Indiana Medicaid Mental Health Parity and Addiction Equity Act of 2008 Compliance

Indiana Family and Social Services Administration
Office of Medicaid Policy and Planning
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Contents

Introduction

Under 42 CFR § 438.920(b), Indiana must review the mental health and substance use disorder and medical/surgical benefits provided through its fee-for-service and risk-based managed care (RBMC) coverage systems to ensure that the full scope of services available to all individuals enrolled through RMBC complies with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Using a toolkit prepared for and in conjunction with the Centers for Medicare and Medicaid Services (CMS) by Truven Health Analytics, Inc., Indiana Medicaid has reviewed its programs for compliance with these final rules. The following report is being made available to demonstrate compliance with the requirements.

Identifying Benefit Packages for Parity Compliance

The final Medicaid/CHIP parity rule applies most provisions of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) to coverage provided to enrollees of Medicaid managed care organizations (MCOs), coverage provided by Medicaid alternative benefit plans (ABPs) and Children's Health Insurance Programs (CHIPs). Using the benefit plans created through *CoreMMIS* as the basis for identifying all possible benefit plans, Indiana Medicaid identified the following list of benefit packages:

Benefit Plan (CoreMMIS)	Benefit Plan Name
AMHH	Adult Mental Health Habilitation
PEIH	Medicaid Inpatient Hospital Services Only (Facility)
PEFP	Presumptive Eligibility Family Planning
HIPMA	HIP Maternity
HIPSB	HIP 2.0 State Plan Basic
HPE	Presumptive Eligibility Adult
BPHC	Behavioral & Primary Health Coordination
HIPSC	HIP 2.0 State Plan Plus Copay
CMHW	Children's Mental Health Wraparound
HIP2	HIP 2.0 Plus
HIPRB	HIP 2.0 Basic
HIPSP	HIP 2.0 State Plan Plus
PASMI	PASRR Mental Illness (MI)
PACE	Program of All-Inclusive Care for the Elderly
TMIH	Medicaid Inpatient Hospital Services Only (Facility)
PEPA	Presumptive Eligibility Package A (Standard Plan)
PKGA	Package A-Standard Plan
MA	Full Medicaid
PEPW	Presumptive Eligibility for Pregnant Women
QMB	Qualified Medicare Beneficiary
SLMB	Specified Low Income Medicare Beneficiary
QI	Qualified Individual

QDWI	Qualified Disabled Working Individual
PKGE	Package E - Emergency Services Only
FPS	Family Planning Eligibility Program
PKGC	Package C - Childrens Health Plan (SCHIP)
590	590 Program
MRT	Medical Review Team
PASMR	PASRR Individuals with Intellectual Disability
MRO	Medicaid Rehabilitation Option
ADWA	Aged and Disabled HCBS Waiver
DDWA	Community Integration and Habilitation HCBS Waiver
TBIWA	Traumatic Brain Injury HCBS Waiver
SSFS	Family Supports HCBS Waiver
MFPAD	MFP Demonstration Grant HCBS Waiver
MFPTB	MFP Traumatic Brain Injury
MFPCI	MFP Community Integration and Habilitation
MFPTR	MFP PRTF Transition from PRTF
MFPTS	MFP Transition from State Owned Facility
PRTFW	PRTF Transition Waiver

A benefit package includes all benefits provided to a specific population group, regardless of how those benefits are delivered. Each benefit package represents either a limited or full benefit provided to Indiana Medicaid members. Benefit packages were subjected to the following two questions:

- *Does the benefit package offer Medicaid State Plan, Alternative Benefit Package, or Children's Health Insurance Program coverage for service?*
- *If the benefit package offers Medicaid State Plan benefits, is the benefit package delivered through the fee-for-service or managed care delivery model?*

A spreadsheet listing each benefit plan and answering each question is included in Appendix A. After answering these questions, the following benefit packages are subject to the Medicaid/CHIP parity requirements:

Benefit Plan (CoreMMIS)	Benefit Plan Name
AMHH	Adult Mental Health Habilitation
BPHC	Behavioral & Primary Health Coordination
CMHW	Children's Mental Health Wraparound
HIPSB	HIP 2.0 State Plan Basic
HPE	Presumptive Eligibility Adult
HIPSC	HIP 2.0 State Plan Plus Copay
HIP2	HIP 2.0 Plus

HIPRB	HIP 2.0 Basic
HIPSP	HIP 2.0 State Plan Plus
HIPMA	HIP Maternity
MA	Full Medicaid (for Hoosier Care Connect)
PEPA	Presumptive Eligibility Package A (Standard Plan)
PKGA	Package A-Standard Plan
PEPW	Presumptive Eligibility for Pregnant Women
PKGC	Package C-Children's Health Plan (SCHIP)

The following programs are, therefore, subject to the parity requirements:

- Healthy Indiana Plan
- Hoosier Care Connect
- Hoosier Healthwise (including Package C Recipients)
- Presumptive Eligibility for Pregnant Women
- Presumptive Eligibility (Adult Population)
- Adult Mental Health Habilitation
- Behavioral & Primary Health Coordination
- Children's Mental Health Wraparound

The following action items have been identified through this section:

Action Item	Completion Date
None	None

Responsibility for Parity Analysis

All of the benefit plans listed above are provided through risk-based managed care (RBMC). Each of the programs' managed care entities (MCEs) are responsible for most behavioral health (mental health/substance use disorder) services. Along with this responsibility, each MCE is contractually obligated to comply with the Mental Health Parity and Addictions Equity Act; however, each MCE is not responsible for performing a parity analysis.

The following behavioral health services are considered "carved out" and are the responsibility of the Traditional Medicaid program:

- Medicaid Rehabilitation Option (MRO) services
- 1915(i) State Plan Home and Community-Based services

Since multiple delivery systems provide behavioral health services to our managed care members, the State is responsible for completing the parity analysis. The state must assure that each enrollee has a benefit package that meets the requirements of the Mental Health Parity and Addiction Equity Act even if the benefits are offered via different programs or through different funding sources.

The following action items have been identified through this section:

Action Item	Completion Date
None	None

Defining Mental Health and Substance Use Disorder (MH/SUD) Benefits

As defined by the Centers for Medicare and Medicaid Services (CMS) alongside Truven Health Analytics, Inc., mental health and substance use disorder (MH/SUD) benefits are benefits for items and services for MH/SUD conditions, while medical/surgical (M/S) benefits are benefits and services for medical conditions or surgical procedures. For ease of identification, the International Classification of Diseases (ICD) will be used to differentiate between MH/SUD benefits and M/S benefits. Indiana Medicaid will use the following rule when determining benefits:

MH/SUD Benefits	Any item or service used to treat a primary ICD-10 diagnosis of F01-F99
M/S Benefits	Any item or service used to treat any primary ICD-10 diagnosis that does not include F01-F99

The following action items have been identified through this section:

Action Item	Completion Date
None	None

Defining Classifications and Mapping Benefits to Classifications

For a complete parity analysis, each MH/SUD benefit and M/S benefit must be mapped to one of four classification of benefits:

- Inpatient
- Outpatient
- Prescription Drugs
- Emergency Care

Indiana Medicaid currently uses the following definitions for each of these classification of services:

405 IAC 5-2-12: "Inpatient services" defined

"Inpatient services" means only those services provided to a member while the member is registered as an inpatient in an acute care or psychiatric hospital.

405 IAC 5-2-19: "Outpatient services" defined

"Outpatient services" means those services provided to a member who is not registered as an inpatient in an acute care or psychiatric hospital except as specifically referenced in a given section.

405 IAC 5-2-9: "Emergency service" defined

"Emergency service" means a service provided to a member after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in:

(1) Placing the patient's health in serious jeopardy;
(2) Serious impairment to bodily functions; or
(3) Serious dysfunction of any bodily organ or part

405 IAC 5-24-2: "Pharmacy services" defined

As used in this rule, "pharmacy services" means legend drugs, nonlegend drugs included on the Medicaid nonlegend drug formulary developed in coordination with the Indiana Medicaid Drug Utilization Review (DUR) board, nutritional supplements, food supplements, and infant formulas.

Taking these current definitions into consideration, Indiana Medicaid's M/S and MH/SUD benefits should be classified according to the following structure:

Benefit Type	Inpatient	Outpatient	Prescription Drugs	Emergency Care
M/S	• Surgery • Skilled Nursing • Lab Work • Radiology	• Preventive Services • Primary Care Services • Home health • Medication during outpatient visit	• Generic drugs • Brand name drugs	• Ambulance • Any service offered during an ED visit
MH/SUD	• Acute psychiatric/SUD services • Residential psychiatric/SUD services • Detoxification	• Psychotherapy • Medicaid Rehabilitation Option (MRO) services • Opioid Treatment Program (OTP) services • Intensive outpatient services	• Generic drugs • Brand name drugs • Medication-Assisted Treatment (MAT) • Nicotine replacement and smoking cessation	• Crisis intervention • Any service offered during an ED visit

The following action items have been identified through this section:

Action Item	Completion Date

Consider amending Indiana Administrative Code to reflect updated definitions for classification levels.	December 31, 2018
After much deliberation and consideration, the State has determined to retain the current definitions for Inpatient Services (405 IAC 5-2-12); Outpatient Services (405 IAC 5-2-19); Pharmacy Services (405 IAC 5-24-2); and Emergency Services (405 IAC 5-2-9).	January 1, 2020

Overview of Financial Requirements, Quantitative Treatment Limitations, and Aggregate Life and Annual Dollar Limits

When analyzing the financial requirements and quantitative treatment limitations rules surrounding parity, the following definitions should be used:

Financial Requirement (FR) – Payments made by members for services in addition to payments made by the State (or others) for those services. These include copayments, coinsurance, and deductibles.

Quantitative Treatment Limitations (QTL) – Limits on the scope or duration of a benefit that are expressed numerically (day or visit limits).

Aggregate Lifetime (AL) or Annual Dollar Limits (ADL) – Dollar limits on the total amount of a specified benefit over a lifetime or on an annual basis

To ensure parity compliance, no FR or QTL may apply to MH/SUD benefits in a classification if the FR or QTL is more restrictive than the predominant financial requirement or treatment limitation of that type that applies to substantially all M/S benefits in the same classification. A cost analysis demonstrating compliance with this rule is necessary unless:

- No FR or QTL apply to MH/SUD benefits in a benefit package
- No FR or QTL apply to MH/SUD benefits in a particular classification
- If a FR or QTL applies to MH/SUD benefits in a particular classification, but on its face, it is no more restrictive than the same FR or QTL that applies to M/S benefits in that classification

Financial Requirements

Appendix B provides an analysis of the financial limitations that apply to each classification level for all of the programs impacted by the final parity rules. After reviewing these financial requirements, there are no copayments, deductibles, or coinsurance specific to just MH/SUD in any of the classifications or benefit packages. As a result, there are no concerns over parity compliance.

The following action items have been identified through this section:

Action Item	Completion Date
None	None

Quantitative Treatment Limitations

Appendix C provides an analysis of the quantitative treatment limitations that apply to each classification level for all programs impacted by the final parity rules.[1] After reviewing these quantitative treatment limitations, there are no quantitative treatment limitations specific to just MH/SUD in any of the classifications or benefit packages. As a result, there are no concerns over parity compliance.

The following action items have been identified through this section:

Action Item	Completion Date
None	None

Aggregate Lifetime (AL) or Annual Dollar Limits (ADL)

Appendix D provides an analysis of the aggregate lifetime or annual dollar limits that apply to each classification level for all programs impacted by the final parity rules. After reviewing these limitations, there are no aggregate lifetime or annual dollar limits specific to just MH/SUD in any of the classifications or benefit packages. As a result, there are no concerns over parity compliance.

The following action items have been identified through this section:

Action Item	Completion Date
None	None

Overview of Non-Quantitative Treatment Limitations (NQTLs)

When analyzing the non-quantitative treatment limitations rules surrounding parity, the following definition should be used:

Non-Quantitative Treatment Limitations (NQTLs) – These are limits on the scope of benefits, including the use of prior authorization or network admission standards. Examples of these limitations include the following:

- Medical management standards for limiting or excluding benefits on the basis of medical necessity or medical appropriateness, or on the basis of whether the treatment is experimental
- Formulary design for prescription drugs

[1] Some service packages have soft limits, which are benefit limits that allow for an individual to exceed numerical limits for M/S or MH/SUD benefits on the basis of medical necessity. These limits are considered non-quantitative treatment limitations (NQTLs) and are addressed at a later section.

- Standards for provider admission to participate in a network, including reimbursement rates
- Refusal to pay for higher-cost therapies until a lower-cost therapy has not been effective
- Conditioning benefits on the completion of a course of treatment
- Restrictions based on geographic location, facility type, or provider specialty
- Standards for providing access to out-of-network providers

To ensure parity compliance, no NQTL can be imposed on MH/SUD benefits in any classification unless, under the policies and procedures of the State or MCE, as written an in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in the classification.

Each MCE was approached to describe any NQTLs each has in place around MH/SUD treatment. Since all four of the MCEs apply the same potential NQTLs across all of Indiana Medicaid's programs, there will be no separate discussion for each program.

I. Inpatient Services

- **Inpatient Services Prior Authorization Process and Procedures** - Inpatient prior authorization policies for MH/SUD and M/S services are developed using hierarchy of standards that account for state and federal laws, as well as a minimum of one nationally recognized standard.
- **Limitations -** All inpatient behavioral health stays, regardless of setting, require prior authorization. A plan of care must be developed by an attending or staff physician and reviewed every 90 days (for individuals 21 and older) or every 60 days (for individuals under 21). For non-ER admissions, there must be a certification of need by telephone and in writing within 10 working days. For ER admissions, there must be a certification by telephone within 48 hours and in writing within 14 working days.

  Each MCE utilizes clinical guidelines when authorizing both inpatient stays for both M/S and MH/SUD inpatient stays. The Indiana Health Coverage Programs (IHCP) uses Milliman Care Guidelines (MCG) as the medical necessity criteria for all non-emergency and urgent care inpatient admissions. Services provided during an inpatient stay are subject to the limitations outlined in the Member's benefit plan and Indiana Administrative Code.

II. Outpatient Services

- **Prior Authorization Process and Procedures -** For outpatient prior authorizations, MCEs are required to use generally accepted standards of medical practice or nationally recognized criteria. Generally accepted standards of medical practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society

recommendations, and the views of physicians practicing in relevant clinical areas and any other relevant factors.

- **Limitations –** All "office visits"[2] are restricted to thirty (30) visits per member, per provider, per rolling twelve (12) months regardless of the subsequent diagnoses being for M/S, MH, or SUD. However, psychotherapy and other mental health services provided in an outpatient or office setting require prior authorization with medical necessity after twenty (20) units per member, per provider, per rolling twelve (12) months. Additionally, service limitations can be exceeded for the following MH/SUD programs
    - AMHH: Service packages are assigned for 360 days. Within the last 60 days of an assigned service package, a provider may reassess the person and a new service package will be assigned to start the day after the existing package ends. Additional units are available, if required.
    - BPHC: Initially offered in 15-minute units up to 48 units/12 hours per 180 days. Additional units are available upon request.
    - CMHW: Hourly service, billed in 15-minute units, is limited to a maximum of two hours (or 8 units) per day. Additional hours are allowed upon request, if necessary.

  To ensure alignment with FFS, the State's MCOs require PA for all inpatient and residential services that are classified as mental health/SUD or medical services. All of the MCOs evaluate the need for PA based on historical claims data. Services that are identified as having the potential to be high-cost and over-utilized require PA. The State's MCOs develop and maintain clinical policies based on nationally recognized guidelines such as InterQual, Milliman Care Guidelines, the American Society of Addiction Medicine (ASAM), etc. A combination of data collection and review, nationally recognized care guidelines, clinical expertise, and service evaluation are used to analyze the limitations.

- **Reduced Reimbursement for Mid-level Practitioners –** When psychotherapy is provided by a mid-level practitioner (licensed psychologist, licensed independent practice school psychologist, licensed clinical social worker, licensed marriage and family therapist, licensed mental health counselor, licensed clinical addiction counselor, a person holding a master's degree in social work, marital and family therapy, mental health counseling, or an advanced practice nurse), reimbursement is cut back to 75% of the Indiana Medicaid-allowed amount for the procedure. All M/S services provided by these mid-level practitioners (including independently practicing respiratory therapists) are cut back to 75% of the fee schedule amount; certified registered nurse anesthetists (CRNAs) are reimbursed at 60% of the fee schedule amount. Since the reimbursement reduction is not limited to just MH/SUD services, this is not an issue for parity compliance.

[2] As defined by CPT Codes as: 99201-99205; 99211-99215; 99381-99387; 99391-99397.

III. Prescription Drug Services

- **Prior Authorization Processes and Procedures -** Generally, the IHCP programs mandated to comply with MHPAEA are subject to the same state laws, policies, and procedures. I.C. § 12-15-35.5 broadly covers the parameters in which mental health and substance abuse pharmacy benefits are managed. The statutory language prohibits Medicaid from establishing preference or step therapy requirements to mental health drugs, but does permit restrictions (to prevent waste (e.g. inappropriate prescribing, inappropriate utilization, or clinically unjustified utilization)) to be implemented by Indiana Medicaid's Mental Health Quality Advisory Committee (MHQAC). Those situations are: "(1) encouraging dosages that enhance recipient adherence to a drug regimen; (2) encouraging monotherapy with limitations on the number of drugs from a specific drug class that a recipient may be taking at any one (1) time when there is no documentation of the severity and intensity of the target symptoms; (3) limiting the total number of scheduled psychiatric medications that a recipient may be taking at any one (1) time, when such limit is based on: (A) established best practices; or (B) guidelines implemented by the division of mental health and addiction for mental health state operated facilities; and (4) encouraging, in accordance with I.C. §16-42-22-10, generic substitution when such a substitution would result in a net cost savings to the Medicaid program," (I.C. § 12-15-35.5-7(h)). Given that the process in which restrictions on MH/SUD pharmacy benefits is prescriptive, Indiana Medicaid has not adopted further regulations to place limits on any other MH/SUD drugs.

  PA for SUD pharmacy benefits (buprenorphine film strips) are applied and administered in a comparable manner to M/S pharmacy benefits that require PA. Which benefits are subject to PA is subject to the drugs listing on the State's Preferred Drug List (PDL).

  The State maintains a PDL consisting of preferred and nonpreferred drugs. Preferred drugs do not require a PA for medical necessity, while nonpreferred drugs do. The Medicaid Drug Utilization Review Board (Board) determines what is to be included on the PDL. Federal rules require that each Medicaid program include comprehensive DUR. These guidelines provide maximum flexibility, but the State must ensure that drugs are dispensed appropriately, and that drug use is retrospectively reviewed. It is the job of the Board and their subcommittees to evaluate drug therapies to ensure that the drug therapies are both clinically appropriate and fiscally sound prescribing practices. As part of their ongoing evaluations of the PDL, the Board conducts retrospective review. A component of this review is to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care associated with specific drugs. Thus, when a specific drug is identified, whether M/S or MH/SUD, utilization edits may be made to reduce potential fraud and abuse.
- **Pharmacy Service Limitations** - Indiana Medicaid does not apply preferred or non-preferred status on its Preferred Drug List for drugs used to treat mental health conditions and substance use disorder. Members have access, based upon medical necessity, to all FDA-approved medications from rebating manufacturers. With the exception of "brand medically necessary" medications, all medications for the treatment of mental health

diagnoses are considered "preferred" by Indiana Medicaid; however, medications for the treatment of substance use disorder may require prior authorization.

IV. Emergency Service Limitations

Emergency services for both MH/SUD and M/S services are covered on a self-referral basis. Per Indiana Administrative Code, both MH/SUD (405 IAC 5-20-5) and M/S (405 IAC 5-17-3) emergency services must be certified by telephone within 48 hours and in writing within 14 working days.

The following action items have been identified through this section:

Action Item	Completion Date
None	None

Specific Compliance with Alternative Benefit Plans (ABP) and the Children's Health Insurance Program (CHIP)

As indicated in Appendix A, Indiana Medicaid utilizes multiple alternative benefit plans (ABPs) through the Healthy Indiana Plan (HIP). Analysis of HIP has been addressed throughout this report.

Indiana also operates a hybrid Children's Health Insurance Program (CHIP) utilizing both Hoosier Healthwise Package A and Package C. HIP adults under 20 and children who receive coverage through Hoosier Healthwise Package A are deemed to meet compliance with the final parity rules due to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) coverage. The State cannot use EPSDT to deem compliance for children receiving Package C, as there are specific quantitative treatment limitations. However, as indicated throughout this report, there are no limitations specific to MH/SUD treatment.

Indiana will be required to submit a CHIP State Plan Amendment (SPA) in the near future to indicate how the Hoosier Healthwise Package C program complies with the parity requirements. Once CMS has released the templates for states, Indiana will complete this amendment process.

The following action items have been identified through this section:

Action Item	Completion Date
Pursue a CHIP State Plan Amendment around parity compliance	Approval received from CMS January 13, 2020

Availability of Information

Each of the MCEs is contractually obligated to make the criteria for medical necessity determinations for MH/SUD benefits available to any current or potential member, or

contracting provider, upon request. Additionally, each MCE is contractually obligated to provide the reason for any denial of reimbursement or payment with respect to MH/SUD benefits to members. For individuals receiving MRO services, the medical necessity criteria is available online through the *Medicaid Rehabilitation Option Services* provider reference module.

The following action items have been identified through this section:

Action Item	Completion Date
None	None

Appendix A: Benefit Plans Analysis

Benefit Plan (Core MMIS)	Benefit Plan Name	Package Scope	Program Type	Delivery System	Parity Rules Apply
AMHH	Adult Mental Health Habilitation	Limited Benefit	Medicaid State Plan Services	FFS	Yes
PEIH	Medicaid Inpatient Hospital Services Only (Facility)	Limited Benefit	Medicaid State Plan Services	FFS	No
PEFP	Presumptive Eligibility Family Planning	Limited Benefit	Medicaid State Plan Services	FFS	Yes
HIPMA	HIP Maternity	Full Benefit	ABP	Managed Care	Yes
HIPSB	HIP 2.0 State Plan Basic	Full Benefit	ABP	Managed Care	Yes
HPE	Presumptive Eligibility Adult	Full Benefit	Medicaid State Plan Services	Managed Care	Yes
BPHC	Behavioral & Primary Health Coordination	Limited Benefit	Medicaid State Plan Services	FFS	Yes
HIPSC	HIP 2.0 State Plan Plus Copay	Full Benefit	ABP	Managed Care	Yes
CMHW	Children's Mental Health Wraparound	Limited Benefit	Medicaid State Plan Services	FFS	Yes
HIP2	HIP 2.0 Plus	Full Benefit	ABP	Managed Care	Yes
HIPRB	HIP 2.0 Basic	Full Benefit	ABP	Managed Care	Yes
HIPSP	HIP 2.0 State Plan Plus	Full Benefit	ABP	Managed Care	Yes
PASMI	PASRR Mental Illness	Limited Benefit	Medicaid State Plan Services	FFS	No
PACE	Program of All-Inclusive Care for the Elderly	Limited Benefit	Medicaid State Plan Services	FFS	No
TMIH	Medicaid Inpatient Hospital Services Only (Facility)	Limited Benefit	Medicaid State Plan Services	FFS	No
PEPA	Presumptive Eligibility Package A (Standard Plan)	Full Benefit	Medicaid State Plan Services	Managed Care	Yes
PKGA	Package A - Standard Plan	Full Benefit	Medicaid State Plan Services	Managed Care	Yes
MA	Full Medicaid	Full Benefit	Medicaid State Plan Services	FFS/Managed Care	Yes (for HCC)
PEPW	Presumptive Eligibility for Pregnant Women	Limited Benefit	Medicaid State Plan Services	Managed Care	Yes
QMB	Qualified Medicare Beneficiary	Other	Medicaid State Plan Services	Other	No
SLMB	Specified Low Income Medicare Beneficiary	Other	Medicaid State Plan Services	Other	No
QI	Qualified Individual	Other	Medicaid State Plan Services	Other	No
QDWI	Qualified Disabled Working Individual	Full Benefit	Medicaid State Plan Services	Other	No
PKGE	Package E - Emergency Services Only	Limited Benefit	Medicaid State Plan Services	FFS	No
FPS	Family Planning Eligibility Program	Limited Benefit	Medicaid State Plan Services	FFS	No
PKGC	Package C - Children’s Health Plan (SCHIP)	Full Benefit	CHIP	Managed Care	Yes
590	590 Program	Limited Benefit	Medicaid State Plan Services	FFS	No
MRT	Medical Review Team	Limited Benefit	Medicaid State Plan Services	FFS	No
PASMR	PASRR Individuals with Intellectual Disability	Limited Benefit	Medicaid State Plan Services	FFS	No
ADWA	Medicaid Rehabilitation Option	Limited Benefit	Medicaid State Plan Services	FFS	Yes
DDWA	Community Integration and Habilitation HCBS Waiver	Limited Benefit	Medicaid State Plan Services	FFS	No
TBIWA	Traumatic Brain Injury HCBS Waiver	Limited Benefit	Medicaid State Plan Services	FFS	No
SSFS	Family Supports HCBS Waiver	Limited Benefit	Medicaid State Plan Services	FFS	No
MFPAD	MFP Demonstration Grant HCBS Waiver	Limited Benefit	Medicaid State Plan Services	FFS	No
MFPTB	MFP Traumatic Brain Injury	Limited Benefit	Medicaid State Plan Services	FFS	No
MFPCI	MFP Community Integration and Habilitation	Limited Benefit	Medicaid State Plan Services	FFS	No
MFPTR	MFP PRTF Transition from PRTF	Limited Benefit	Medicaid State Plan Services	FFS	No
MFPTS	MFP Transition from State Owned Facility	Limited Benefit	Medicaid State Plan Services	FFS	No
PRTFW	PRTF Transition Waiver	Limited Benefit	Medicaid State Plan Services	FFS	No

Appendix B: Financial Requirements Analysis

Program	Inpatient		Outpatient		Pharmacy		Emergency Services	
	M/S	MH/SUD	M/S	MH/SUD	M/S	MH/SUD	M/S	MH/SUD
AMHH	None	None	None	None	None	None	None	None
BPHC	None	None	None	None	None	None	None	None
CMHW	None	None	None	None	None	None	None	None
HIP Basic	$75 copay per visit	$75 copay per visit	$4 copay per service	$4 copay per service	$4 copay for preferred drugs; $8 for nonpreferred	$4 copay for preferred drugs; $8 for nonpreferred	$8 copay for 1st nonemergency use; $25 for each use after	$8 copay for 1st nonemergency use; $25 for each use after
HIP Plus	None	None	None	None	None	None	$8 copay for 1st nonemergency use; $25 for each use after	$8 copay for 1st nonemergency use; $25 for each use after
HIP State Plan Basic	$75 copay per visit	$75 copay per visit	$4 copay per service	$4 copay per service	$4 copay for preferred drugs; $8 for nonpreferred	$4 copay for preferred drugs; $8 for nonpreferred	$8 copay for 1st nonemergency use; $25 for each use after	$8 copay for 1st nonemergency use; $25 for each use after
HIP State Plan Plus	None	None	None	None	None	None	$8 copay for 1st nonemergency use; $25 for each use after	$8 copay for 1st nonemergency use; $25 for each use after
Hoosier Care Connect	None	None	$1 copay for one-way non-emergency trip	$1 copay for one-way non-emergency trip	$3 copay for each prescription	$3 copay for each prescription	$3 copay for each nonemergency use	$3 copay for each nonemergency use
Hoosier Healthwise (Package A)	None	None	None	None	None	None	None	None
Hoosier Healthwise (Package C)	None	None	$10 copay for ambulance transportation	$10 copay for ambulance transportation	$3 copay for generic drugs; $10 copay for brand name drugs	$3 copay for generic drugs; $10 copay for brand name drugs	None	None

Presumptive Eligibility (Adult Population)	$75 copay per visit	$75 copay per visit	$4 copay per service	$4 copay per service	$4 copay for preferred drugs; $8 for nonpreferred	$4 copay for preferred drugs; $8 for nonpreferred	$8 copay for 1st nonemergency use; $25 for each use after	$8 copay for 1st nonemergency use; $25 for each use after
Presumptive Eligibility for Pregnant Women (PEPW)	None	None	None	None	None	None	None	None

Appendix C: Quantitative Treatment Limitations Analysis

Program	Inpatient		Outpatient		Pharmacy		Emergency Services	
	M/S	MH/SUD	M/S	MH/SUD	M/S	MH/SUD	M/S	MH/SUD
HIP Basic	90 days annual max for inpatient cardiac rehab 100 days skilled nursing facility/benefit period	None	100 home health visits /year 60 visits PT/OT/ST/cardiac rehab/year	None	30 days prescription supplies	30 days prescription supplies	None	None
HIP Maternity (Package A)	None	None	50 chiropractic office visits or treatments /year 1 full spinal x-rays/year Various dental limitations Various DME limitations Various audiology limitations Various vision limitations 6 routine foot care visits /year 16 units of DMST /year without PA	None	None	None	None	None
HIP Plus	90 days annual max for inpatient cardiac rehab 100 days skilled nursing facility /benefit period	None	100 home health visits /year 6 routine footcare visits /year 75 combined PT/OT/ST/cardiac rehab /year Specific vision and dental limits	None	90 days prescription supply	90 days prescription supply	None	None

HIP State Plan Basic	None	None	50 chiropractic office visits or treatments /year 1 full spinal x-rays/year Various dental limitations Various DME limitations Various audiology limitations Various vision limitations 6 routine foot care visits /year 16 units of DMST /year without PA	None	None	None	None	None
HIP State Plan Plus	None	None	50 chiropractic office visits or treatments /year 1 full spinal x-rays/year Various dental limitations Various DME limitations Various audiology limitations Various vision limitations 6 routine foot care visits /year 16 units of DMST /year without PA	None	None	None	None	None
Hoosier Care Connect	None	None	50 chiropractic office visits or treatments /year 1 full spinal x-rays/year Various dental limitations Various DME limitations Various audiology limitations Various vision limitations 6 routine foot care visits /year 16 units of DMST /year without PA	None	None	None	None	None
Hoosier Healthwise (Package A)	None	None	50 chiropractic office visits or treatments /year 1 full spinal x-rays/year Various dental limitations Various DME limitations Various audiology limitations Various vision limitations 6 routine foot care visits /year 16 units of DMST /year without PA	None	None	None	None	None

Hoosier Healthwise (Package C)	None	None	5 chiropractic visits; 14 procedures per 12 months	None	None	None	None	None
Presumptive Eligibility (Adult Population)	90 days annual max for inpatient cardiac rehab 100 days skilled nursing facility/benefit period	None	100 home health visits /year 60 visits PT/OT/ST/cardiac rehab/year	None	30 days prescription supplies	30 days prescription supplies	None	None
Presumptive Eligibility for Pregnant Women (PEPW)	None	None	None	None	None	None	None	None

Appendix D: Aggregate Lifetime and Annual Dollar Limit Analysis

Program	Inpatient		Outpatient		Pharmacy		Emergency Services	
	M/S	MH/SUD	M/S	MH/SUD	M/S	MH/SUD	M/S	MH/SUD
HIP Basic	None	None	None	None	None	None	None	None
HIP State Plan Basic	None	None	None	None	None	None	None	None
HIP State Plan Plus	None	None	None	None	None	None	None	None
Hoosier Care Connect	None	None	None	None	None	None	None	None
Hoosier Healthwise (Package A)	None	None	None	None	None	None	None	None
Hoosier Healthwise (Package C)	None	None	$2,000 per year/$5,000 per lifetime for DME	None	None	None	None	None
Presumptive Eligibility (Adult Population)	None	None	None	None	None	None	None	None
Presumptive Eligibility for Pregnant Women (PEPW)	None	None	None	None	None	None	None	None

- Noting the final definitions for the classifications (inpatient, outpatient, prescription drugs, emergency);
  - After much deliberation and consideration, the State has determined to retain the current definitions for Inpatient Services (405 IAC 5-2-12); Outpatient Services (405 IAC 5-2-19); Pharmacy Services (405 IAC 5-24-2); and Emergency Services (405 IAC 5-2-9).
- Changes to benefits or limits that have since been made to comply with parity (e.g., prior authorization for smoking cessation), including for CHIP:
  - Below is a list of changes made due to MHPAEA compliance by benefit package

Benefit Plan Name (Abbreviation)	MHPAEA Compliance Changes
All IHCPs	• Removal of the previously established requirement to obtain prior authorization (PA) if exceeding 180 days of tobacco cessation therapy • Removing PA for buprenorphine except buprenorphine films
Hoosier Healthwise (Package C)	• Removal of 50 Visit Limits for Physical Therapy; Occupational Therapy; Speech Therapy; and Respiratory Therapy • Submitted conforming rule changes to the Indiana Administrative Code. Rule is currently being reviewed by the State.
Adult Mental Health Habilitation (AMHH)	• The ability for additional units was implemented in the 04/01/2020 through prior authorization. The DMHA State Evaluation Team (SET) will review the prior authorization (PA) request accept or deny the request and then enter it into the DARMHA system which will trigger CoreMMIS.
Children's Mental Health Wraparound (CMHW)	• Still being discussed with DMHA. OMPP has reached out with one of our physicians on staff to provide answers to DMHA about how mental health parity will impact the CMHW program.
Behavioral and Primary Health Coordination (BPHC)	• Submitting amendment for BPHC to CMS on 07/01/2020. The DMHA State Evaluation Team (SET) will review the PA request accept or deny the request and then enter it into the DARMHA system which will trigger CoreMMIS. This amendment has a projected implementation date of 10/01/2020.

- Updates to the NQTL summary section to include any clarifications that were provided by the MCOs since the initial submission of this report.
    - The NQTL summary section has been updated with clarifications and additional information provided by the MCOs.