiana Administrative Code ("IAC") 5-37. Treatment may include prescription of any combination of FDA-approved tobacco dependence treatment products and counseling. Providers can prescribe one or more modalities of treatment. Providers must include counseling in any combination of treatment.

Guidance: In order to provide a benefit package consistent with section 2103(c)(5) of the Act, MAT benefits are required for the treatment of opioid use disorders. However, if the state provides MAT for other SUD conditions, please include a description of those benefits below at section 6.3.2.3- BH.

**6.3.2.3- BH** ☒ Medication Assisted Treatment
Provided for: ☒ Substance Use Disorder

For children who may not meet the OTP criteria, buprenorphine and naltrexone can be provided to a member as a pharmacy benefit outside of the OTP bundle when prescribed by licensed providers practicing within their scope. Additionally, all FDA approved MAT medications are available as part of the benefit. Certain psychiatric codes in combination are subject to 20 units per member per provider per rolling 12-month period without prior authorization. Additional units may be authorized via the prior authorization (PA) process. Other services that are traditionally associated with MAT are covered outside of OTPs including, but not limited to the following:

- Evaluation to assess for medications associated with treatment of substance use disorder (including alcohol, sedative hypnotic, nicotine, or opioid use disorder)
- Prescribing medication for treatment of substance use disorder when clinically indicated
- Daily, weekly, or monthly follow-up assessment with patient associated with prescribing medication for treatment of a substance use disorder
- Laboratory or other medical monitoring necessary for medication associated with treatment of substance use disorder
- Prescribing additional FDA approved medications as medically needed by patient

**6.3.2.3.1- BH** ☒ Opioid Use Disorder

The State currently covers Opioid Treatment Program ("OTP") services as long as beneficiaries meet the defined medical necessity criteria. Services in an OTP are provided as part of a weekly bundled rate The weekly bundled rate includes reimbursement for the following services (listed with restrictions):

- U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication assisted treatment (MAT) medication
- Dispensing and administration of MAT medications
- Substance use disorder counseling
- Toxicology testing
- Group or individual psychotherapy, as required by Division of Mental Health and Addiction ("DMHA")
- Intake activities
- Periodic assessments

Other services not defined as OTP services in this section may be reimbursable by an opioid treatment program provider if deemed appropriate by the Office of Medicaid Policy and Planning (OMPP).

Medical Necessity Criteria:

- Must be addicted to an opioid drug
- Must have two documented unsuccessful attempts at short-term withdrawal management or drug-free addiction treatment within a 12-month period preceding admission
    - If CHIP beneficiary is aged 18 -19 years old then this requirement becomes: "Must have been addicted for at least one year before admission to the OTP."

- Must meet the criteria for the Opioid Treatment Services (OTS) level of care, according to all six dimensions of the ASAM Patient Placement Criteria

**6.3.2.3.2- BH** ☒ Alcohol Use Disorder

Same restrictions as listed above in Section 6.3.2.3.1.

**6.3.2.3.3- BH** ☐ Other

**6.3.2.4- BH** ☒ Peer Support
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Peer recovery services are individual, face-to-face services that provide structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Peer recovery services are available without prior authorization up to 365 hours (1,460 units) per rolling calendar year. Additional units may be authorized via the prior authorization (PA) process.

**6.3.2.5- BH** ☐ Caregiver Support
Provided for: ☐ Mental Health ☐ Substance Use Disorder

**6.3.2.6- BH** ☐ Respite Care
Provided for: ☐ Mental Health ☐ Substance Use Disorder

These services are provided fee-for-service to S-CHIP children if the services are determined to be medically necessary on an individual basis in order to treat, correct, or ameliorate an illness or condition.

**6.3.2.7- BH** ☐ Intensive in-home services
Provided for: ☐ Mental Health ☐ Substance Use Disorder

These services are provided fee-for-service to S-CHIP children if the services are determined to be medically necessary on an individual basis in order to treat, correct, or ameliorate an illness or condition.

**6.3.2.8- BH** ☒ Intensive outpatient
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Intensive Outpatient Treatment ("IOT") is a treatment program that operates at least 3 hours per day, at least 3 days per week. IOT is planned and organized with mental and behavioral health professionals and clinicians providing multiple treatment service components for rehabilitation of alcohol and other drug abuse or dependence in a group

setting. IOT includes individual and family therapy, group therapy, skills training, medication training and support, peer recovery services, care coordination, and counseling. The State requires Prior Authorization and the provision of at least 120 minutes of therapeutic interventions (for example, individual/family or group therapy) per 3 hour session.

**6.3.2.9- BH** ☒ Psychosocial rehabilitation
Provided for: ☒ Mental Health ☒ Substance Use Disorder

The State incorporates Psychosocial Rehabilitation into its Medicaid Rehabilitation Option (MRO) services. The State defines Psychosocial Rehabilitation as services delivered through a community-based accredited clubhouse setting in which the member, with staff assistance, is engaged in operating all aspects of the program, including clerical, reception, janitorial, and food services, as well as receiving other member services such as employment training, housing assistance, and educational support. However, for Psychosocial Rehabilitation services to be considered appropriate for a member, the member serious mental illness and/or a co-occurring substance use disorder who have a Child and Adolescent Needs and Strengths ("CANS") or Adult Needs and Strengths Assessment ("ANSA") Level of Need (LON) of 3 or higher.

If determined that a CHIP enrollee meets the clinical criteria, then the CHIP beneficiary may receive Psychosocial Rehabilitation and other medically necessary MRO services, without transitioning to Medicaid. However, CHIP MRO services are subject to the same coverage policies and benefit limitations as traditional Medicaid.

Guidance: If the state considers day treatment and partial hospitalization to be the same benefit, please indicate that in the benefit description. If there are differences between these benefits, such as the staffing or intensity of the setting, please specify those in the description of the benefit's amount, duration, and scope.

**6.3.3- BH** ☐ Day Treatment
Provided for: ☐ Mental Health ☐ Substance Use Disorder

The state considers day treatment and partial hospitalization to be the same benefit

**6.3.3.1- BH** ☒ Partial Hospitalization
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Partial hospitalization programs are highly intensive, time-limited medical services intended to either provide a transition from inpatient psychiatric hospitalization to community-based care or, in some cases, substitute for an inpatient admission.

Partial hospitalization programs must include four to six hours of active treatment per day and must be provided at least four days a week.

Any Child & Adolescent Needs and Strengths Assessment ("CANS") level of need can qualify for partial hospitalization services. All partial hospitalization services will require prior authorization and review by the health plan for medical necessity.

**6.3.4- BH** ☒ Inpatient services, including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Sections 2110(a)(10) and 2110(a)(18))

Provided for: ☒ Mental Health ☒ Substance Use Disorder

CHIP members must meet medical necessity to be eligible for acute inpatient psychiatric or inpatient substance abuse services. Reimbursement is available to managed care entities for inpatient care provided in a freestanding psychiatric hospital or in the psychiatric unit of an acute care hospital only when the need for admission has been certified. Inpatient services furnished in a State Psychiatric Facility are reimbursable fee-for-service as long as the CHIP beneficiary is in a certified wing.

Guidance: If applicable, please clarify any differences within the residential treatment benefit (e.g. intensity of services, provider types, or settings in which the residential treatment services are provided).

**6.3.4.1- BH** ☒ Residential Treatment

Provided for: ☒ Mental Health ☒ Substance Use Disorder

Coverage for short-term low-intensity and high-intensity residential treatment for MH, OUD, and other SUD treatment in settings of all sizes, including facilities that qualify as IMDs. Services built into the daily per diem residential payment include:

- Individual therapy
- Group therapy
- Medication training and support
- Case management
- Drug testing
- Peer recovery supports

Prior Authorization is required for all residential MH and SUD stays. Admission criteria for residential stays for MH, OUD, or other SUD treatment is based on the American Society of Addiction Medicine (ASAM) Patient Placement Criteria.

Residential stays are allowed to be authorized with a statewide average length of 30 calendar days, based on medical necessity. If a facility determines that a member requires more time than was initially authorized, the facility should submit a PA update request showing that the member has made progress but can be expected to show more progress given more treatment time. An additional length of stay can be approved based on documentation of medical necessity.

Members must be disenrolled or suspended from managed care, respectively, and their coverage converted to a fee-for-service (FFS) benefit during their PRTF stay.

**6.3.4.2- BH** ☒ Detoxification
Provided for: ☒ Substance Use Disorder

Prior Authorization is required for inpatient detoxification. Please refer to Section 6.3.4 for additional details.

Detoxification services are defined in Indiana state code and shall and shall be available twenty-four (24) hours per day, seven (7) days per week.

Guidance: Crisis intervention and stabilization could include services such as mobile crisis, or short term residential or other facility based services in order to avoid inpatient hospitalization.

**6.3.5- BH** ☒ Emergency services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Emergency services are covered subject to the prudent layperson standard of an emergency medical condition. All medically necessary screening services provided to an individual who presents to an emergency department with an emergency medical condition are covered.

**6.3.5.1- BH** ☒ Crisis Intervention and Stabilization
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Crisis intervention is a short-term emergency behavioral health service, available 24 hours a day, 7 days a week. Crisis Intervention includes, but is not limited to, the following:

- Crisis assessment, planning, and counseling specific to the crisis,
- Intervention at the site of the crisis (when clinically appropriate)
- Prehospital assessment.

**6.3.6- BH** ☒ Continuing care services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Managed Care Entities are contractually obligated to employ behavioral health case managers to monitor the care of members receiving behavioral health services. Through provider contract provisions, Managed Care Entities require that members receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. This treatment shall be provided within seven (7) calendar days from the date of the member's discharge. If a member misses an outpatient follow-up or continuing treatment, the Contractor shall ensure that a behavioral health care provider or the Contractor's behavioral health case manager contacts that member within three (3) business days of notification of the missed appointment.

**6.3.7- BH** ☒ Care Coordination
Provided for: ☒ Mental Health ☒ Substance Use Disorder

The State contractually requires the MCE to coordinate services for individuals with multiple diagnoses of mental illness, substance abuse, and physical illness.

Care Coordination ensures the coordination of physical and behavioral health services provided to the member, between all providers treating the member. Further, care coordination provides oversight of the member's behavioral and physical health service utilization and facilitates exchange of the member's health information between all providers.

**6.3.7.1- BH** ☐ Intensive wraparound
Provided for: ☐ Mental Health ☐ Substance Use Disorder

These services are provided fee-for-service to S-CHIP children if the services are determined to be medically necessary on an individual basis in order to treat, correct, or ameliorate an illness or condition.

**6.3.7.2- BH** ☐ Care transition services
Provided for: ☐ Mental Health ☐ Substance Use Disorder

**6.3.8- BH** ☒ Case Management
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Case Management Services include, but are not limited to the following: direct consumer

contacts to provide members with scheduling; location of specialists and specialty services; transportation needs; access to a 24-Hour Nurse Line; general preventive (e.g. mammography) and disease specific reminders (e.g. Hgb A1C), pharmacy refill reminders; tobacco cessation education and materials; and education regarding use of primary care and emergency services. For CHIP members with special needs or co-morbidities, in addition to the services above, the MCOs develop care plans and provide referrals to supporting programs in order to address the medical, social, educational, and other services needed by the member.

**6.3.9- BH** ☐ Other
Provided for: ☐ Mental Health ☐ Substance Use Disorder

## 6.4- BH Assessment Tools

**6.4.1- BH** Please specify or describe all of the tool(s) required by the state and/or each managed care entity:

☒ ASAM Criteria (American Society Addiction Medicine)
☒ Mental Health ☒ Substance Use Disorders

☒ InterQual
☒ Mental Health ☒ Substance Use Disorders

☒ MCG Care Guidelines
☒ Mental Health ☒ Substance Use Disorders

☐ CALOCUS/LOCUS (Child and Adolescent Level of Care Utilization System)
☐ Mental Health ☐ Substance Use Disorders

☐ CASII (Child and Adolescent Service Intensity Instrument)
☐ Mental Health ☐ Substance Use Disorders

☒ CANS (Child and Adolescent Needs and Strengths)
☒ Mental Health ☒ Substance Use Disorders

☐ State-specific criteria (e.g. state law or policies) (please describe)
☐ Mental Health ☐ Substance Use Disorders

☐ Plan-specific criteria (please describe)
☐ Mental Health ☐ Substance Use Disorders

☐ Other (please describe)
☐ Mental Health ☐ Substance Use Disorders

☐ No specific criteria or tools are required
☐ Mental Health ☐ Substance Use Disorders

Guidance: Examples of facilitation efforts include requiring managed care organizations and their networks to use such tools to determine possible treatments or plans of care, providing education, training, and technical resources, and covering the costs of administering or purchasing the assessment tools.

**6.4.2- BH** ☒ Please describe the state's strategy to facilitate the use of validated assessment tools for the treatment of behavioral health conditions.

The State currently requires each managed care entity and their networks to utilize the tools in Section 6.4.1 to determine possible treatments and identify plans of care. At this time, the State disseminates information through the use of provider manuals containing information on how to access the latest guidance from the American Academy of Pediatrics/Bright Futures periodicity schedule. The periodicity schedule includes links to all recommended pediatric screening and assessment tools. Policy changes that lead to a manual update or edit are also communicated with providers through bulletins which are electronic notices sent to all providers to sign up for the service. A bulletin is published as needed throughout the year, manuals are updated every 6 months.

**6.2.5- BH Covered Benefits** The State assures the following related to the provision of behavioral health benefits in CHIP:

☒ All behavioral health benefits are provided in a culturally and linguistically appropriate manner consistent with the requirements of section 2103(c)(6), regardless of delivery system.

☒ The state will provide all behavioral health benefits consistent with 42 CFR 457.495 to ensure there are procedures in place to access covered services as well as appropriate and timely

treatment and monitoring of children with chronic, complex or serious conditions.

**8.2.1-DS** ☒ Premiums:

Effective April 1, 2022, individuals eligible for extended postpartum coverage will not be charged premiums during the pregnancy and 12 month postpartum period.

**8.2.2-DS** ☐ Deductibles:

**8.2.3-DS** ☒ Coinsurance or copayments:

Effective April 1, 2022, individuals eligible for extended postpartum coverage will not be charged copayments during the pregnancy and 12 month postpartum period.