



"People
helping people
help
themselves"

Frank O'Bannon, Governor
State of Indiana

Indiana Family and Social Services Administration

402 W. WASHINGTON STREET, P.O. BOX 7083
INDIANAPOLIS, IN 46207-7083

Peter A. Sybinsky, Ph.D., Secretary

September 20, 1999

Richard Fenton, Deputy Director
Family and Children's Health Programs Group
The Health Care Financing Administration
7500 Security Boulevard
Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

Dear Mr. Fenton:

It is my pleasure to provide you with a copy of the State Plan Amendment for the Children's Health Insurance Program (CHIP). The State Plan Amendment pertains to Phase II of Indiana's CHIP program. The Phase I Medicaid expansion was already approved by HCFA in June of 1998 and will remain in place.

The CHIP Phase II program is a separate program that will be integrated into Hoosier Healthwise — Indiana's Medicaid managed care program. The Phase II CHIP program will utilize the same delivery system as Hoosier Healthwise, but will have some key differences primarily in the areas of eligibility, benefits and cost-sharing. The authorizing legislation mandated that the Phase II program shall be implemented (assuming federal approval) on January 1, 2000.

Indiana is eager to begin this new phase of coverage for targeted low-income children. We look forward to working with HCFA during this approval process. Please direct any inquiries to my office:

Children's Health Insurance Program
Mail Stop #07
FSSA
402 West Washington Street, Room W382
Indianapolis, IN 46204-2739
317-232-4305

Sincerely,

Nancy Cobb, Director
Children's Health Insurance Program

cc: Cheryl Tarver
Jean Hall

Equal Opportunity / Affirmative Action Employer



**INDIANA'S APPLICATION FOR
STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
STATE CHILDREN'S HEALTH INSURANCE PROGRAM**

Preamble

This draft model application template outlines the types of information that are likely to be included in the state child health plan required under Title XXI. It has been designed to reflect many of the requirements that will be necessary for state plans under Title XXI. It is not intended to be comprehensive or final. We provide it for preliminary guidance as well as to solicit additional information from states and other interested parties on the appropriate content.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like benefits definitions, maintenance of effort provisions, collection of baseline data, and methods for preventing substitution of new Federal funds for existing state and private funds. As such guidance becomes available, the model application template will be revised and finalized. We will work to distribute it in a timely fashion to provide assistance as states submit their state plans.

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

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

State/Territory: State of Indiana

As a condition for receipt of Federal funds under Title XXI of the Social Security Act,

Frank O'Bannon, Governor, State of Indiana

9/16/99
(Date Signed)

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours (or minutes) 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, please write to: HCEA, P.O. Box 28684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, DC 20503.

Proposed Effective Date January 1, 2000 2

Section 1. General Description and Purpose of the State Child Health Plans (Section 2101)

The state will use funds provided under Title XXI primarily for (Check appropriate **box**):

- 1.1. Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (Section 2103); **OR**
- 1.2. Providing expanded benefits under the State's Medicaid plan (Title XIX); **OR**
- 1.3. ^{*} A combination of both of the above. (Medicaid expansion under Phase I of the CHIP program was approved June 26, 1998. This State Plan Amendment pertains to Phase II of the program).

Section 2. General Background and Description of State Approach to Child Health Coverage
(Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

2.1. Health Insurance Coverage

Low-Income Children:

The total number of Indiana children under 19 is estimated to be between 1,536,000 and 1,595,000. This number varies depending upon which Census Bureau CPS data is utilized. The reported average of 1996, 1997 and 1998 CPS data indicates that there are 1,536,000 children under 19 in Indiana. Whereas, the reported average of 1995, 1996 and 1997 CPS data indicates that there are 1,595,000 children under 19 in the State.

Eighty-six percent of the children in Indiana are estimated to be Caucasian; 10% are estimated to be African-American; 3% are estimated to be Hispanic; less than 1% are estimated to be Asian; and less than 1% are estimated to be Native American.

Using the reported average of the 1996, 1997 and 1998 CPS data, it is estimated that there are 491,000 children in the State who are under 200% FPL.

Health Coverage of Low-Income Children:

The March 1999 Employee Benefit Research Institute (EBRI) analysis of the March 1998 CPS data found that the uninsured rate for children in Indiana was 12.4%. Approximately 121,000 of these uninsured children are below 200% federal poverty level (FPL).

It is estimated that about half of all uninsured children under 200% FPL reside in the five largest counties of the State. Certain other counties also have a high number of uninsured children.

Over 289,000 children in Indiana are currently enrolled in the Medicaid program. Approximately, 65% of these children are White, 29% Black, 5% Hispanic and less than 1% each are Native American and Asian. Over half of these children reside in the five largest counties in the **State**. The Medicaid expansion under the Phase I program and the heightened outreach program **has** resulted in a significant increase in the number of children enrolled in Medicaid. Since July 1, 1998, there has been a net increase of 85,310 children enrolled in Hoosier Healthwise (the State's Medicaid managed care program). More than 21,000 of these children became eligible **as** a result of the CHIP Phase I Medicaid expansion.

According to the EBRI July 1997 analysis of the March 1996 CPS data, 76.4% of children in Indiana are covered by private insurance. Sixty-eight percent of children are covered under employer-based plans, while the remaining 8.4% are covered by other private insurance plans. More recent data from the EBRI March 1999 analysis of the March 1998 CPS data indicate that the percentage of children covered by employer-based plans has increased to 72.5 percent. There are no data regarding private coverage of low-income children available at the present time.

2.2 Current State Efforts to Provide or Obtain Creditable Coverage for Uncovered Children

2.2.1. Current Strategies for Enrollment of Children in Public Health Insurance Programs.

Medicaid:

The primary public health insurance available in Indiana is through the Medicaid program. As was previously mentioned, over 289,000 children are currently enrolled in Medicaid under either Title XIX or Title XXI. In recent years, Hoosier Healthwise, a mandatory managed care program under Medicaid, has been phased-in. Hoosier Healthwise is comprised of a Primary Care Case Management (PCCM) system and a Risk-Based Managed Care (RBMC) system. Under both of these systems, primary medical providers (PMPs) provide preventive and primary medical care, and furnish authorizations and referrals for most specialty services. Children who became eligible for Medicaid through the Title XXI expansion under the first phase of Indiana's CHIP program have been integrated into these managed care networks.

Families of eligible children are given thirty days from the date of enrollment to choose a PMP. In cases where a family fails to choose a PMP within the thirty day time period, an assignment is made by the program. Enrollment in the PCCM system and the RBMC system is determined based upon which program the PMP participates. Where the PMP participates under the RBMC system, the child is enrolled in the RBMC system, and where the PMP participates under the PCCM system, the child is enrolled in the PCCM system. Families who wish **their** child to be enrolled in one of the specific systems choose a PMP who participates under that system.

Individuals currently apply for Hoosier Healthwise at one of the 487 enrollment centers or 120 Division of Family and Children (DFC) offices located throughout the State. Over 1,500 Public Assistance caseworkers have responsibility for processing Hoosier Healthwise applications. Individuals can apply at any of the various enrollment centers or file an application by mail. If a DFC caseworker is not on site, the application is forwarded to the local DFC office for authorization. In order to facilitate enrollment of eligible newborns, many local offices also have arrangements with the hospitals in their communities, whereby the hospitals inform the caseworkers of babies born to Hoosier Healthwise recipients. These children are enrolled in the program without the parent having to contact the DFC office. A more detailed discussion of enrollment can be found in Section 5.

Other Child-Related Programs:

There are a number of other public programs in Indiana that provide health related services to children. DFC caseworkers refer families for these services, where appropriate. As these child-related programs engage in outreach activities that target individuals eligible for the services they offer, they also strive to identify other programs for which the children may be eligible and to make the appropriate referrals.

The Healthy Families Indiana Program, a voluntary home visitation program, is designed to prevent child abuse and neglect by linking families to a variety of services, including child development, health care, and parent education programs. The Healthy Families Indiana Program strives to ensure that every child has a medical home and that every child has up to date immunizations. Healthy Families also makes referrals to Hoosier Healthwise and various other child-related programs in the State. Each individual community develops its own Healthy Families outreach plan.

The Children's Special Health Care Services (CSHCS) program is a supplementary program that provides medical assistance to approximately 8,000 families of children who have certain chronic medical conditions and who also meet medical and financial eligibility requirements. Children are referred to the CSHCS program by providers and by other programs throughout the State. CSHCS requires that children who apply for the program also apply for Medicaid. Children with special medical needs and their siblings who are eligible for Medicaid are identified by the CSHCS care coordinator when the care coordinator first receives the case and also during the annual re-evaluation. To help identify eligible children and to streamline administrative hurdles, the CSHCS program has developed a combined intake system with other public programs. Intake sites include the County Office of Family and Children; the county System Point of Entry; Riley Hospital, the State's children's hospital; as well as through the care coordinators. A pilot project has been set up through a SPRANS grant to use the combined enrollment form to take applications through select newborn intensive care units to try and identify special needs children early and to get them into care.

The Indiana Maternal and Child Health (MCH) program requires direct service grantees to facilitate their clients into Medicaid if they meet eligibility requirements. Children under 100% of poverty are served free of charge. MCH funds 22 child or adolescent health clinics and 4 school based health clinics. Services for children are also provided at other MCH sites. Forty-two of the 50 MCH grantees are Medicaid providers, and several of these act as PMPs under Hoosier Healthwise. Each individual MCH grantee handles its own outreach and marketing. Grant applications address collaborative efforts. The MCH grantees also document referrals to other programs on the encounter forms and enter that information into the project data base, so that follow-up can be performed during the next visit.

The MCH program also operates the Indiana Family Helpline which provides health care information and referrals through a toll free telephone number. The Family Helpline staff screen all clients for Hoosier Healthwise eligibility and provide appropriate referrals. MCH clinics also participate as Hoosier Healthwise enrollment centers. The Helpline is advertised through flyers distributed throughout the State. The telephone number is also included in mailings which are sent to consumers by the Family and Social Services Administration (FSSA).

Local Health Departments (LHDs) provide immunizations, lead screenings and other direct services to individuals throughout Indiana. Many of these activities are funded with federal and state dollars channeled through the Indiana State Department of Health (ISDH). Some LHDs have special staff dedicated specifically to outreach activities. The state is currently working to increase coordination between the ISDH lead screening and immunization programs and the Hoosier Healthwise program. Efforts are also being made to coordinate provider participation in the various programs.

Indiana has a Step Ahead initiative which is designed to develop, at the local level, comprehensive seamless delivery systems for children from birth to age thirteen. The initiative is designed to support county efforts to centralize programs in order to reduce duplication and fragmentation of services. Local Planning Councils work to address child issues in the community. At the state level, Step Ahead strives to coordinate funding streams and remove barriers that create problems for families and providers.

First Steps, Indiana's early intervention system for infants and toddlers who have developmental delays, brings together federal, state, local, and private funding sources in order to create a coordinated, community-based system of services. In each community, a "child find" system is developed and is utilized to identify, locate and evaluate children who are eligible for early intervention services. Networks of traditional and non-traditional providers are established. Providers in the networks include MCH programs; community mental health centers; Women, Infants and Children (WIC) programs; developmental disabilities agencies; MCH agencies; CSHCS programs; private health care providers; child care providers; United Way agencies; and independent providers and service coordinators. First Steps collaborates with the DFC by distributing information about the Hoosier Healthwise program.

Very important health care services for children are also provided by Community Health Centers (CHCs). These centers design their services around needs identified in their particular communities. Many of the CHCs engage in significant outreach activities and some serve as Hoosier Healthwise enrollment centers. A more detailed discussion of the activities of the CHCs can be found in Section 2.2.2.

Special Populations:

The State has several initiatives designed to assure that health services are provided to special populations. The ISDH has developed a collaboration with the Indiana Minority Health Coalition (IMHC) to promote healthy lifestyles through disease prevention and health awareness; and, to provide referrals, information services, community outreach, and program services. The ISDH provides the state and local Coalitions with funds for health promotion activities. The agency also collaborates with these coalitions on outreach activities for the immunization program and other programs administered by the agency. In addition, Indiana has developed statewide enrollment partnerships with Indiana Black Expo, the Wishard Hospital Hispanic Health Project and the Indiana Primary Health Care Association (IPHCA).

A Consolidated Outreach Project (COP) provides intake assessment for migrant farmworkers who enter Indiana for seasonal employment. The project is offered through a FQHC and is funded by the DOE, Department of Workforce Development, the Social Services Block Grant, and the Community Services Block Grant. Through the COP project, families are referred to the various health care programs and other programs for services while they are in the state. Additional information regarding this project may

be found in Section 2.2.2.

2.2.2. Public/Private Health Insurance Efforts

There are several current initiatives that provide health services to children through collaborative public and private efforts. These efforts include a collaboration between the ISDH and the IPHCA; managed care contracts between the Division of Mental Health (DMH) and managed care providers; and a health insurance high risk pool for medically challenged individuals that is financed through a partnership between the beneficiaries, the health insurance industry and the State. In addition, the Medicaid program and the CSHCS program may both be considered public/private initiatives due to the fact that these programs contract with private providers to provide services to beneficiaries. A more detailed discussion of Medicaid and the CSHCS program may be found in Section 2.2.1.

Another public/private initiative that increases access to care is the \$10,000,000 that the Indiana General Assembly budgets for the development of Community Health Centers. The ISDH allocates and administers this money.

Start-up and planning funds were provided in the 1995 biennium budget, and funds for expanding existing services, start-up and planning were provided in the 1997 and 1999 biennium budgets. Applicants for these funds were required to address community needs, special populations, and collaborative linkages. This arrangement was designed to improve access to primary health care programs for the medically underserved; individuals at poverty level; working poor; migrant and seasonal farmworkers; the homeless; and individuals who lack health care due to geographic, financial and/or cultural barriers. The ISDH also worked collaboratively with IPHCA to allocate funds that the General Assembly earmarked for CHCs. Overall, there are approximately 35 state and/or federally funded CHCs in Indiana. In 1996, the federally funded sites alone served over 28,000 children. Over 4,000 of the individuals served by these FQHCs were migrant farmworkers. The 1996 data indicate that approximately 59% of the clients served at the FQHCs are Caucasian, 27% African-American, 14% Hispanic, and less than 1% combined are Native American or Asian. The CHCs that are not federally funded also provide health services to the communities; however, such data are not currently available. The IPHCA also recently received a grant to promote the development of enrollment centers in federally qualified health centers (FQHCs). This grant is used to augment the state outreach efforts.

Many of the CHCs utilize outreach workers to market their services to potential clients in the individual communities. These outreach workers often go door to door to target potential clients. CHCs located in areas with high concentrations of Hispanics and migrant farm workers use Spanish speaking outreach workers and providers. As part of the COP partnership, the CHCs provide health services to migrant farmworkers.

The DMH has undertaken a collaborative effort with mental health providers throughout the state. The providers act as mini-HMOs in that they receive a payment up-front from the DMH, and, in return, provide a full array of mental health services to seriously emotionally disturbed children who are at 200% of poverty or below. The DMH is also involved in the Dawn Project, a collaborative effort with the DOE

Division of Special Education, the Marion County Office of Family and Children, the Marion County Superior Court Juvenile Division and the Marion County Mental Health Association. The goal of **this** pilot project is to provide community based services to children and youth in Marion County who **are** seriously emotionally disturbed and who are at imminent risk of long-term inpatient psychiatric hospitalization or residential care. Families are assigned a service coordinator who works with the family to design an array of services that meet the individual needs of the child and family. Referrals to the program come primarily from the Office of Family and Children, the DOE and the Juvenile **Court**.

A partnership between the health insurance industry and the State is the underlying principle behind the financing of an insurance risk pool for medically challenged individuals who are unable to obtain traditional health insurance. The Indiana Comprehensive Health Insurance Association (ICHIA), a private non-profit association created by the Indiana General Assembly, covers more than 100 children. State programs make referrals to ICHIA where appropriate. ICHIA is funded through premiums, and an assessment on insurance companies licensed in the State. Since the insurance companies are able to obtain a State tax credit for these assessments, the State is an important partner in this initiative **as** well.

2.3. Coordination of Title XXI Program with Current Efforts

CHIP Phase I:

The first phase of the Indiana Title XXI CHIP plan included a two part Medicaid expansion:

- Adding u(3) children (“Waxman Kids”) between the ages of 14 and 18 up to 100% of the FPL to the Medicaid program; and
- Expanding Medicaid to all children ages 0-18 up to 150% of the FPL.

The Phase I expansion, which was approved by HCFA on June 26, 1998, was designed to build upon the Medicaid program under Title XIX and the other child-related programs in the State. Enrollment in the Title XXI Medicaid expansion has been coordinated with the Medicaid enrollment process. The Medicaid eligibility determination system known **as** “ICES” (Indiana Client Eligibility System) reflects Title XXI **as** a separate eligibility category. ICES establishes an applicant’s category of assistance based upon a hierarchy that prioritizes categories with full coverage and the least restrictive eligibility requirements over other categories. Since the Title XXI category **is** lower in the hierarchy than the Title XIX poverty level categories, eligibility is first explored under the Title XIX categories, and only children with higher incomes who do not qualify for Title XIX are placed in the Title XXI category. Reevaluations are conducted on a quarterly basis for those receiving food stamps, and on an **annual** basis for those only eligible for Medicaid or CHIP.

Over the past two years, Indiana made considerable efforts to coordinate the CHIP program with existing public programs. A central theme underlying the DFC’s efforts to develop different enrollment center models was the importance of utilizing and building upon resources and programs from within each individual community. While local DFC directors were given considerable flexibility in fashioning enrollment center designs that are appropriate for the specific enrollment centers, they were also required

to consult with a myriad of entities in their community. These organizations included: Head **Start**, First Steps, community action programs, community health centers, childcare voucher agents, disproportionate share hospitals, WIC clinics, MCH clinics, county health departments, Planned Parenthood, schools and township trustees. The outstation model at Wishard Hospital, Indiana's largest public hospital, has been expanded so that hospital personnel will do the intake processing. A more detailed discussion of outstationing and information regarding outreach activities can be found in Section **5.1**.

Following the enactment of the federal CHIP program, Indiana established a state technical advisory group to enhance coordination between the various child-related programs in the State. Representatives at these weekly meetings included top executive staff of the CHIP, the Office of Medicaid Policy and Planning (OMPP), the DFC, the ISDH, the DMH, the Budget Agency and the Department of Insurance (DOI). In addition, recommendations regarding enhancing coordination between programs were made by the Governor's Advisory Panel on the CHIP and the Lewin Group, an outside consulting practice.

The Indiana Department of Education (DOE) includes a check-off box on its school lunch application form that allows families to communicate their interest in learning more about the Hoosier Healthwise program. This also serves as a means for enabling families to authorize the DOE to relay, to the DFC, the families' interest in the program. Many other programs in the State also collaborate with the DFC by distributing information about the Hoosier Healthwise program, educating families, and making referrals. These programs include: Head **Start** community mental health centers, energy assistance, IMPACT (welfare to work), child welfare, and domestic violence programs. Collaborations have also been undertaken with the Department of Workforce Development, the DOE, the Bureau of Motor Vehicles, the Department of Commerce, and the Juvenile Justice Institute. In addition, many State health and human service contractors also are required to inform families about the Hoosier Healthwise program, distribute program brochures, and refer families to the Helpline.

CHIP Phase II:

Phase II of the CHIP program, authorized by Public Law **273-1999** (Attachment B), will provide coverage to children less than nineteen years of age who are members of families with annual incomes greater than 150% FPL and not more than **200%** FPL, provided they meet certain other eligibility requirements. A more detailed discussion of eligibility can be found in Section **4**).

Phase II provides for a separate CHIP program that has different eligibility criteria, a separate benefits package, and imposes cost-sharing and other obligations and restrictions. In order to streamline the administration of the Phase II CHIP program, Public Law **273-1999** requires the administration of the CHIP program to be closely aligned with that of the Medicaid program. This statute mandates that CHIP, to the greatest extent possible, must utilize the same eligibility determination, enrollment, provider network and claims payment systems that are used by the Medicaid managed care program for children.

Thus, the second Phase of the Indiana Title XXI CHIP plan will be administered as part of the existing Hoosier Healthwise program and will be referred to as "Hoosier Healthwise Package C - Children's Health Plan". Since the administration of the CHIP and Medicaid programs will be closely coordinated, administrative hurdles and duplicity will be reduced, and coverage and coordination will be maximized.

Public Law **273-1999** also provides for a long-term mechanism for enhancing coordination between

CHIP and other programs serving children. A Children's Health Policy Board was mandated in order to direct policy coordination. The Policy Board, which meets monthly, is charged with examining issues such as: the development of a more appropriate delivery system and a more seamless system of care; maximizing efficiencies through the use of program funding; establishing the optimal provider participation in various programs; considering the potential for expanding health insurance coverage to other populations; examining the appropriate state organizational structure to implement health policy; and overseeing implementation of the CHIP program. The following individuals serve as members of the Policy Board: the Secretary of the FSSA, the State Health Commissioner, the State Insurance Commissioner, the State Personnel Director, the State Budget Director, the State Superintendent of Public Instruction, and the Director of the DMH.

In order to ensure that wrap around services are provided for children with special health care needs, Public Law 273-1999 also created an Advisory Committee for Children with special health care needs. One of the functions of the Advisory Committee is to advise and assist the Policy Board in developing, coordinating and evaluating policies that impact children with special needs, and to provide assistance with the integration of services. To further coordination between programs, the State is including information about CSHCS and First Steps in the Hoosier Healthwise provider manual, and is utilizing the benefit advocates to provide families of children with special needs with information about the CSHCS and First Steps programs.

Section 3. General Contents of State Child Health Plan (Section 2102)(a)(4))

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

- 3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children: **(Section 2102)(a)(4)**

Rather than duplicate the delivery system already in place for Indiana's Medicaid program, the new Phase II CHIP program will utilize the Hoosier Healthwise delivery system. Access to specialty care will be the same for CHIP as it is under Medicaid Hoosier Healthwise; the same services will be carved out of both Medicaid and CHIP; the same vendors will be used (except a premium vendor will also be utilized under CHIP); and all participating Medicaid providers, including clinics, will be considered providers under CHIP. The CHIP program will differ from the Medicaid component of Hoosier Healthwise primarily in the areas of eligibility, benefits and cost-sharing.

Hoosier Healthwise is divided into two systems: a PCCM system and a RBMC system. Both the PCCM system and the RBMC system are managed care programs that utilize PMPs to provide primary care services, make appropriate referrals for specialty services, and monitor health care utilization. Both of these programs, which operate under a 1915(b) waiver, require that health services be provided by either the PMP or another provider to whom the recipient was referred to by the PMP. Hoosier Healthwise currently has an extensive provider network in place, and the program continuously reviews provider network availability, member enrollment and expected member enrollment, to determine where provider participation needs to be increased. Still, there are several counties where the State wants to increase the number of PMPs serving the county.

Families of children enrolled in Hoosier Healthwise have 30 days to select a PMP from a list provided to them. Assistance in selecting a PMP and choosing between the various managed care options is provided by Benefit Advocates (BAs) in each county. If a family fails to make a selection, an auto-assignment is made which takes into consideration the family's geographic region, and, in cases of re-enrollment, the last provider of care. The auto-assignment rotates placements between the PCCM system and the RBMC system. With certain restrictions, opportunities are available for changing PMPs.

Providers who serve as PMPs may choose to participate in both the PCCM and the RBMC systems; however, they may accept new recipients in only one of the two systems at any given time. In the case of the RBMC system, PMPs may only participate in one managed care organization (MCO) in each region. With limited exceptions for former patients, new family members, and medically underserved areas, the PMP panel size is limited to a maximum of 2,000 combined Medicaid and CHIP recipients for both the RBMC system and the PCCM system together. PMPs are expected to accept a minimum of 150 enrollees, and must be available to see patients at least 20 hours per week, with certain exceptions. In addition, PMPs, or their clinically qualified designees, must be available 24 hours a day, 7 days a week. The 24 hour number is monitored randomly to assure compliance with this requirement.

There are currently 1941 PMPs enrolled throughout the state, 1433 in the PCCM system and 508 in the RBMC system. To serve as a PMP, a physician must be in one of the following specialty areas: family practice, pediatrics, general practice, obstetrics/gynecology or internal medicine. PMPs can practice in any setting, including in FQHCs.

PMPs are available to enrollees in every county in the State. Between June of 1998 and June of 1999, almost 110 PMPs have joined the Hoosier Healthwise program. Targeted recruitment efforts are currently being focused on several counties where the State wants to increase the numbers of PMPs serving the county. For these counties, new enrollees may either remain in the fee for service program whereby they can access any Medicaid enrolled physician, or choose PMPs in contiguous counties.

The PMP to recipient ratio is currently approximately 231 enrollees for every PMP. Public Law 273-1999 mandates that providers who participate under the Medicaid program are also considered to participate under the CHIP program. Even if all of the estimated eligible children were to enroll in CHIP and Medicaid, the average enrollment per PMP would still be significantly below the maximum PMP panel size.

PCCM System:

The PCCM system, called Primestep, is composed of PMPs who practice in the various counties throughout the state. PMPs who participate under PrimeStep must comply with the PMP standards addressed above.

Providers who choose to participate in the PCCM program enroll directly through the State. These providers receive a patient management fee of \$3 per month for each enrollee. Reimbursement for health care services is paid on a fee for service basis.

RBMC System:

Under the RBMC system, the OMPP contracts, through a competitive bidding process, with MCOs to provide health care services for Medicaid recipients enrolled in their managed care plan. Providers who serve as PMPs under the RBMC program enroll directly with the individual MCOs. Each MCO is paid a fully capitated rate per enrollee. The OMPP and the DOI regulate MCOs' fiscal solvency by establishing minimum net worth and reserve amounts. The OMPP is also responsible for monitoring the contractors and providing quality assurance.

Indiana is currently contracting with two MCOs: Maxicare Indiana in the Northern, Central and Southern regions of the State, and Managed Health Services in the Central region.

MCOs who participate under the RBMC system must have a provider network that is capable of offering quality care and meeting the needs of recipients within the region. MCOs must ensure that they have a comprehensive network development plan in place and that the participating PMPs have 24 hour coverage available 7 days a week. The MCOs must target areas where further network development is needed, prioritize target areas and establish workcharts with project completion timelines. The development plans must be updated quarterly. Special priority must be given to

network development in rural areas.

MCOs must also have a process in place for handling the differing needs of enrollees based on culture, race, disability and language. In addition, MCOs are required to have credentialing policies in place, and procedures for monitoring and sanctioning providers. Where MCOs fail to comply with contract requirements, the State can impose liquidated damages, suspend monthly premium payments and/or suspend the right to enroll new participants,

Indiana will not utilize the 10 percent set aside for service delivery this year because such funds will be needed for administrative start-up costs of the Phase II program.

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children: (Section 2102)(a)(4)

Hoosier Healthwise has a number of utilization control mechanisms in place that are designed to ensure that health care use is appropriate and medically necessary. These mechanisms will be utilized under Phase II of the CHIP program.

Indiana utilizes the Medicaid Management Information System (MMIS), developed by the United States Department of Health and Human Services, to control program costs and increase efficiency within the Hoosier Healthwise program. The MMIS contains a Surveillance and Utilization Review (SUR) Retrospective Analysis Management System (RAMS 11) subsystem, which together with the IndianaAIM system (Indiana's MMIS), provides a comprehensive method for conducting utilization review and program management. Under this system, computerized reports are generated that provide a statistical profile of provider practices and recipient utilization. The system allows for the flagging of areas where there is deviation from peers. Rankings are made to indicate which individuals have the greatest amount of deviation. SUR analysts work with the Associate Medical Director, and further action is taken where warranted. The objective is for misuse of health services to be identified, investigated, and corrected. Provider desk reviews are conducted based upon Federal and State requirements, and prepayment review and other action is taken where warranted. Recipient restricted card procedures are implemented in cases of recipient overutilization.

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

The managed care system established under Hoosier Healthwise also has some built in utilization controls. The PMP serves as a gatekeeper who provides or authorizes primary care services and makes referrals for specialty care (except those which may be self-referred) where appropriate. Referrals must be documented in the patient's medical record.

In addition, MCOs are required to have written utilization review (UR) programs in place. The

program must include a utilization review committee directed by the Medical Director of the MCO; utilization management practices that conform to industry standards; and resources for evaluating, and, if necessary, modifying the UR process.

In order for the State to track expenditures and service utilization in the RBMC program, shadow claims are required to be reported for patient encounters. The shadow claims provide details regarding diagnoses, procedures, place of services, billed amounts and providers.

Section 4. Eligibility Standards and Methodology. (Section 2102(b))

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 5.

- 4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section 2102)(b)(1)(A))
- 4.1.1. Geographic area served by the Plan: Not applicable.
- 4.1.2 *Age: Children must be less than 19 years of age.
- 4.1.3 * Income: Family income must be more than 150% of FPL to no more than 200% FPL. Families with higher incomes will be subject to higher premiums. (A more detailed discussion on cost sharing can be found in Section 8).
- 4.1.4 Resources (including any standards relating to spend downs and disposition of resources): Not applicable.
- 4.1.5 *Residency: Children must be residents of Indiana.
- 4.1.6 Disability Status (so long as any standard relating to disability status does not restrict eligibility): Not applicable.
- 4.1.7 *Access to or coverage under other health coverage: Children cannot have other creditable health care coverage. A three-month waiting period from the date the child was last covered will be imposed. Exceptions to the waiting period will be provided if the coverage was lost involuntarily (such as through the loss of employment, divorce etc) or if the child was previously covered by Medicaid.
- 4.1.8 *Duration of eligibility: Children are eligible for the earlier of 12 months following eligibility determination or until they reach age 19. Families will be asked to notify their caseworker if health insurance coverage is obtained during the continuous eligibility period. Also, if during the third party liability (TPL) matching process, it is discovered that a child obtains other health coverage, an alert will be sent to the caseworker so that eligibility can be redetermined. (A more detailed discussion of TPL can be found in Section 4.4.1)
- 4.1.9 *Other standards (identify and describe): To be eligible for Phase II of CHIP, families must agree to cost-sharing requirements. The CHIP program is also permitted to adjust eligibility requirements based upon available resources.

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: **(Section 2102)(b)(1)(B))**

- 4.2.1. * These standards do not discriminate on the basis of diagnosis.
- 4.2.2. * Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
- 4.2.3. * These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment.
(Section 2102)(b)(2))

The application process and eligibility determination process for Phase II of the CHIP program will be integrated into the application and eligibility determination process for Hoosier Healthwise. The two page Hoosier Healthwise enrollment form and the accompanying enrollment book will be modified to include the Phase II CHIP program. Families who apply for benefits will be advised of the cost sharing requirements under CHIP II (or Package C), and, to be considered for eligibility under CHIP II, they must sign a statement indicating that they agree to meet the cost-sharing requirements if the child is found eligible.

Eligibility determinations for CHIP Phase II will be made by the DFC. The DFC already has responsibility for eligibility determinations under Title XIX and under the Medicaid expansion under CHIP Phase I. Since the same application form, income definition, and income methodologies will be utilized, administrative efficiencies will be enhanced. Applicants will first be screened for eligibility under Title XIX, and if found ineligible, they will be screened for eligibility under Title XXI. A more detailed discussion of the screening process can be found in Section 2.3.

Before an application will be approved, income of a parent or guardian must be verified by supporting documentation from the payer. Acceptable items for verifying earnings include: paystubs, statements from employers, or a wage verification form that is completed by employers.

When it is determined that a child is eligible for the Phase II program, a conditional approval notice will be sent to the family and a record will be sent to the premium collection vendor. Once the first premium payment is made, the child becomes enrolled in the program. A detailed discussion of cost-sharing responsibilities and the premium payment process can be found in Section 8.

As required by the Balanced Budget Act (BBA), Indiana will conduct follow-up screening to identify when coverage is available through another plan. Although 12 months continuous coverage is going to be provided (see Section 4.1.8), families will be required to notify the State if other health coverage is obtained. CHIP coverage will be discontinued beginning the day the child receives other creditable coverage. As described in Section 4.1.8 and 4.4.1, TPL matches will be conducted as a mechanism

for detecting whether health coverage has been obtained during the continuous eligibility period.

4.4. Describe the procedures that assure:

4.4.1. Through intake and follow-up screening, that only targeted low-income children who are ineligible for either Medicaid or other creditable coverage are furnished child health assistance under the state child health plan. (Section 2102)(b)(3)(A))

All individuals who apply for CHIP will first be screened for Medicaid eligibility under Title XIX. Since the CHIP categories are lower in the hierarchy than the Title XIX categories, eligibility for Title XXI will be explored only after it is determined that a child is not eligible under Title XIX. (For a more detailed discussion, see Section 4.4.2).

Steps will also be taken to ensure that children enrolled under Title XXI do not have other health insurance. At the time of application and upon re-certification, families will have to attest to the fact that the child does not have other health insurance, and will also be required to specify when coverage was last provided. To qualify for CHIP (or Package C), the child must not have had creditable health insurance during the previous three months, unless the child was involuntarily dropped from the plan or the child was previously covered under Title XIX. Since ICES captures data regarding the employment of the applicants' parents, the system will detect children who are ineligible for CHIP due to their eligibility for dependent coverage under the state employee health plan.

As a method of further ensuring that only targeted low income children receive services under the program, the state will conduct TPL data matches to help detect coverage under other plans. Three primary methods of third party liability policy gathering will be utilized: absent parent data match using data from the State Wage Information Collection Agency; a match with data from the Department of Defense that shows CHAMPUS coverage for dependents, and a match through Health Management Systems which matches claims information from the IndianaAim system with insurance information from private insurance policies. The State will utilize the employment section of the application form to identify children who are eligible for dependant coverage under the state employees health plan.

4.4.2. That children found through the screening to be eligible for medical assistance under the state Medicaid plan under Title XIX are enrolled for such assistance under such plan. (Section 2102)(b)(3)(B))

All children who apply for Hoosier Healthwise are screened for Medicaid eligibility under Title XIX, and, if found eligible, are enrolled under the Title XIX program. The Title XXI CHIP program are new categories in the ICES eligibility determination system. As discussed in Section 2.3, the ICES system establishes an applicant's category of assistance based upon a hierarchy of eligibility categories. The CHIP categories are lower in the hierarchy than the Title XIX categories, and, thus, eligibility is first explored under the Title XIX categories, and only those children with higher incomes who do not qualify under Title XIX are considered for the Title XXI program.

Children who are found not eligible for Medicaid under Title XIX, are enrolled in the Title XXI Medicaid expansion if they are up to 150% FPL and do not have other insurance. Title XIX, rather than Title XXI, is used to provide services for children who are under 150% FPL but who have other health insurance. The enhanced match does not apply for these children since they do not fall under the targeted low-income definition due to their other insurance coverage. Children who are above 150% but not more than 200% FPL, who do not have other health coverage and who meet the other CHIP eligibility requirements, will be enrolled in the Phase II CHIP program if they agree to the cost sharing obligation. *for children insured*

4.4.3. That the insurance provided under the state child health plan does not substitute for coverage under group health plans. (Section 2102)(b)(3)(C))

Indiana has instituted a number of mechanisms designed to address crowd out. To ensure that CHIP Phase I and Phase II enrollees do not have other health insurance, the State will require that all CHIP recipients attest to the lack of current health care coverage and specify the date of last coverage. Since Phase I of the CHIP program limited family income to 150% of poverty, crowd out is not a significant issue because many of the lower income families do not have the option of employer-based health insurance. Crowd out is of greater concern under Phase II due to the higher income threshold. As such, Indiana will institute waiting periods and premiums as crowd out deterrents under the Phase II program.

As an additional crowd out deterrent, provisions included in Public Law 273-1999 prohibit insurers from knowingly or intentionally referring children covered under their dependent coverage policies to the CHIP program. A more detailed discussion regarding crowd out can be found in Section 5.2).

4.4.4. The provision of child health assistance to targeted low-income children in the state who are Indians (as defined in section 40 of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c). (Section 2102)(b)(3)(D))

Indiana has contracted with the IMHC to assure health assistance to targeted low-income children who are Indians. The IMHC has a local Native American coalition which is working closely with the IMHC and the State to develop culturally sensitive materials targeting a Native American audience. The State will continue to engage in collaborations with the Native American Minority Health Coalition to assure that Native American children who are eligible for the program receive assistance.

4.4.5. Coordination with other public and private programs providing creditable coverage for low-income children. (Section 2102)(b)(3)(E))

As described in detail in Sections 2.3 and 3, the CHIP Phase II program, the CHIP Phase I Medicaid expansion, and the Title XIX Medicaid program will all be closely coordinated. Individuals who

apply for benefits will be considered for each of the programs. Since Phase II of the CHIP program will be a component of Hoosier Healthwise, the Phase II CHIP program will utilize the same delivery system as is already in place for Medicaid. The goal is to provide a medical home for each child, and to establish a seamless system of care.

Efforts are underway to coordinate CHIP with the CSHCS and First Steps programs so that children with special needs are able to receive the various services they require. Coordination with other programs will be enhanced through the efforts of the Children's Health Policy Board which is charged with overseeing the implementation of the CHIP program and with enhancing coordination among the various programs serving children. A more detailed discussion regarding the Policy Board's coordination responsibilities can be found in Section 2.3).

As discussed in Section 5, Indiana has taken significant steps to coordinate CHIP outreach and enrollment with that of other public and private programs throughout the State. These endeavors have utilized a myriad of public and private entities to maximize the number of individuals reached, and to make the enrollment process convenient for families.

Section 5. Outreach and Coordination (Section 2102(c))

5.1. New Outreach Strategies

In order to reach out to families of children eligible for Hoosier Healthwise, and to encourage them to enroll their children, Indiana recently implemented new outreach strategies which built upon efforts already underway in the State. The State's goals were to: encourage simplicity, establish processes that are convenient for families, and eliminate duplicative interviewing.

Central Office Activities:

The central DFC office has taken a number of steps to strengthen outreach and increase enrollment. These efforts include: issuing a new policy directive regarding enhancing outreach and enrollment; analyzing the number of uninsured children per county; reviewing equipment specifications and technical needs so that local providers and agencies who want to partner with the State can purchase compatible equipment; developing a simplified shortened Hoosier Healthwise application form; including Hoosier Healthwise on a joint application that allows families to apply for Hoosier Healthwise at the same time that they apply for other programs; developing program brochures, posters, and mail-in application booklets in English and Spanish; delinking Hoosier Healthwise from TANF in the computer system; redesigning the membership card so that enrollees can be proud to carry the card; undertaking a media campaign designed to inform the public about the availability of the Hoosier Healthwise program; creating a new training curriculum for caseworkers and other individuals; coordinating the heightened outreach campaign among the various state agencies; promoting the new outreach efforts at a myriad of community service and health service meetings; and establishing a significant presence at Indiana Black Expo and the state and county fairs. The presence at the county fairs is especially helpful in providing outreach in rural areas of the State.

The DFC also met with individuals representing hospitals, schools, health centers and social service agencies to discuss collaborative outreach and enrollment center opportunities that may exist. These discussions led to the development of a number of models that could be utilized in different communities and in different types of settings. These models range from a co-location to a partnership where a facility hires a full-time employee to collect the necessary application information. The goal is for the information to be obtained, verified and collected by a person at the enrollment center location. This information will then be forwarded to the local DFC office for evaluation and authorization. If all of the necessary documents are submitted by the enrollment center worker, the caseworker will authorize the case within twenty-four hours.

Local Efforts:

While the new policy directive was developed by the central DFC office, much of the responsibility for developing and implementing specific efforts was given to the DFC directors in the individual counties. Every DFC director was given a county-specific enrollment target and was furnished a list of names of individuals and entities who they were required to contact to discuss outreach and enrollment center opportunities. The county directors are responsible for working with these and other potential partners in the individual communities, and for fashioning enrollment centers that meet the needs of the individual communities and the particular partners. This local design responsibility is

especially important in rural areas where different outreach strategies may have to be utilized. The county directors were also required to develop local outreach plans geared to the specific communities. These plans were developed with input from the local office staff, local welfare planning councils, local health departments, local health care providers, Step Ahead Councils, and other community planning boards that address children's issues. In order to carry out their new responsibilities, each county director was given a specific outreach appropriation for advertising and information distribution. A temporary executive position was created at the central DFC office to coordinate the outreach and outstationing activities throughout the state.

The county directors' increased involvement with their communities has enhanced their ability to connect children with other appropriate child-related programs in Indiana. It has also provided them with new opportunities to coordinate Hoosier Healthwise outreach with outreach for other child-related programs.

State and Local Collaborations:

The State is also working with eight community coalitions on a three year Robert Wood Johnson (RWJ) *Covering Kids* outreach grant which targets hard to reach populations. Grant funds were recently received and coalition kick-offs are being undertaken. Some of these communities are also seeking to raise other funds to augment RWJ funding

Provisions designed to encourage outreach at the community level are included in Public Law **273-1999**. The statute provides that the CHIP program may contract with community entities for services such as outreach and enrollment, and consumer education.

Special Populations:

The State has contracted with Black Expo, the IMHC, and the Wishard Hospital Hispanic Health Access Initiative to develop culturally sensitive materials and to implement outreach initiatives. The **COP** will also continue to be utilized to provide outreach for children in families of migrant farmworkers.

5.2. Coordination of the administration of this program with other public and private health insurance programs:

Crowd Out:

Indiana's Title XXI Medicaid expansion, under Phase I of the State's CHIP plan, limited family income to 150% of poverty. This serves as an indirect measure to address crowd-out as many of the lower income families do not have the option of employer-based health insurance. Since a higher income threshold is used under the CHIP Phase II program, crowd out is of greater concern. Therefore, Indiana invested considerable time examining various crowd out deterrents that could be utilized under Phase II.

A Subcommittee of various experts was formed to address eligibility and crowd out issues. Michael Birnbaum, an expert on crowd out issues from the Alpha Center was also consulted. After a rather extensive analysis, the State decided to utilize, for the Phase II program, two primary mechanisms for addressing crowd out: premiums and waiting periods.

Under Phase II, sliding scale premiums for those above 150% of FPL will be imposed. This will ensure that children of families with lower incomes will be favored over children of families with higher incomes. With certain exceptions for those who lose coverage involuntarily, a three month waiting period will also be required to be met before individuals who previously had creditable health coverage are able to enroll in the program. These two mechanisms will provide appropriate disincentives for substituting CHIP coverage for employer based coverage.

Administration of the Federal Allocation:

The FSSA has modified ICES, IndianaAIM FSSA's cost allocation plan, and other related systems to correctly reflect expenditures eligible for reimbursement from Indiana's federal CHIP allocation.

Coordination of Administration:

By integrating CHIP and Medicaid outreach efforts, developing a joint application form, utilizing a Medicaid expansion approach for Phase I of the CHIP program, and integrating the administration and delivery systems of the Phase II CHIP program into the Hoosier Healthwise program, the State will assure that the CHIP and Medicaid programs are closely coordinated. The newly created Policy Board will also be a key tool for enhancing coordination between programs.

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)
Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 7.

- 6.1. The state elects to provide the following forms of coverage to children:
(Check all that apply.)
- 6.1.1. Benchmark coverage; (Section 2103(a)(1))
 - 6.1.1.1. FEHBP-equivalent coverage; (Section 2103(b)(1))
(If checked, attach copy of the plan.)
 - 6.1.1.2. State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)
 - 6.1.1.3. HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)
 - 6.1.2. * Benchmark-equivalent coverage; (Section 2103(a)(2)) Specify the coverage, including the amount, scope and duration of each service, **as well as** any exclusions or limitations. Please attach signed actuarial report that meets the requirements specified in Section 2103(c)(4). **See instructions.** (See Attachment C, benefits package, and Attachment D, actuarial report)
 - 6.1.3. Existing Comprehensive State-Based Coverage; (Section 2103(a)(3)) [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If "existing comprehensive state-based coverage" is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value **as** of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for "existing comprehensive state-based coverage."
 - 6.1.4. Secretary-Approved Coverage. (Section 2103(a)(4))

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

For discussion of scope of services, amount, duration, exclusions and limitations, see Attachment C.

- 6.2.1. * Inpatient services **(Section 2110(a)(1))**
- 6.2.2. * Outpatient services **(Section 2110(a)(2))**
- 6.2.3. * Physician services **(Section 2110(a)(3))**
- 6.2.4. * Surgical services **(Section 2110(a)(4))**
- 6.2.5. * Clinic services (including health center services) and other ambulatory health care services. **(Section 2110(a)(5))**
- 6.2.6. * Prescription drugs **(Section 2110(a)(6))**
- 6.2.7. * Over-the-counter medications **(Section 2110(a)(7))** Coverage only applies to insulin.
- 6.2.8. * Laboratory and radiological services **(Section 2110(a)(8))**
- 6.2.9. * Prenatal care and pre-pregnancy family services and supplies **(Section 2110(a)(9))**
- 6.2.10. * Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services **(Section 2110(a)(10))**
- 6.2.11. * Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services **(Section 2110(a)(11))**
- 6.2.12. * Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) **(Section 2110(a)(12))**
- 6.2.13. * Disposable medical supplies **(Section 2110(a)(13))** Coverage subject to limitations.
- 6.2.14. * Home and community-based health care services **(Section 2110(a)(14))**
- 6.2.15. * Nursing care services **(Section 2110(a)(15))**
- 6.2.16. * Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest **(Section 2110(a)(16))**
- 6.2.17. * Dental services **(Section 2110(a)(17))**

- 6.2.18. * Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))
- 6.2.19. * Outpatient substance abuse treatment services (Section 2110(a)(19))
- 6.2.20. Case management services (Section 2110(a)(20)) Not covered.
- 6.2.21. Care coordination services (Section 2110(a)(21)) Not covered.
- 6.2.22. * Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
- 6.2.23. * Hospice care (Section 2110(a)(23))
- 6.2.24. * Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (Section 2110(a)(24))
- 6.2.25. Premiums for private health care insurance coverage (Section 2110(a)(25)) Not covered.
- 6.2.26. * Medical transportation (Section 2110(a)(26))
- 6.2.27. Enabling services (such as transportation, translation, and outreach services (Section 2110(a)(27)) Not covered.
- 6.2.28. * Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))

- 6.3. **Waivers - Additional Purchase Options.** If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate waiver. Review and approval of the waiver application(s) will be distinct from the state plan approval process. **To** be approved, the state must address the following: (Section 2105(c)(2) and(3)) .

Not applicable.

- 6.3.1. **Cost Effective Alternatives.** Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following:
- 6.3.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; **Describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.28.** (Section 2105(c)(2)(B)(I))
- 6.3.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; and **Describe the cost of such coverage on an average per child basis.** (Section 2105(c)(2)(B)(ii))
- 6.3.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923 of the Social Security Act. **Describe the community based delivery system.** (Section 2105(c)(2)(B)(iii))

6.3.2. **Purchase of Family Coverage.** Describe the plan to provide family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: (Section 2105(c)(3))

6.3.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and **(Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.)** (Section 2105(c)(3)(A))

6.3.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B))

Section 7. Quality and Appropriateness of Care

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 8.

- 7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (2102(a)(7)(A))

Indiana will utilize a number of different strategies to assure quality and appropriateness of care under Phase II of the CHIP program. The State is contracting with an evaluation consultant who will develop performance criteria, and also provide assistance in designing the evaluation and annual reports. The performance criteria will be an important tool for measuring quality of care, particularly with respect to well-baby care, well-child care, and immunizations. A more detailed discussion of performance measures and the evaluation consultant can be found in Section 9.

Quality assurance requirements are imposed on MCOs that contract with the State under Hoosier Healthwise. MCOs must have quality improvement (QI) programs in place that meet the federal requirements (42 CFR 434.34) and the National Committee for Quality Assurance (NCQA) standards. The QI programs must be based on annual plans that are approved by the OMPP. In addition, MCOs must meet a number of other QI requirements, including: establishing a QI Committee overseen by the MCO Medical Director; submitting Quarterly QI reports; conducting focused studies, including medical data abstraction and data entry, in areas of clinical priority for the Indiana Medicaid population; establishing internal systems for monitoring services; conducting a quality of care chart audit of providers of services; attending monthly Hoosier Healthwise Quality Improvement Committee (QIC) meetings; submitting QI data to the State; and taking other steps to improve quality of services.

Will the state utilize any of the following tools to assure quality?

7.1.1. * Quality Standards:

- MCOs that provide services under Hoosier Healthwise must have QI programs in place that meet NCQA standards.
- PMPs will be required to comply with universally accepted standards for preventive care, as endorsed by the American Academy of Pediatrics, the Academy of Family Physicians, the American College of Obstetrics and Gynecology, and the American Society of Internal Medicine. Specifically, these standards apply to the following areas: childhood immunizations, pregnancy, lead toxicity, comprehensive well child periodic health assessment, HIV status, asthma, diabetes, ETOH and drug abuse, sexually transmitted diseases, motor vehicle accidents, pregnancy prevention, prevention of influenza, smoking prevention and cessation, and others. Clinical practice guidelines from the Agency for Health Care Policy and Research and the Indiana Medicaid Coordinated Care Technical Assistance Group (TAG) may also be recommended.

- Through the Clinical Advisory Committee, providers provide the OMPP with input on Hoosier Healthwise policies affecting quality, accessibility, appropriateness and cost effectiveness of care.
- e The Hoosier Healthwise QIC oversees quality of care and appropriateness of care and integrates the quality improvement process. The QIC membership consists of MCO medical directors, MCO QI staff representatives, the OMPP staff members, and representatives of Health Care Excel and Lifemark. MCOs must provide the QIC with monthly reports regarding inquires made through the plans' toll free numbers and provide a status update on all grievances.
- e Requests to disenroll are documented, tracked and monitored.

7.1.2. * Performance measurement:

- MCOs must conduct annual member satisfaction surveys, and present this information to the OMPP, recipients and providers.
- The State conducts annual recipient surveys.

During focus studies, MCOs must comply with HEDIS measures.

- e The evaluation consultant will develop performance criteria to measure the quality of services provided under CHIP. These measurements will include health status indicators and EPSDT compliance.

7.1.3. * Information strategies:

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

7.1.4. * Quality improvement strategies:

- The State has a toll free 1-800 telephone number for recipients and providers. Staff investigates inquires and complaints received through this phone line.

- The State monitors PMPs 24-hour accessibility by making random calls to PMPs during regular business hours and after hours.
- The State monitors several key indicators to assure that access problems do not arise. These indicators include: waiting periods; access to care after hours; referrals to specialists; and access to emergency or family planning services.
- MCOs must conduct focus studies on areas of clinical priority.

7.2. Describe the methods used, including monitoring, to assure access to covered services, including emergency services. (2102(a)(7)(B))

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

Since the number of panel slots available exceeds the number of individuals that would be expected to enroll in both the CHIP and Medicaid components of Hoosier Healthwise, Indiana expects there to be sufficient providers available to serve all CHIP enrollees. The State will monitor panel size and PMP to recipient ratio to ensure that there is not a problem. For the counties where there is a concern about the number of PMPs participating in Hoosier Healthwise, the State will continue to provide targeted recruitment efforts and take other steps to make certain that enrollees are able to access services. For a more detailed discussion regarding sufficiency of participating providers, see Section 3.

Section 8. Cost Sharing and Payment (Section 2103(e))

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

8.1. Is cost-sharing imposed on any of the children covered under the plan?

8.1.1. * YES

8.1.2. NO, skip to question 8.5.

8.2. Describe the amount of cost-sharing and any sliding scale based on income:
(Section 2103(e)(1)(A))

8.2.1. Premiums

Sliding scale premiums (see chart below) will be imposed on families of children eligible for Title XXI under Phase II of the program. Cost-sharing for these families (with incomes above 150% of FPL), will not exceed five percent of the family's yearly income. Individuals eligible under Phase I of the program (with incomes up to 150% of FPL) will continue to comply with cost-sharing limitations established under Medicaid. Phase II applicants will be given the option of paying their premiums on a monthly, quarterly, or annual basis. Discounts will be provided for fees paid annually and quarterly.

At the time of application, applicants must sign a statement agreeing to fulfill any cost-sharing responsibilities. If they are unwilling to sign this statement, they will be informed that they may still be eligible for Medicaid (including the Medicaid expansion under Phase I), but will not be eligible for the CHIP Phase II program. If the applicant agrees to the cost sharing responsibilities, and is determined to be eligible for CHIP II (or Package C), ICES holds the account in suspense, and information regarding the eligibility status and cost-sharing responsibilities is transferred to the premium-collection vendor. The premium-collection vendor issues a premium statement and provides detailed information regarding the cost-sharing requirements.. If the premium is paid by the due date, the premium-collection vendor transfers this information to ICES and the applicant's account is changed from suspended status to enrolled. The applicant becomes retroactively eligible for CHIP coverage beginning the first day of the month the application was submitted to the DFC.

If the premium is not paid by the due date (the 14th day of the month following eligibility determination), the applicant's ICES account will remain in suspense and a second premium notice will be sent. If the premium has not been paid by the last day of the month following eligibility determination, the applicant will be notified that the application has been denied.

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

grace period, the child will be disenrolled from the program. The child will be re-enrolled without having to go through the eligibility verification process if the outstanding payments are made within the 12 month continuous eligibility period.

PREMIUMS

Income (as a percent of FPL)	Monthly <i>One Child</i>	Monthly <i>Two or More</i>	Quarterly <i>One Child</i>	Quarterly <i>Two or More</i>	Annually <i>One Child</i>	Annually <i>Two or More</i>
<i>150 to 175 percent</i>	\$11	\$16.50	\$31.50	\$47.25	\$120	\$180
<i>175 to 200 percent</i>	\$16.50	\$24.75	\$47.25	\$71	\$180	\$270

8.2.3. Coinsurance:

Copayments for certain services will be imposed under the Phase II program. (See chart below). These copayments will be established primarily as a utilization control mechanism. Providers will be responsible for collecting these nominal copayments.

Service	Copayment
Prescription Drugs — Generic, Compound and Sole-Source	\$3
Prescription Drugs — Brand Name	\$10
Emergency Ambulance Transportation	\$10
Emergency Room Visit that does not result in Hospitalization	\$20

8.2.4. Other:

Not applicable

8.3. Describe how the public will be notified of this cost-sharing and any differences based on income:

A number of methods will be utilized to inform the public about cost-sharing requirements under CHIP. These include:

- notice in the Hoosier Healthwise brochure;
- notice in the application form (if the family does not agree to the cost-sharing requirements under CHIP II, the child will be considered only for Medicaid and will not be considered for CHIP II);
- notice in the conditional approval form which is sent to the family after the child is found conditionally eligible for CHIP but before the family has received the premium notice;
- notice in the first premium voucher which is sent to the family by the premium collection vendor; and
- notice in the members' handbooks which are sent once the first premium has been paid and the child has been enrolled.

8.4. The state assures that it has made the following findings with respect to the cost sharing and payment aspects of its plan: (Section 2103(e))

- *
8.4.1. Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B))
- *
8.4.2. No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2))
- *
8.4.3. No child in a family with income less than 150% of the Federal Poverty Level will incur cost-sharing that is not permitted under 1916(b)(1)
- *
8.4.4. ~~NO~~ Federal funds will be used toward state matching requirements. (Section 2105(c)(4))
- *
8.4.5. No premiums or cost-sharing will be used toward state matching requirements. (Section 2105(c)(5))
- *
8.4.6. No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title.
(Section 2105(c)(6)(A))

- 8.4.7. * Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1))
- 8.4.8. * No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or **if** the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B))
- 8.4.9. * No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except **as** described above). (Section 2105)(c)(7)(A))

8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family’s annual income for the year involved: (Section 2103(e)(3)(B))

Since the cost-sharing requirements imposed under the Phase II program are set relatively low, a formal tracking mechanism **for** the 5 percent cost-sharing maximum will not be necessary. As an additional precaution, however, Indiana will utilize a “shoe box” approach, similar to that used by the Massachusetts CHIP program. In cases where the 5 percent cap is reached, families can submit copies of their expense receipts to the program. After the program verifies that the 5 percent maximum has been met, the family’s cost sharing responsibilities will cease for the year involved. Should any payment exceed the 5 percent threshold amount before a determination **is** made that the 5 percent maximum has been met, payments will be promptly refunded. The 5 percent maximum is calculated based upon the gross annual income of the enrollees’ families from the first day of the month following authorization of the application — the date when the continuous eligibility period begins and the month for which families begin paying the premiums.

8.6. The state assures that, with respect to pre-existing medical conditions, one **of** the following two statements applies to its plan:

8.6.1. * The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); **OR**

8.6.2. The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.3.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2109(a)(1),(2)).

Section 9. Strategic Objectives and Performance Goals for the Plan Administration (Section 2107)

As mandated by Public Law 1999-273, the State is about to release a BAA for the services of an evaluation consultant. The consultant will provide assistance in developing the evaluation and the annual reports, and will also be responsible for developing measures of CHIP quality. The evaluation consultant will be utilized to develop performance measurements of the following:

- the effectiveness of the CHIP program in reducing the number of uninsured, low-income children and increasing the number of children with health coverage;
- the extent to which crowd out is occurring;
- the effectiveness of the program in addressing the health care needs of the uninsured;
- the quality of services provided under CHIP;
- a profile of service utilization (how often, how effectively, and how appropriately services are utilized) by program enrollees;
- the health status of children enrolled in the program;
- the extent to which recipients are receiving early screening, diagnosis, and treatment services in accordance with the HealthWatch Indiana EPSDT Program; and
- the changes and trends in Indiana that affect the provision of accessible, affordable health insurance and health care.

Since the process of contracting with an evaluation consultant is still underway, the State has developed other provisional performance criteria that will be utilized until the performance criteria developed with the assistance of the evaluation consultant are put into place. These performance criteria are based upon the performance criteria utilized for the Medicaid expansion under the CHIP Phase I program. Thus, they will serve as a link between the Phase I and Phase II CHIP programs.

The chart below documents Indiana's strategic objectives, and the corresponding performance goals and performance measures. The material has been combined into one chart for the sake of simplification.

9.1 Strategic Objective	3.2 Performance Goal	3.3 Objective Means of Measuring Performance
<p>9.1.1</p> <p>Targeted low-income children will have health insurance through the Phase II CHIP program.</p>	<p>By September 30, 2000, 12,000 targeted low income children will have health insurance through CHIP Phase II.</p>	<p>Hoosier Healthwise data will reveal the number of children enrolled under CHIP Phase II from January 1, 2000 until the September 30, 2000.</p>
<p>9.1.2</p> <p>Children enrolled in Indiana's Title XXI Program will have a consistent source of care medical and dental.</p>	<p>By September 30, 2000, 100% of children enrolled in the CHIP Phase II program will select or be assigned a PMP.</p> <p>By September 30, 2000, 95% of children enrolled in the Phase II CHIP program will self-select a PMP.</p>	<p>Hoosier Healthwise enrollment data in the IndianaAIM system will verify PMP selection or assignment.</p> <p>Hoosier Healthwise enrollment data in the IndianaAIM system will verify PMP selection.</p>
<p>9.1.3</p> <p>Parents of children enrolled in XXI will be satisfied with the program.</p>	<p>At least 75% of parents surveyed during the first year of their child's participation under the CHIP Phase II program will express overall satisfaction with the program.</p>	<p>Hoosier Healthwise recipient survey results will be utilized to show the satisfaction rate.</p>
<p>9.1.4</p> <p>Providers who participate in the Phase II CHIP program will express satisfaction with the terms and conditions of their participation.</p>	<p>At least 50% of providers surveyed will express overall satisfaction with the Phase II CHIP program during the first year of implementation.</p>	<p>Annual Hoosier Healthwise provider survey results will be used to show the provider satisfaction rate.</p>
<p>9.1.5</p> <p>Children enrolled in Phase II of the CHIP program will enjoy improved health status.</p>	<p>At least 60% of 2 year olds enrolled in the Phase II CHIP program will receive immunizations consistent with HEDIS recommendations.</p> <p>At least 60% of enrollees in the CHIP Phase II program will receive recommended preventive</p>	<p>Reporting by Hoosier Healthwise providers will be used to verify percent of 2 year olds receiving immunizations as per HEDIS recommendations</p> <p>Sample chart reviews will be used to indicate the percent of enrollees who received well-</p>

	services.	child services.
--	------------------	------------------------

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

- 9.3.1. * The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
- 9.3.2. * The reduction in the percentage of uninsured children.
- 9.3.3. The increase in the percentage of children with a usual source of care.

- 9.3.4. * The extent to which outcome measures show progress on one or more of the health problems identified by the state.
- 9.3.5. HEDIS Measurement Set relevant to children and adolescents younger than 19.
- 9.3.6. Other child appropriate measurement set. List or describe the set used.
- 9.3.7. If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
 - 9.3.7.1. * Immunizations
 - 9.3.7.2. Well child care
 - 9.3.7.3. Adolescent well visits
 - 9.3.7.4. Satisfaction with care
 - 9.3.7.5. Mental health
 - 9.3.7.6. Dental care
 - 9.3.7.7. Other, please list:
- 9.3.8. Performance measures for special targeted populations.
- 9.4. * The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1))
- 9.5. * The state assures it will comply with the annual assessment and evaluation required under Section 10.1. and 10.2. (See Section 10) Briefly describe the state's plan for these annual assessments and reports. (Section 2107(b)(2))

The State assures that it will submit the required evaluation by March 31, 2000. The State also assures that it will complete an **annual** assessment of the progress made in reducing the number of uncovered low-income children, and report to the Secretary on the result of the assessment.

The assessments will be based largely upon the strategic objectives set forth in Section 9 and program evaluation criteria designed by the evaluation consultant. The strategic objectives focus on enrolling children, establishing usual sources of care, measuring enrollee and provider satisfaction, and improving health status. The data used to measure performance will be compiled from existing databases. Additional databases may later be created in order to complete some of the measurements developed by the evaluation consultant. The CHIP office will monitor progress and conduct the annual assessment.

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

9.7. * The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed.

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

- *
9.8.1. Section 1902(a)(4)(C) (relating to conflict of interest standards)
- *
9.8.2. Paragraphs (2), (16) and (17) of Section 1903(I) (relating to limitations on payment)
- *
9.8.3. Section 1903(w) (relating to limitations on provider donations and taxes)
- *
9.8.4. Section 1115 (relating to waiver authority)
- *
9.8.5. Section 1116 (relating to administrative and judicial review), but only insofar as consistent with Title XXI
- *
9.8.6. Section 1124 (relating to disclosure of ownership and related information)
- *
9.8.7. Section 1126 (relating to disclosure of information about certain convicted individuals)
- *
9.8.8. Section 1128A (relating to civil monetary penalties)
- *
9.8.9. Section 1128B(d) (relating to criminal penalties for certain additional charges)
- *
9.8.10. Section 1132 (relating to periods within which claims must be filed)

9.9. Public Input

Public Input on Plan Design:

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

- A twenty-one member bi-partisan Governor's Advisory Panel representing a cross-section of Indiana experts was appointed to develop a blueprint on implementation of the CHIP program.

Members on the panel included: hospital representatives, physicians, insurance executives, parents, advocates, school officials, health clinic representatives, and members of the Indiana General Assembly. Numerous press releases were utilized to publicize the work of the Advisory Panel. All meetings were publicized and covered by the news media. Further, there was significant news coverage during the General Assembly's deliberations on the Governor's CHIP proposal.

- e Five subcommittees were established to provide a broader range of input and allow for in-depth discussion and analysis on key areas of importance. Membership on the subcommittees included: hospitals, physicians, nurses, pharmacists, local health department representatives, optometrists, mental health providers, economists, academics, numerous community and social services programs, migrant farmworkers and homeless parents, and various other experts. The subcommittees focused on the following key topics: **Coordination/Infrastructure/Provider Supply/Community Systems; Benefits and Cost Sharing; Eligibility and Crowd Out; Outreach and Education; and Data, Evaluation and Outcomes.** The subcommittees reports were submitted to the Advisory Panel for consideration.

- e A series of eight public forums were held across the state in order to allow for a wide range of input from individuals and entities within individual communities. The forums provided opportunities for citizens to share their concerns regarding methods for improving and for building upon the state's current health care system, and mechanisms for encouraging parents to access health services. In order to maximize awareness and participation, the forums were held at a number of different sites and at varying times. The local social service and health promotion agencies helped select the most appropriate time and location for each hearing. To promote the forums, the organizers worked closely with numerous individuals and entities. Assistance was provided by the local WIC sites, local MCH agencies, local immunization sites, local Medicaid providers, community health centers, local DFC offices, the LHDs, and the Indiana Coalition on Housing and Homeless Issues. In order to make it easier for parents to attend, child care was provided during the forums. Individuals who were not able to attend were encouraged to submit written comments. State and local news media were notified in advance of all public forums through a myriad of sources. News releases, media advisories and telephone calls were all utilized in an effort to maximize press coverage.

- e Numerous focus groups were established to draw upon the expertise, experience, and perspectives of homogeneous groups of individuals. The focus groups consisted of groups of providers, advocates, parents and adolescents. The groups met in various locations throughout the State and discussed key issues from their own specific perspectives.

- e The Phase II benefits package was sent to a large audience with requests for comments.

- Discussion of plan design will also occur during the rulemaking process. At least one public hearing will also be held during this process.

- As part of its CHIP oversight responsibility, the Policy Board is establishing broad based committees. Each year, the Policy Board will hold 3 public hearings as a method of obtaining feedback regarding the program.
- Legislative oversight of the CHIP program will be provided by the Select Joint Committee on Medicaid Oversight.

Promotion of Plan Implementation:

The Chair of the Governor’s Advisory Panel appeared before various editorial boards as a means of increasing awareness of the CHIP program. A CHIP website was developed to provide information regarding the Phase II CHIP program. This website (<http://www.state.in.us/chip>) is updated regularly.

Radio and television public service announcements have been aired throughout the State. A radio blitz that included information about Hoosier Healthwise in a “Back to School” message was run throughout the State for a six week period of time. Billboards, bus placards, and newspaper ads have also been used to promote the program. And, with the assistance of local DFC offices, local newspapers have run articles informing families about Hoosier Healthwise.

9.10.’ Budget: Estimates and Cost Projections under CHIP (FFYs 1999,2000,2001)

	FFY 1999	FFY 2000	FFY 2001
BENEFIT COSTS			
<i>Insurance Payments</i>			
Managed Care	63,434,000	80,704,000	95,354,000
Per member/ per month @ # of eligibles	146.83/per month @ 36,000	140.11/per month @ 48,000	124.15/per month @ 64,000
Fee-for-Service	0	0	0
TOTAL BENEFIT COSTS	63,434,000	80,704,000	95,354,000
(Offsetting beneficiary cost sharing payments)	0	1,620,000	5,040,000
Net Benefit Costs	63,434,000	79,084,000	90,314,000
ADMINISTRATION			

COSTS			
Personnel	130,000	385,000	400,000
General Administration	1,658,000	3,615,000	3,625,000
Contractors/Brokers (e.g. enrollment centers)	600,000	1,385,000	1,285,000
Claims Processing	540,000	1,165,000	865,000
Outreach/Marketing costs	0	100,000	100,000
Other	0	1,146,000	146,000
TOTAL ADMINISTRATION COSTS	2,928,000	7,796,000	6,421,000
10% Admin Cost Ceiling	0	0	0
Federal Shared (multiplied by enhanced FMAP rate)	48,251,810	64,799,700	74,519,655
State Share	18,110,190	23,700,300	27,255,345
TOTAL PROGRAM COSTS	66,362,000	88,500,000	101,775,000

Notes:

1. Increases in total program costs of approximately 25 percent in FFY 2000 and 15 percent in FFY 2001 from the previous year are anticipated.
2. Total benefit costs for FFY 2000 assume that expenses will be higher during the first year of CHIP Phase II than subsequent years due to pent-up demand and adverse selection.
3. The estimates for beneficiary cost-sharing payments were based on an average of \$15 per month per beneficiary enrolled in CHIP Phase II.
4. Managed care includes both primary care case management and risk-based managed care. All CHIP beneficiaries will be enrolled in either primary care case management or risk-based managed care. Primary care case management providers are reimbursed on a fee-for-service basis.

Funding Source:

The state portion of the expenditures will be generated from the State's tobacco settlement money. State general revenues will be used as a supplement, if needed.

Section 10. Annual Reports and Evaluations (Section 2108)

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

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

10.1.2. * Report to the Secretary, January 1 following the end of the fiscal year, on the result of the assessment.

10.2. * State Evaluations. The state assures that **by** March 31, 2000 it will submit to the Secretary an evaluation of each of the items described and listed below: (Section 2108(b)(A)-(H))

10.2.1. * An assessment of the effectiveness of the state plan in increasing the number of children with creditable health coverage.

10.2.2. A description and analysis of the effectiveness of elements **of** the state plan, including:

10.2.2.1. * The characteristics **of** the children and families assisted under *the* state plan including age **of** the children, family income, and the assisted child's access to or coverage by other health insurance prior to the state plan and after eligibility for the state plan ends;

10.2.2.2. * The quality **of** health coverage provided including the types of benefits provided;

10.2.2.3. * The amount and level (including payment of part or all **of** any premium) of assistance provided by the state;

10.2.2.4. * The service area of the state plan;

10.2.2.5. * The time limits for coverage **of** a child under the state plan;

10.2.2.6. * The state's choice **of** health benefits coverage and other methods used for providing child health assistance, and

10.2.2.7. * The sources of non-Federal funding used in the state plan.

- 10.2.3. * An assessment of the effectiveness of other public and private programs in the state in increasing the availability of affordable quality individual and family health insurance for children.
- 10.2.4. * A review and assessment of state activities to coordinate the plan under this Title with other public and private programs providing health care and health care financing, including Medicaid and maternal and child health services.
- 10.2.5. * An analysis of changes and trends in the state that affect the provision of accessible, affordable, quality health insurance and health care to children.
- 10.2.6. * A description of any plans the state has for improving the availability of health insurance and health care for children.
- 10.2.7. * Recommendations for improving the program under this Title.
- 10.2.8. * Any other matters the state and the Secretary consider appropriate.
- 10.3. * The state assures it will comply with future reporting requirements as they are developed.
- 10.4. * The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

(ATTACHMENT A)

ACRONYMS

- BA— Benefit Advocate.
- BBA — Balanced Budget Act.
- CHC— Community Health Center.
- CHIP — Children's Health Insurance Program.
- COP — Consolidated Outreach Project.
- CSHCS — Children's Special Health Care Services program.
- DFC — Division of Family and Children.
- DMH — Division of Mental Health.
- DOE — Department of Education.
- DOI — Department of Insurance
- EBRI — Employee Benefit Research Institute.
- FPL — Federal Poverty Level.
- FQHC — Federally Qualified Health Centers.
- FSSA — Family and Social Services Administration.
- ICES — Indiana Client Eligibility System.
- ICHIA — Indiana Comprehensive Health Insurance Association.
- IMHC — Indiana Minority Health Coalition.
- IMPACT — Welfare to **work** program.
- IPHCA — Indiana Primary Health Care Association.

- e ISDH — Indiana State Department of Health.
- e LHD — Local Health Departments.
- e MCH — Maternal and Child Health program.
- e MCO — Managed Care Organization.
- e MMIS — Medicaid Management Information System.
- e NCQA — National Committee for Quality Assurance.
- e OMPP — Office of Medicaid Policy and Planning.
- e PCCM — Primary Care Case Management System.
- e PMP — Primary Medical Provider.
- e QI — Quality Improvement.
- QIC — Quality Improvement Committee.
- e RAMS II — Retrospective Analysis Management System.
- RBMC — **Risk** Based Managed Care System.
- e SUR — Surveillance and Utilization Review.
- e TAG — Indiana Medicaid Coordinated Care Technical Assistance Group.
- e TPL — Third Party Liability.
- e UR — Utilization Review.
- e WIC — Women, Infants and Children program.

(Attachment B)

after the emergency rule expires.

(15) An emergency rule adopted by the Indiana election commission under IC 3-6-4.1-14.

(16) An emergency rule adopted by the department of natural resources under IC 14-10-2-5.

(17) **An** emergency rule adopted by the Indiana gaming commission under IC 4-33-4-2, IC 4-33-4-3, or IC 4-33-4-14.

(18) **An** emergency rule adopted by the alcoholic beverage commission under IC 7.1-3-17.5, IC 7.1-3-17.7, or IC 7.1-3-20-24.4.

(19) An emergency rule adopted by the department of financial institutions under IC 28-15-11.

(20) **An** emergency rule adopted by the office of the secretary of family and social services under IC 12-8-1-12.

(21) **An emergency rule adopted by the office of the children's health insurance program under IC 12-17.6-2-11.**

(b) The following do not apply to rules described in subsection (a):

(1) Sections 24 through 36 of this chapter.

(2) IC 13-14-9.

(c) After a rule described in subsection (a) has been adopted by the agency, the agency shall submit the rule to the publisher for the assignment of a document control number. The agency shall submit the rule in the form required by section 20 of this chapter and with the documents required by section 21 of this chapter. The publisher shall determine the number of copies of the rule and other documents to be submitted under this subsection.

(d) After the document control number has been assigned, the agency shall submit the rule to the secretary of state for filing. The agency shall submit the rule in the form required by section 20 of this chapter and with the documents required by section 21 of this chapter. The secretary of state shall determine the number of copies of the rule and other documents to be submitted under this subsection.

(e) Subject to section 39 of this chapter, the secretary of state shall:

(1) accept the rule for filing; and

(2) file stamp and indicate the date and time that the rule is accepted on every duplicate original copy submitted.

(f) A rule described in subsection (a) takes effect on the latest of the following dates:

(1) The effective date of the statute delegating authority to the agency to adopt the rule.

(2) The date and time that the rule is accepted for filing under subsection (e).

(3) The effective date stated by the adopting agency in the rule.

(4) The date of compliance with every requirement established by law as a prerequisite to the adoption or effectiveness of the rule.

(g) Subject to subsection (h), IC 14-10-2-5, IC 14-22-2-6, and IC 22-8-1.1-16.1, a rule adopted under this section expires not later than ninety (90) days after the rule is accepted for filing under subsection (e). Except for a rule adopted under subsection (a)(14), the rule may be extended by adopting another rule under this section, but only for one (1) extension period. A rule adopted under subsection (a)(14) may be extended for two (2) extension periods. Except for a rule adopted under subsection (a)(14), for a rule adopted under this section to be effective after one (1) extension period, the rule must be adopted under:

(1) sections 24 through 36 of this chapter; or

(2) IC 13-14-9;

as applicable.

(h) A rule described in subsection (a)(6), (a)(9), or (a)(13) expires on the earlier of the following dates:

(1) The expiration date stated by the adopting agency in the rule.

(2) The date that the rule is amended or repealed by a later rule adopted under sections 24 through 36 of this chapter or this section.

(i) This section may not be used to readopt a rule under IC 4-22-2.5.

SECTION 161. IC 4-23-26 IS ADDED TO THE INDIANA CODE AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:

Chapter 26. Advisory Committee for Children With Special Health Needs



Sec. **1.** ~~As~~ used in this chapter, "committee" refers to the advisory committee for children with special health needs established by section **2** of this chapter.

Sec. **2.** The advisory committee for children with special health needs is established.

Sec. **3.** (a) The committee consists of the following members:

- (1) The director of the children's special health care services program.
- (2) The director of the first steps program.
- (3) The chair of the governor's interagency coordinating council for early intervention.
- (4) The chair of the children's special health care services advisory council under **410 IAC 3.2-11**.
- (5) The director of the division of special education created under IC **20-1-6-2.1**.
- (6) The director of the division of mental health.
- (7) One (1) representative of the Indiana chapter of the American Academy of Pediatrics.
- (8) One (1) representative of a family advocacy group.
- (9) Three (3) parents of children with special health needs.
- (10) Three (3) parents of children who are enrolled in the:
 - (A) children's health insurance program under IC **12-17.6**; or
 - (B) Medicaid managed care program for children.

(b) The members under subdivisions (1) and (2) are nonvoting members.

Sec. **4.** (a) The governor shall appoint the committee members under section **3(7), 3(8), 3(9), and 3(10)** of this chapter.

(b) The term of each member appointed under subsection (a) is three (3) years.

(c) A committee member identified in subsection (a) may be reappointed to serve consecutive terms.

Sec. **5.** (a) The director of the children's special health care services program is chair of the committee during odd numbered years.

(b) The director of the first steps program is chair of the committee during even numbered years.

Sec. **6.** The committee shall meet at least quarterly at the call of the chair.

Sec. **7.** Eight (8) members of the committee constitute a quorum.

Sec. **8.** (a) Each member of the committee who is not a state employee is entitled to receive both of the following:

(1) The minimum salary per diem provided by IC **4-10-11-2.1(b)**.

(2) Reimbursement for travel expenses and other expenses actually incurred in connection with the member's duties, as provided in the state travel policies and procedures established by the Indiana department of administration and approved by the budget agency.

(b) Each member of the committee who is a state employee is entitled to reimbursement for travel expenses and other expenses actually incurred in connection with the member's duties, as provided in the state travel policies and procedures established by the Indiana department of administration and approved by the budget agency.

Sec. **9.** The committee shall advise and assist the children's health policy board established by IC **4-23-27-2** in the development, coordination, and evaluation of policies that have an impact on children, with a focus on children with special health needs, by doing the following:

(1) Seeking information from families, service providers, advocacy groups, and health care specialists about state or local policies that impede the provision of quality service.

(2) Taking steps to ensure that relevant health policy issues that have an impact on children are forwarded to the children's health policy board.

(3) Advising the children's health policy board with respect to the integration of services across:

(A) programs; and

(B) state agencies;

for children with special health needs.



SECTION 162.IC4-23-27 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:

Chapter **27**. Children's Health Policy Board

Sec. **1.** **As** used in this chapter, "board" refers to the children's health policy board established by section 2 of **this** chapter.

Sec. **2.** The children's health policy board is established.

Sec. **3.** The board consists of the following members:

- (1) The secretary of the family and social services administration.
- (2) The state health commissioner.
- (3) The insurance commissioner of Indiana.
- (4) The state personnel director.
- (5) The budget director.
- (6) The state superintendent of public instruction.
- (7) The director of the division of mental health.

Sec. **4.** The governor shall appoint a member of the board as chair of the board.

Sec. **5.** (a) Four **(4)** members of the board constitute a quorum.

(b) The affirmative vote of at least four **(4)** members of the board is required for the board to take any official action.

Sec. **6.** (a) The board shall meet monthly at the call of the chair.

(b) The board shall hold public hearings in diverse locations throughout the state at least three **(3)** times each year.

Sec. **7.** The board shall direct policy coordination of children's health programs by doing the following:

(1) Developing a comprehensive policy in the following areas:

- (A) Appropriate delivery systems of care.
- (B) Enhanced access to care,
- (C) The use of various program funding for maximum efficiency.
- (D)** The optimal provider participation in various programs.
- (E) The potential for expanding health insurance coverage to other populations.
- (F) Technology needs, including development of an electronic claim administration, payment, and data collection system that allows providers to have the following:
 - (i) Point of service claims payments.
 - (ii) Instant claims adjudication.
 - (iii) Point of service health status information.
 - (iv) Claims related data for analysis.
- (G) Appropriate organizational structure to implement health **policy** in the state.

(2) Coordinating **aspects** of existing children's health programs, including the children's health insurance program, Medicaid managed care for children, **first** steps, and children's special health care services, in order to achieve a more seamless system easily accessible by participants and providers, specifically in the following areas:

- (A) Identification of potential enrollees.
- (B) Outreach.
- (C) Eligibility criteria.
- (D) Enrollment.
- (E) Benefits and coverage issues.
- (F) Provider requirements.
- (G) Evaluation.
- (H) Procurement policies.
- (I) Information technology systems, including technology to coordinate payment for services provided through the Children's health insurance program under IC **12-17.6** with:
 - (I) services provided to children with special health needs: and



- (ii) public health programs designed to protect all children.
- (3) Reviewing, analyzing, disseminating, and using data when making policy decisions.
- (4) Overseeing implementation of the children's health insurance program under IC **12-17.6**, including:

(A) reviewing:

- (I) benefits provided by:
- (ii) eligibility requirements for; and
- (iii) each evaluation of;

the children's health insurance program on an annual basis in light of available funding; and

(B) making recommendations for changes to the children's health insurance program to the office of the children's health insurance program established under IC **12-17.6-2-1**.

Sec. 8. The board may draw upon the expertise of other boards, committees, and individuals whenever the board determines that such expertise is needed.

SECTION 163. IC 12-7-2-52.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 52.2. "Crowd out", for purposes of IC **12-17.6**, has the meaning set forth in IC **12-17.6-1-2**.

SECTION 164. IC 12-7-2-91 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 91. "Fund" means the following:

- (1) For purposes of IC 12-12-1-9, the fund described in IC 12-12-1-9.
- (2) For purposes of IC 12-13-8, the meaning set forth in IC 12-13-8-1.
- (3) For purposes of IC 12-15-20, the meaning set forth in IC 12-15-20-1.
- (4) For purposes of IC 12-17-12, the meaning set forth in IC 12-17-12-4.
- (5) For purposes of IC **12-17.6**, the meaning set forth in IC **12-17.6-1-3**.
- ~~(5)~~ (6) For purposes of IC 12-18-4, the meaning set forth in IC 12-18-4-1.
- ~~(6)~~ (7) For purposes of IC 12-18-5, the meaning set forth in IC 12-18-5-1.
- ~~(7)~~ (8) For purposes of IC 12-19-3, the meaning set forth in IC 12-19-3-1.
- ~~(8)~~ (9) For purposes of IC 12-19-4, the meaning set forth in IC 12-19-4-1.
- ~~(9)~~ (10) For purposes of IC 12-19-7, the meaning set forth in IC 12-19-7-2.
- ~~(10)~~ (11) For purposes of IC 12-23-2, the meaning set forth in IC 12-23-2-1.
- ~~(11)~~ (12) For purposes of IC 12-24-6, the meaning set forth in IC 12-24-6-1.
- ~~(12)~~ (13) For purposes of IC 12-24-14, the meaning set forth in IC 12-24-14-1.
- ~~(13)~~ (14) For purposes of IC 12-30-7, the meaning set forth in IC 12-30-7-3.

SECTION 165. IC 12-7-2-134 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 134. "Office" means the following:

- (1) Except as provided in subdivisions (2) and (3), the office of Medicaid policy and planning established by IC 12-8-6-1.
- (2) For purposes of IC 12-10-13, the meaning set forth in IC 12-10-13-4.
- (3) For purposes of ~~IC 12-17-18~~, IC **12-17.6**, the meaning set forth in ~~IC 12-17-18-1~~ IC **12-17.6-1-4**.

SECTION 166. IC 12-7-2-146 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 146. "Program" refers to the following:

- (1) For purposes of IC 12-10-7, the adult guardianship services program established by IC 12-10-7-5.
- (2) For purposes of IC 12-10-10, the meaning set forth in IC 12-10-10-5.
- (3) For purposes of IC **12-17.6**, the meaning set forth in IC **12-17.6-1-5**.

SECTION 167. IC 12-7-2-149 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 149. "Provider" means the following:

- (1) For purposes of IC 12-10-7, the meaning set forth in IC 12-10-7-3.
- (2) For purposes of the following statutes, an individual, a partnership, a corporation, or a governmental entity that is enrolled in the Medicaid program under rules adopted under IC 4-22-2



by the office of Medicaid policy and planning:

- (A) IC 12-14-1 through IC 12-14-9.
- (B) IC 12-15, except IC 12-15-32, IC 12-15-33, and IC 12-15-34.
- (C) IC 12-17-10.
- (D) IC 12-17-11.
- (E) **IC 12-17.6.**

(3) For purposes of IC 12-17-9, the meaning set forth in IC 12-17-9-2.

~~(4) For purposes of IC 12-17-18, the meaning set forth in IC 12-17-18-2.~~

~~(5) For the purposes of IC 12-17.2, a person who operates a child care center or child care home under IC 12-17.2.~~

~~(6) (5) For purposes of IC 12-17.4, a person who operates a child caring institution, foster family home, group home, or child placing agency under IC 12-17.4.~~

SECTION 168. IC 12-13-8-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 4. For taxes first due and payable in 1990, each county shall impose a medical assistance property tax levy equal to the amount determined using the following formula:

STEP ONE: Determine the sum of the amounts that were incurred by the county as determined by the state board of accounts for all medical care, including psychiatric care and institutional psychiatric care, for wards of the county office (described in ~~IC 12-15-2-15~~ **IC 12-15-2-16**) that was provided in 1986, 1987, and 1988.

STEP TWO: Subtract from the amount determined in STEP ONE the sum of:

- (A) the amount of bank taxes (IC 6-5-10);
- (B) the amount of savings and loan association taxes (IC 6-5-11);
- (C) the amount of production credit association taxes (IC 6-5-12); plus
- (D) the amount of motor vehicle excise taxes (IC 6-6-5);

that were allocated to the county welfare fund and used to pay for the medical care for wards provided in 1986, 1987, and 1988.

STEP THREE: Divide the amount determined in STEP TWO by three (3).

STEP FOUR: Adjust the amount determined in STEP THREE by the amount determined by the state board of tax commissioners under section 6 of this chapter.

STEP FIVE: Multiply the amount determined in STEP FOUR by the greater of:

- (A) the assessed value growth quotient determined under IC 6-1.1-18.5-2 for the county for property taxes first due and payable in 1990; or
- (B) the statewide average assessed value growth quotient using the county assessed value growth quotients determined under IC 6-1.1-18.5-2 for property taxes first due and payable in 1990.

STEP SIX: Multiply the amount determined in STEP FIVE by the statewide average assessed value growth quotient, using all the county assessed value growth quotients determined under IC 6-1.1-18.5-2 for the year in which the ~~tax~~ levy under this section will be first due and payable.

SECTION 169. IC 12-8-1-15 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 15. The office of the secretary shall improve its system through the use of technology and training of staff to do the following:**

- (1) Simplify, streamline, and destigmatize the eligibility and enrollment processes in all health programs serving children.**
- (2) Ensure an efficient provider payment system.**
- (3) Improve service to families.**
- (4) Improve data quality for program assessment and evaluation.**

SECTION 170. IC 12-15-1-19 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 19. The office may, in administering managed care programs, contract with community entities, including private entities, for the following:**

- (1) Outreach for and enrollment in the managed care program.**
- (2) Provision of services.**



(3) Consumer education and public health education.

SECTION 171. IC 12-15-2-14 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 14. (a) An individual:

- (1) who is less than ~~one (1) year~~ **nineteen (19) years** of age;
- (2) who is not described in 42 U.S.C. 1396a(a)(10)(A)(I); and
- (3) whose family income does not exceed the income level established in subsection (b);

is eligible to receive Medicaid.

(b) **An** individual described in this section is eligible to receive Medicaid, subject to 42 U.S.C. 1396a et seq., if the individual's family income does not exceed one hundred fifty percent (150%) of the federal income poverty level for the same size family.

(c) The office may apply a resource standard in determining the eligibility of **an** individual described in this section.

SECTION 172. IC 12-15-2-15.7 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE **JULY 1, 1999**]: Sec. 15.7. ~~(a)~~ **An** individual who is less than nineteen (19) years of age and who is eligible for Medicaid under ~~sections section 14 through 15-6~~ of this chapter is eligible to receive Medicaid until the earlier of the following:

- (1) The end of a period of twelve (12) consecutive months following a determination of the individual's eligibility for Medicaid.
- (2) The individual becomes nineteen (19) years of age.

~~(b) This section expires August 31, 1999.~~

SECTION 173. IC 12-15-4-5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 5. The office shall implement outreach strategies that build on community resources.**

SECTION 174. IC 12-15-20-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 2. The Medicaid indigent care trust fund is established to pay the state's share of the following:

- (1) Enhanced disproportionate share payments to providers under IC 12-15-19.
- (2) Disproportionate share payments and significant disproportionate share payments for certain outpatient services under IC 12-15-17-3.
- (3) Medicaid payments for pregnant women described in IC 12-15-2-13 and infants and children described in IC ~~12-15-2-14. IC 12-15-2-15.~~ . .
- (4) Municipal disproportionate share payments to providers under IC ~~12-15-19-8.~~

SECTION 175. IC 12-15-33-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 2. The Medicaid advisory committee is created **to** act in an advisory capacity to the **following**:

- (1)** The office in the administration of the Medicaid program.
- (2)** **The children's health policy board established by IC 4-23-27-2 in the board's responsibility to direct policy coordination of children's health programs.**

SECTION 176. IC 12-15-33-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 3. The committee shall be appointed **as** follows:

- (1) One (1) member shall be appointed by the administrator of the office to represent each of the following organizations:
 - (A) Indiana Council of Community Mental Health Centers.
 - (B) Indiana State Medical Association.
 - (C) Indiana State Chapter of the American Academy of Pediatrics.
 - (D) Indiana Hospital Association.
 - (E) Indiana Dental Association.
 - (F) Indiana State Psychiatric Association.
 - (C) Indiana State Osteopathic Association.
 - (H) Indiana State Nurses Association.
 - (I) Indiana State Licensed Practical Nurses Association.



- (J) Indiana State Podiatry Association.
 - (K) Indiana Health Care Association.
 - (L) Indiana Optometric Association.
 - (M) Indiana Pharmaceutical Association.
 - (N) Indiana Psychological Association.
 - (O) Indiana State Chiropractic Association.
 - (P) Indiana Ambulance Association.
 - (Q) Indiana Association for Home Care.
 - (R) Indiana Academy of Ophthalmology.
 - (S) Indiana Speech and Hearing Association.
- (2) **Eight (8) Ten (10)** members shall be appointed by the governor **as** follows:
- (A) One (1) member who represents agricultural interests.
 - (B) One (1) member who represents business and industrial interests.
 - (C) One (1) member who represents labor interests.
 - (D) One (1) member who represents insurance interests.
 - (E) One (1) member who represents a statewide taxpayer association.
 - (F) Two (2) members who are parent advocates.
 - (G) Three (3) members who represent Indiana citizens.
- (3) One (1) member shall be appointed by the president pro tempore of the senate acting in the capacity **as** president pro tempore of the senate to represent the senate.
- (4) One (1) member shall be appointed by the speaker of the house of representatives to represent the house of representatives.

SECTION 177.IC 12-17.6 IS ADDED TO THE INDIANA CODE AS A **NEW ARTICLE TO READ AS FOLLOWS** [EFFECTIVE UPON PASSAGE]:

ARTICLE 17.6. CHILDREN'S HEALTH INSURANCE PROGRAM

Chapter 1. Definitions

Sec. 1. The definitions in this chapter apply throughout this article.

Sec. 2. "Crowd out" means the extent to which:

- (1) families substitute coverage offered under the program for employer sponsored health insurance coverage for children; or
 - (2) employers:
 - (A) reduce or eliminate health insurance benefits for children under an employer based health insurance plan; or
 - (B) increase the employee's share of the cost of benefits for children under an employer based health insurance plan relative to the total cost of the plan:
- as** a result of the program.

Sec. 3. "Fund" refers to the children's health insurance program fund established by **IC 12-17.6-7-1**.

Sec. 4. "Office" refers to the office of the children's health insurance program established by **IC 12-17.6-2-1**.

Sec. 5. "Program" refers to the children's health insurance program established by **IC 12-17.6-2**.

Sec. 6. "Provider" has the meaning set forth in **IC 12-7-2-149(2)**.

Chapter 2 Program Administration

Sec. 1. The office of the children's health insurance program is established within the office of the secretary.

Sec. 2. The office shall design and administer a system to provide health benefits coverage for children eligible for the program.

Sec. 3. To the greatest extent possible, the office shall use the same:

- (1) eligibility determination;
- (2) enrollment;
- (3) provider networks; and



- (4) claims payment systems;
as are used by the Medicaid managed care program for children.
- Sec. 4. The office shall evaluate the feasibility of the Following:
- (1) Establishing a program to subsidize employer sponsored coverage under the program.
 - (2) Expanding health insurance coverage under the program to other populations as provided under section **2105(c)(3)** of the federal Social Security Act.
- Sec. 5. Reviews of the program shall:
- (1) be conducted in compliance with federal requirements; and
 - (2) include an analysis of the extent to which crowd out is occurring.
- Sec. 6. The office shall do the following:
- (1) Establish performance criteria and evaluation measures.
 - (2) Monitor program performance.
 - (3) Adopt a formula that:
 - (A) specifies the premiums, if any, to be paid by the parent or guardian of a child enrolled in the program; and
 - (B) is based on the child's family income.
- Sec. 7. (a) The office shall contract with **an** independent organization to evaluate the program.
(b) The office shall report the results of each evaluation to the:
- (1) children's health policy board established by IC **4-23-27-2**; and
 - (2) select joint committee on Medicaid oversight established by **P.L.130-1998**.
- (c) This section does not **modify** the requirements of other statutes relating to the confidentiality of medical records.
- Sec. 8. The office may, in administering the program, contract with community entities, including private entities, for the following:
- (1) Outreach for and enrollment in the managed care program.
 - (2) Provision of services.
 - (3) Consumer education and public health education.
- Sec. 9. (a) The office shall incorporate creative methods, reflective of community level objectives and input, to do the following:
- (1) Encourage beneficial and appropriate use of health care services.
 - (2) Pursue efforts to enhance provider availability.
- (b) In determining the best approach For each area, the office shall do the following:
- (1) Evaluate distinct market areas.
 - (2) Weigh the advantages and disadvantages of alternative delivery models, including the following:
 - (A) Risk based managed care only.
 - (B) Primary care gatekeeper model only.
 - (C) **A** combination of clauses **(A)** and **(B)**.
- Sec. 10. (a) The office may establish a program to subsidize employer sponsored coverage for:
- (1) eligible individuals; and
 - (2) the families of eligible individuals;
- c nsistent with federal law.
- (b) If the office establishes a program under subsection (a), the employer sponsored benefit package must comply with Federal law.
- Sec. 11. (a) The office shall adopt rules under IC **4-22-2** to implement the program.
(b) The office may adopt emergency rules under IC **4-22-2-37.1** to implement the program on **an** emergency basis.
- Sec. 12. Not later than April **1**, the office shall provide a report describing the program's activities during the preceding calendar year to the:
- (1) budget committee;
 - (2) legislative council:



- (3) children's health policy board established by IC 4-23-27-2; and
- (4) select joint committee on Medicaid oversight established by P.L.130-1998.

Chapter 3. Eligibility, Outreach, and Enrollment

Sec. 1. This chapter does not apply until January 1, 2000.

Sec. 2. (a) To be eligible to enroll in the program, a child must meet the following requirements:

- (1) The child is less than nineteen (19) years of age.
- (2) The child is a member of a family with an annual income of:
 - (A) more than one hundred fifty percent (150%); and
 - (B) not more than two hundred percent (200%);

of the federal income poverty level.

(3) The child is a resident of Indiana.

(4) The child meets all eligibility requirements under Title XXI of the federal Social Security Act.

(5) The child's family agrees to pay any cost sharing amounts required by the office.

(b) The office may adjust eligibility requirements based on available program resources under rules adopted under IC 4-22-2.

Sec. 3. (a) Subject to subsection (b), a child who is eligible for the program shall receive services from the program until the earlier of the following:

- (1) The end of a period of twelve (12) consecutive months following the determination of the child's eligibility for the program.
- (2) The child becomes nineteen (19) years of age.

(b) Subsection (a) applies only if the child and the child's family comply with enrollment requirements.

Sec. 4. The office shall implement outreach strategies that build on community resources.

Sec. 5. A child may apply at an enrollment center as provided in IC 12-15-4-1 to receive health care services from the program if the child meets the eligibility requirements of section 2 of this chapter.

Chapter 4. Benefits, Crowd Out, and Cost Sharing

Sec. 1. This chapter does not apply until January 1, 2000.

Sec. 2. (a) The benefit package provided under the program shall focus on age appropriate preventive, primary, and acute care services.

(b) The office shall offer health insurance coverage for the following basic services:

- (1) Inpatient and outpatient hospital services.
- (2) Physicians' services provided by a physician (as defined in 42 U.S.C. 1395x(r)).
- (3) Laboratory and x-ray services.
- (4) Well-baby and well-child care, including:
 - (A) age appropriate immunizations; and
 - (B) periodic screening, diagnosis, and treatment services according to a schedule developed by the office.

The office may offer services in addition to those listed in this subsection if appropriations to the program exist to pay for the additional services.

(c) The office shall offer health insurance coverage for the following additional services if the coverage for the services has an actuarial value equal to or greater than the actuarial value of the services provided by the benchmark program determined by the children's health policy board established by IC 4-23-27-2:

- (1) Prescription drugs.
- (2) Mental health services.
- (3) Vision services.
- (4) Hearing services.
- (5) Dental services.

(d) Notwithstanding subsections (b) and (c), the office may not impose treatment limitations or



financial requirements on the coverage of services for a mental illness if similar treatment limitations or financial requirements are not imposed on coverage for services for other illnesses.

Sec. 3. Premium and cost sharing amounts established by the office are limited by the following:

(1) Deductibles, coinsurance, or other cost sharing is not permitted with respect to benefits for well-baby and well-child care, including age appropriate immunizations.

(2) Premiums and other cost sharing may be imposed based on family income. However, the total annual aggregate cost sharing with respect to all children in a family under this article may not exceed five percent (5%) of the family's income for the year.

Sec. 4. The office may do the following:

(1) Determine cost sharing amounts.

(2) Determine waiting periods that may not exceed three (3) months and exceptions to the requirement of waiting periods for potential enrollees in the program.

(3) Adopt additional methods for complying with federal requirements relating to crowd out.

Sec. 5. (a) It is a violation of IC 27-4-1-4 if an insurer, or an insurance agent or insurance broker compensated by the insurer, knowingly or intentionally refers an insured or the dependent of an insured to the program for health insurance coverage when the insured already receives health insurance coverage through an employer's health care plan that is underwritten by the insurer.

(b) The office shall coordinate with the children's health policy board under IC 4-23-27 to evaluate the need for mechanisms that minimize the incentive for an employer to eliminate or reduce health care coverage for an employee's dependents.

Sec. 6. Community health centers shall be used to provide health care services.

Chapter 5. Provider Contracts

Sec. 1. This chapter does not apply until January 1, 2000.

Sec. 2. A provider agreement must include information that the office finds necessary to facilitate carrying out this article.

Sec. 3. A provider who participates in the program, including a provider who is a member of a managed care organization, must comply with the enrollment requirements that are established under IC 12-15.

Sec. 4. (a) A provider that participates in the Medicaid program is considered a provider for both the Medicaid program and the program under this article.

(b) If an enrollee in the Medicaid managed care program for children has direct access to a provider who has entered into a provider agreement under IC 12-15-11, an enrollee in the program has direct access to the same provider.

Chapter 6. Provider Sanctions, Theft, Kickbacks, and Bribes

Sec. 1. This chapter does not apply until January 1, 2000.

Sec. 2. If after investigation the office finds that a provider has violated this article or rule adopted under this article, the office may impose at least one (1) of the following sanctions:

(1) Deny payment to the provider for program services provided during a specified time.

(2) Reject a prospective provider's application for participation in the program.

(3) Terminate a provider agreement allowing a provider's participation in the program.

(4) Assess a civil penalty against the provider in an amount not to exceed three (3) times the amount paid to the provider that exceeds the amount that was legally due.

(5) Assess an interest charge, at a rate not to exceed the rate established by IC 24-4.6-1-101(2) for judgments on money, on the amount paid to the provider that exceeds the amount that was legally due. The interest charge accrues from the date of the overpayment to the provider.

Sec. 3. In addition to any sanction imposed on a provider under section 2 of this chapter, a provider convicted of an offense under IC 35-43-5-7.2 is ineligible to participate in the program for ten (10) years after the conviction.

Sec. 4. A provider may appeal a sanction imposed under section 2 of this chapter under rules concerning Medicaid provider appeals that are adopted by the secretary under IC 4-22-2.

Sec. 5. After exhausting all administrative remedies, a provider may obtain judicial review of



a sanction under IC 4-21.5-5.

Sec. 6. A final directive may be issued by the office that:

(1) denies payment to a provider for medical services provided during a specified period; or
(2) terminates a provider agreement permitting a provider's participation in the program;
must direct the provider to inform each eligible recipient of services, before services are provided, that the office will not pay for those services if provided.

Sec. 7. Subject to section 8 of this chapter, a final directive:

(1) denying payment to a provider;
(2) rejecting a prospective provider's application for participation in the program; or
(3) terminating a provider agreement allowing a provider's participation in the program;
must be for a sufficient time, in the opinion of the office, to allow for the correction of all deficiencies or to prevent further abuses.

Sec. 8. Except as provided in section 10 of this chapter, a provider sanctioned under section 2 of this chapter may not be declared reinstated as a provider under this article until the office has received the following:

(1) Full repayment of the amount paid to the provider in excess of the proper and legal amount due, including any interest charge assessed by the office.
(2) Full payment of a civil penalty assessed under section 2(4) of this chapter.

Sec. 9. Except as provided in section 10 of this chapter, a provider sanctioned under section 2 of this chapter may file an agreement as provided in IC 12-17.6-5.

Sec. 10. A provider who has been:

(1) convicted of a crime relating to the provision of services under this chapter; or
(2) subjected to a sanction under section 2 of this chapter on three (3) separate occasions by directive of the office;

is ineligible to submit claims for the program.

Sec. 11. Evidence that a person or provider received money or other benefits as a result of a violation of:

(1) a provision of this article; or
(2) a rule established by the office under this article;

constitutes prima facie evidence, for purposes of IC 35-43-4-2, that the person or provider intended to deprive the state of a part of the value of the money or benefits.

Sec. 12. A person who furnishes items or services to an individual for which payment is or may be made under this chapter and who knowingly or intentionally solicits, offers, or receives a:

(1) kickback or bribe in connection with the furnishing of the items or services or the making or receipt of the payment; or
(2) rebate of a fee or charge for referring the individual to another person for the furnishing of items or services;

commits a Class A misdemeanor.

Chapter 7. Funding

Sec. 1. The children's health insurance program fund is established for the purpose of paying expenses relating to:

(1) the program;
(2) services offered through the program for children enrolled in the program; and
(3) services and administration eligible for reimbursement under Title XXI of the federal Social Security Act for children enrolled in Medicaid under IC 12-15-2-14.

Sec. 2. The office shall administer the fund.

Sec. 3. The fund consists of the following:

(1) Amounts appropriated by the general assembly.
(2) Amounts appropriated by the federal government.
(3) Fees, charges, gifts, grants, donations, money received from any other source, and other income funds as may become available.



Sec. 4. The treasurer of state shall invest the money in the fund not currently needed to meet the obligations of the fund in the same manner as other public funds may be invested.

Sec. 5. Money in the fund at the end of a state fiscal year does not revert to the state general fund.

Chapter 8. Appeals and Hearings

Sec. 1. This chapter does not apply until January 1, 2000.

Sec. 2. An applicant for or a recipient of services under the program may appeal to the office if at least one (1) of the following occurs:

(1) An application or a request is not acted upon by the office within a reasonable time after the application or request is filed.

(2) The application is denied.

(3) The applicant or recipient is dissatisfied with the action of the office.

Sec. 3. The secretary shall conduct hearings and appeals concerning the program under IC 4-21.5.

Sec. 4. The office shall, upon receipt of notice of appeal under section 2 of this chapter, set the matter for hearing and give the applicant or recipient an opportunity for a fair hearing in the county in which the applicant or recipient resides.

Sec. 5. (a) At a hearing held under section 4 of this chapter, the applicant or recipient and the office may introduce additional evidence.

(b) A hearing held under section 4 of this chapter shall be conducted under rules adopted by the secretary for applicants and recipients of Medicaid that are not inconsistent with IC 4-21.5 and the program.

Sec. 6. The office:

(1) may make necessary additional investigations; and

(2) shall make decisions concerning the:

(A) granting of program services; and

(B) amount of program services to be granted;

to an applicant or a recipient that the office believes are justified and in conformity with the program.

Chapter 9. Confidentiality and Release of Information

Sec. 1. This chapter does not apply until January 1, 2000.

Sec. 2. The following concerning a program applicant or recipient under the program are confidential, except as otherwise provided in this chapter:

(1) An application.

(2) An investigation report.

(3) An information.

(4) A record.

Sec. 3. The use and the disclosure of the information described in this chapter to persons authorized by law in connection with the official duties relating to:

(1) financial audits;

(2) legislative investigations; or

(3) other purposes directly connected with the administration of the program;

is authorized.

Sec. 4. (a) The release and use of information of a general nature shall be provided as needed for adequate interpretation or development of the program.

(b) The information described in subsection (a) includes the following:

(1) Total program expenditures.

(2) The number of recipients.

(3) Statistical and social data used in connection with studies.

(4) Reports or surveys on health and welfare problems.

Sec. 5. The office shall make available the following to providers for immediate access to



information indicating whether an individual is eligible for the program:

- (1) A twenty-four (24) hour telephone system.
- (2) A computerized data retrieval system.

Sec. 6. Information released under section 5 of this chapter is limited to the following:

- (1) Disclosure of whether an individual is eligible for the program.
- (2) The date the individual became eligible for the program and the individual's program number.
- (3) Restrictions, if any, on the scope of services to be reimbursed under the program for the individual.

Sec. 7. Information obtained by a provider under this chapter concerning an individual's eligibility for the program is confidential and may not be disclosed to any person.

Sec. 8. If it is established that a provision of this chapter causes the program to be ineligible for federal financial participation, the provision is limited or restricted to the extent that is essential to make the program eligible for federal financial participation.

SECTION 178. IC 16-41-40-5, AS AMENDED BY HEA 1547-1999, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 5. (a) A program established under this chapter must include the distribution of readily understandable information and instructional materials regarding childhood hazards. Information concerning shaken baby syndrome, must explain its medical effect on infants and children and emphasize preventive measures.

(b) The information and instructional materials described in subsection (a) concerning shaken baby syndrome must be provided without cost by the following:

- (1) Each hospital licensed under IC 16-21, to a parent or guardian of each newborn upon discharge from the hospital.
- (2) The division of family and children to each provider (as defined in IC 12-7-2-149(4)) or ~~IC 12-7-2-149(5))~~ when:
 - (A) the provider applies for a license from the division under IC 12-17.2 or IC 12-17.4; or
 - (B) the division inspects a facility operated by a provider.

SECTION 179. IC 35-43-5-7.1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2000]: Sec. 7.1. (a) Except as provided in subsection (b), a person who knowingly or intentionally:

- (1) files a Medicaid claim, including an electronic claim, in violation of IC 12-15;
- (2) obtains payment from the Medicaid program under IC 12-15 by means of a false or misleading oral or written statement or other fraudulent means;
- (3) acquires a provider number under the Medicaid program except as authorized by law;
- (4) alters with the intent to defraud or falsifies documents or records of a provider (as defined in 42 CFR 1002.301) that are required to be kept under the Medicaid program; or
- (5) conceals information for the purpose of applying for or receiving unauthorized payments from the Medicaid program;

commits Medicaid fraud, a Class D felony.

(b) The offense described in subsection (a) is a Class C felony if the fair market value of the claim or payment offense is at least fifty one hundred thousand dollars (~~\$50,000~~) (\$100,000).

SECTION 180. IC 35-43-5-7.2 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2000]: Sec. 7.2. (a) Except as provided in subsection (b), a person who knowingly or intentionally:

- (1) files a children's health insurance program claim, including an electronic claim, in violation of IC 12-17.6;
- (2) obtains payment from the children's health insurance program under IC 12-17.6 by means of a false or misleading oral or written statement or other fraudulent means;
- (3) acquires a provider number under the children's health insurance program except as authorized by law;
- (4) alters with intent to defraud or falsifies documents or records of a provider (as defined in 42 CFR 1002.301) that are required to be kept under the children's health insurance program;



or
(5) conceals information for the purpose of applying for or receiving unauthorized payments from the children's health insurance program:
commits insurance fraud, a Class D felony.

(b) The offense described in subsection (a) is a Class C felony if the fair market value of the offense is at least one hundred thousand dollars (\$100,000).

SECTION 181. THE FOLLOWING ARE REPEALED [EFFECTIVE UPON PASSAGE]:
IC 12-7-2-139.1; IC 12-17-18.

SECTION 182. THE FOLLOWING ARE REPEALED [EFFECTIVE JULY 1, 1999]: IC 12-15-2-15;
IC 12-15-2-15.5.

SECTION 183. P.L. 130-1998, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: (a) As used in this SECTION, "committee" refers to the select joint committee on Medicaid oversight established by this SECTION.

(b) As used in this SECTION, "office" refers to the office of Medicaid policy and planning.

(c) The select joint committee on Medicaid oversight is established.

(d) The committee consists of twelve (12) voting members appointed as follows:

(1) Six (6) members shall be appointed by the president pro tempore of the senate, not more than three (3) of whom may be from the same political party.

(2) Six (6) members shall be appointed by the speaker of the house of representatives, not more than three (3) of whom may be from the same political party.

(e) A vacancy on the committee shall be filled by the appointing authority.

(f) The president pro tempore of the senate shall appoint a member of the committee to serve as chairman of the committee from:

(1) January 31, 1998, until December 31, 1998;

(2) **January 1, 2000, until December 31, 2000; and**

(3) **January 1, 2002, until December 31, 2002.**

(g) The speaker of the house of representatives shall appoint a member of the committee to serve as chairman of the committee from:

(1) January 1, 1999, until December 31, 1999; and

(2) **January 1, 2001, until December 31, 2001.**

(h) The committee shall meet at the call of the chairman.

(i) The committee shall study, investigate, and oversee the following:

(1) Whether the contractor of the office under IC 12-15-30 that has responsibility for processing provider claims for payment under the Medicaid program has properly performed the terms of the contractor's contract with the state.

(2) Legislative and administrative procedures that are needed to eliminate Medicaid claims reimbursement backlogs, delays, and errors.

(3) The establishment and implementation of a case mix reimbursement system designed for Indiana Medicaid certified nursing facilities developed by the office.

(4) Any other matter related to Medicaid.

(5) **All matters related to the establishment and implementation of the children's health insurance program established by IC 12-17.6.**

(j) If the office awards a contract for processing provider claims for payment before January 1, 1999, the office shall submit the contract to the:

(1) committee; and

(2) budget committee established by IC 4-12-1-3;

for review before signing the contract or a document related to the contract.

(k) The committee is under the jurisdiction of the legislative council. The legislative services agency shall provide staff support to the committee.

(l) Unless specifically authorized by the legislative council, the chairman may not create subcommittees.



(m) The committee may not recommend proposed legislation to the general assembly unless the proposed legislation is approved by a majority of the voting members appointed to serve on the committee. All votes taken by the committee must be:

- (1) by roll call vote; and
- (2) recorded.

(n) This SECTION expires December 31, ~~1999~~ **2002**.

SECTION 184. [EFFECTIVE UPON PASSAGE] (a) The office may apply to the Secretary of the United States Department of Health and Human Services for a waiver to provide family coverage from the children's health insurance program under IC **12-17.6**, as added by this act, when it is economically efficient to provide family coverage.

(b) This SECTION expires January **1, 2001**.

SECTION 185. [EFFECTIVE JULY 1, 1999] (a) The definitions in IC **12-7-2** apply to this SECTION.

(b) The office in conjunction with the office of Medicaid policy and planning and the division of mental health shall complete a study of mental health services provided to a class of children who are eligible for:

- (1) mental health services funded by the division of mental health;
- (2) the Medicaid program; or
- (3) the children's health insurance program.

(c) The study must include, but is not limited to, the projected cost of mental health services provided through alternative service delivery plan designs.

(d) Information considered in the course of the study must include:

- (1) The number of children described in subsection (b) who are expected to access mental health services; and
- (2) the range and extent of mental health services that will be accessed.

(e) A preliminary report on the study's outcomes shall be completed before January **1, 2000**.

(f) The final report for the study shall be submitted to the select joint committee on Medicaid oversight and the children's health policy board before July **1, 2001**.

(g) This SECTION expires July **1, 2002**.

SECTION 186. [EFFECTIVE UPON PASSAGE] (a) Notwithstanding IC **16-41-40-5**, for purposes of IC **16-41-40-5(b)(2)**, the meaning of "provider" is defined in IC **12-7-2-149(4)**, as amended by this act, and is not defined in IC **12-7-2-149(5)**, as amended by this act.

(b) This SECTION expires July **1, 1999**.

SECTION 187. IC 4-34-3-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]:
Sec. 2. (a) ~~Two million dollars (\$2,000,000) from~~ Money in the fund shall be allocated annually to libraries, including the **INSPIRE** project.

(b) The Indiana library and historical board established by IC 4-23-7-2 and the budget agency may jointly make rules necessary or appropriate to the administration of this chapter.

(c) Each library in Indiana is entitled in each calendar year to apply to the Indiana library and historical board for a grant for a technology project. From time to time, but not more often than semiannually, the Indiana library and historical board shall make recommendations to the budget agency as to grants from the Indiana technology fund. After review by the budget committee established by IC 4-12-1-3 and approval by the governor, the budget agency may allot money to the Indiana library and historical board for the grants.

SECTION 188. IC 4-34-3-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]:
Sec. 4. ~~Three million dollars (\$3,000,000) from~~ Money in the fund shall be allocated annually to the intelenet commission (IC 5-21-2-1) to make matching grants to school corporations or to make payments directly to vendors for Internet connections and related equipment for a school corporation. The intelenet commission shall develop a plan to implement grants under this section. The budget committee shall review the plan. The budget agency must approve of the plan.

SECTION 189. IC 4-34-3-5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]:



Sec. 5. **The following amount from Money** in the fund shall be allocated annually to the technology grant plan program established under IC 20-10.1-25.3 for the following purpose:

~~Fifteen million dollars (\$15,000,000)~~ For technology plan grants to school corporations under IC 20-10.1-25.3. ~~The department of education shall develop a plan for funding all school corporations within a six (6) year cycle. The total technology grant amount to a qualifying school corporation is the amount determined by the department multiplied by the school corporation's ADM. The amount may not exceed two hundred dollars (\$200).~~

SECTION 190. IC 20-10.1-25.3-9 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1991: Sec. 9. The total technology plan grant amount to a qualifying school corporation is the amount determined by the department, with advice from the council, multiplied by the school corporation's ADM. The amount ~~may not exceed two~~ is one hundred dollars ~~(\$200)~~. (\$100). However, for the purposes of determining the ADM of a school corporation, students who are transferred under IC 20-8.1-6.1 or IC 20-8.1-6.5 shall be counted as students having legal settlement in the transferee corporation and not having legal settlement in the transferor corporation.

SECTION 191. IC 4-13.5-1-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1991: Sec. 1. As used in this article:

"Commission" refers to the state office building commission.

"Construction" means the erection, renovation, refurbishing, or alteration of all or any part of buildings, improvements, or other structures, including installation of fixtures or equipment, landscaping of grounds, site work, and providing for other ancillary facilities pertinent to the buildings or structures.

"Correctional facility" means a building, a structure, or an improvement for the custody, care, confinement, or treatment of committed persons under IC 11.

"Department" refers to the Indiana department of administration.

"Mental health facility" means a building, a structure, or an improvement for the care, maintenance, or treatment of persons with mental or addictive disorders.

"Facility" means all or any part of one (1) or more buildings, structures, or improvements (whether new or existing), or parking areas (whether surface or an above or below ground parking garage or garages), owned or leased by the commission or the state for the purpose of:

- (1) housing the personnel or activities of state agencies or branches of state government;
- (2) providing transportation or parking for state employees or persons having business with state government; ~~or~~
- (3) providing a correctional facility; or
- (4) providing a mental health facility.**

"Person" means an individual, a partnership, a corporation, a limited liability company, an unincorporated association, or a governmental entity.

"State agency" means an authority, a board, a commission, a committee, a department, a division, or other instrumentality of state government but does not include a state educational institution (as defined in IC 20-12-0.5-1).

SECTION 192. IC 4-4-10.9-3.1 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1991: Sec. 3.1. "Child care facility" means a:

- (1) child care center licensed under IC 12-17.2-4;**
- (2) child care home licensed under IC 12-17.2-5; or**
- (3) child care ministry licensed under IC 12-17.2-6.**

SECTION 193. IC 4-4-10.9-3.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1991: Sec. 3.2. "Child care facility project" includes the acquisition of land, site improvements, infrastructure improvements, buildings or structures, rehabilitation, renovation, and enlargement of buildings and structures, machinery, equipment, working capital, furnishings, or facilities (or any combination of these):

- (1) comprising or being functionally related and subordinate to a child care facility; and**
- (2) not used or to be used primarily:**
 - (A) for sectarian care;**



- (B) as a place for devotional activities; or**
- (C) in connection with any part of the program of a:**
 - (i) church;**
 - (ii) school; or**
 - (iii) department of divinity;**

for any religious denomination.

SECTION 194. IC 4-4-10.9-11 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 11. (a) Except as provided in subsection (b), "industrial development project" includes:

(1) the acquisition of land, site improvements, infrastructure improvements, buildings, or structures, rehabilitation, renovation, and enlargement of buildings and structures, machinery, equipment, furnishings, or facilities (or any combination of these), comprising or being functionally related and subordinate to any project (whether manufacturing, commercial, agricultural, environmental, or otherwise) the development or expansion of which serves the public purposes set forth in IC 4-4-11-2; **and**

(2) educational facility projects; **and**

(3) **child care facility projects.**

(b) For purposes of the industrial development guaranty fund program, "industrial development project" includes the acquisition of land, interests in land, site improvements, infrastructure improvements, buildings, or structures, rehabilitation, renovation, and enlargement of buildings and structures, machinery, equipment, furnishings, or facilities (or any combination of these), comprising or being functionally related and subordinate to any of the following:

(1) A pollution control facility.

(2) A manufacturing enterprise.

(3) A business service enterprise involved in:

(A) computer and data processing services; or

(B) commercial testing services.

(4) A business enterprise the primary purpose of which is the operation of an education and permanent marketing center for manufacturers and distributors of robotic and flexible automation equipment.

(5) Any other business enterprise, if the use of the guaranty program creates a reasonable probability that the effect on Indiana employment will be creation or retention of at least **fifty (50)** jobs.

(6) An agricultural enterprise in which:

(A) the enterprise operates pursuant to a producer or growout agreement; and

(B) the output of the enterprise is processed predominantly in Indiana.

(7) A business enterprise that is required by a state, federal, or local regulatory agency to make capital expenditures to remedy a violation of a state or federal law or a local ordinance.

(8) A recycling market development project.

SECTION 195. IC 4-4-11-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]:

Sec. 2. (a) The legislature makes the following findings of fact:

(1) That there currently exists in certain areas of the state critical conditions of unemployment or environmental pollution, including water pollution, air pollution, sewage and solid waste, radioactive waste, thermal pollution, radiation contamination, and noise pollution, and that these conditions may well exist, from time to time, in other areas of the state.

(2) That in some areas of the state such conditions are chronic and of long standing and that without remedial measures they may become so in other areas of the state.

(3) That economic insecurity due to unemployment or environmental pollution is a menace to the health, safety, morals, and general welfare of not only the people of the affected areas but of the people of the entire state.

(4) That involuntary unemployment and its resulting burden of indigency falls with crushing force upon the unemployed worker and ultimately upon the state in the form of public assistance and unemployment compensation.



(5) That security against unemployment and the resulting spread of indigency and economic stagnation in the areas affected can best be provided by:

(A) the promotion, attraction, stimulation, rehabilitation, and revitalization of industrial development projects, rural development projects, mining operations, and agricultural operations that involve the processing of agricultural products;

(B) the promotion and stimulation of international exports; and

(C) the education, both formal and informal, of people of all ages throughout the state by the promotion, attraction, construction, renovation, rehabilitation, and revitalization of educational facility projects.

(6) That the present and prospective health, safety, morals, right to gainful employment, and general welfare of the people of the state require as a public purpose the abatement or control of pollution, the promotion of increased educational enrichment (including cultural, intellectual, scientific, or artistic opportunities) for people of all ages through new, expanded, or revitalized educational facility projects, and the promotion of employment creation or retention through development of new and expanded industrial development projects, rural development projects, mining operations, and agricultural operations that involve the processing of agricultural products.

(7) That there is a need to stimulate a larger flow of private investment funds from commercial banks, investment bankers, insurance companies, other financial institutions, and individuals into such industrial development projects, rural development projects, mining operations, international exports, and agricultural operations that involve the processing of agricultural products in the state.

(8) That the authority can encourage the making of loans or leases for creation or expansion of industrial development projects, rural development projects, mining operations, international exports, and agricultural operations that involve the processing of agricultural products, thus putting a larger portion of the private capital available in Indiana for investment to use in the general economic development of the state.

(9) That the issuance of bonds of the authority to create a financing pool for industrial development projects promoting a substantial likelihood of opportunities for:

(A) gainful employment;

(B) business opportunities;

(C) educational enrichment (including cultural, intellectual, scientific, or artistic opportunities);

(D) the abatement, reduction, or prevention of pollution; or

(E) the removal or treatment of any substances in materials being processed that otherwise would cause pollution when used; or

(F) increased options for and availability of child care;

will improve the health, safety, morals, and general welfare of the people of the state and constitutes a public purpose for which the authority shall exist and operate.

(10) That the issuance of bonds of the authority to create a funding source for the making of guaranteed participating loans will promote and encourage an expanding international exports market and international exports sales and will promote the general welfare of all of the people of Indiana by assisting Indiana businesses through stimulation of the expansion of international exports sales for Indiana products and services, especially those of small and medium-sized businesses, by providing financial assistance through the authority.

(b) The Indiana development finance authority shall exist and operate for the public purposes of:

(1) promoting opportunities for gainful employment and business opportunities by the promotion and development of industrial development projects, rural development projects, mining operations, international exports, and agricultural operations that involve the processing of agricultural products, in any areas of the state;

(2) promoting the educational enrichment (including cultural, intellectual, scientific, or artistic opportunities) of all the people of the state by the promotion and development of educational facility projects;

(3) promoting affordable farm credit and agricultural loan financing at interest rates that are



consistent with the needs of borrowers for farming and agricultural enterprises; ~~and~~

(4) preventing and remediating environmental pollution, including water pollution, air pollution, sewage and solid waste disposal, radioactive waste, thermal pollution, radiation contamination, and noise pollution affecting the health and well being of the people of the state by the promotion and development of industrial development projects; and

(5) promoting affordable and accessible child care for the people of the state by the promotion and development of child care facilities.

SECTION 196.IC4-4-11- 17 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]:

Sec. 17. (a) The authority may enter into negotiations with one (1) or more persons concerning the terms and conditions of financing agreements for industrial development projects. The authority shall consider whether a proposed industrial development project may have an adverse competitive effect on similar industrial development projects already constructed or operating in the local governmental unit where the industrial development project will be located. Preliminary expenses in connection with negotiations under this section may be paid from:

(1) money furnished by the proposed user or developer;

(2) money made available by the state or federal government, or by any of their departments or agencies; or

(3) money of the authority, exclusive of the industrial development project guaranty fund.

(b) The authority shall prepare a report that:

(1) briefly describes the proposed industrial development project;

(2) estimates the number and expense of public works or services that would be made necessary or desirable by the proposed industrial development project, including public ways, schools, water, sewers, street lights, and fire protection;

(3) estimates the total costs of the proposed industrial development project;

(4) for an industrial development project that is not exclusively either a pollution control facility or an educational facility project, estimates the number of jobs and the payroll to be created or saved by the project;

(5) for pollution control facilities, describes the facilities and how they will abate, reduce, or prevent pollution; and

(6) for educational facility projects, describes the facilities and how the facilities promote the educational enrichment (including cultural, intellectual, scientific, or artistic opportunities) of the people of the state; and

(7) for child care facility projects, describes the facilities and how the facilities promote accessibility to and increased options for child care for the people of the state.

The report shall be submitted to the executive director or chairman of the plan commission, if any, having jurisdiction over the industrial development project and, if the number of new jobs estimated exceeds one hundred (100), to the superintendent of the school corporation where the industrial development project will be located. The executive director or chairman of the plan commission and the school superintendent may formulate their written comments concerning the report and transmit their comments, if any, to the authority within five (5) days from the receipt of the report.

(c) The authority shall hold a public hearing, which may be conducted by the authority, or any officer, member, or agent designated thereby, on the proposed financing agreement for the industrial development project, after giving notice by publication in one (1) newspaper of general circulation in the city, town, or county where the industrial development project is to be located at least ten (10) days in advance of this public hearing.

(d) If the authority finds that the industrial development project will be of benefit to the health, safety, morals, and general welfare of the area where the industrial development project is to be located, and complies with the purposes and provisions of this chapter, it may by resolution approve the proposed financing agreement. This resolution may also authorize the issuance of bonds payable solely from revenues and receipts derived from the financing agreement or from payments made under an agreement to guarantee obligations of the developer, a user, a related person, or the authority by a developer, a user,



a related person thereto, or the authority pursuant to the industrial development project guaranty fund. The bonds are not in any respect a general obligation of the state, nor are they payable in any manner from revenues raised by taxation.

(e) A financing agreement approved under this section must provide for payments in an amount sufficient to pay the principal of, premium, if any, and interest on the bonds authorized for the financing of the industrial development project. However, interest payments for the anticipated construction period, plus a period of not more than one (1) year, may be funded in the bond issue. The term of a financing agreement may not exceed fifty (50) years from the date of any bonds issued under the financing agreement. However, a financing agreement does not terminate after fifty (50) years if a default under that financing agreement remains uncured, unless the termination is authorized by the terms of the financing agreement. If the authority retains an interest in the industrial development project, the financing agreement must require the user or the developer to pay all costs of maintenance, repair, taxes, assessments, insurance premiums, trustee's fees, and any other expenses relating to the industrial development projects, so that the authority will not incur any expenses on account of the industrial development projects other than those that are covered by the payments provided for in the financing agreement.

SECTION 197. IC 4-4-11-17.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 17.5. (a) In addition to all other authority granted to the authority under this chapter, including the authority to borrow money and to issue bonds to finance directly or indirectly the acquisition or development of industrial development projects undertaken or initiated by the authority, the authority may initiate programs for financing industrial development projects for developers and users in Indiana through the issuance of bonds under this chapter. In furtherance of this objective, the authority may do any of the following:

- (1) Establish eligibility standards for developers and users, without complying with IC 4-22-2. However, these standards have the force of law if the standards are adopted after a public hearing for which notice has been given by publication under IC 5-3-1.
- (2) Contract with any entity securing the payment of bonds issued under this chapter and authorizing the entity to approve the developers and users that can finance or refinance industrial development projects with proceeds from the bond issue secured by that entity.
- (3) Lease to a developer or user industrial development projects upon terms and conditions that the authority considers proper and, with respect to the lease:
 - (A) charge and collect rents;
 - (B) terminate the lease upon the failure of the lessee to comply with any of its obligations under the lease or otherwise as the lease provides; and
 - (C) include in the lease provisions that the lessee has the option to renew the term ~~of~~ the lease for such periods and at such rents ~~as~~ may be determined by the authority or to purchase any or all of the industrial development projects to which the lease applies.
- (4) Lend money, upon such terms and conditions as the authority considers proper, to a developer or user under an installment purchase contract or loan agreement to:
 - (A) finance, reimburse, or refinance the cost of an industrial development project; and
 - (B) take back a secured or unsecured promissory note evidencing such a loan or a security interest in the industrial development project financed or refinanced with the loan.
- (5) Sell or otherwise dispose of any unneeded or obsolete industrial development project under terms and conditions determined by the authority.
- (6) Maintain, repair, replace, and otherwise improve or cause to be maintained, repaired, replaced, and otherwise improved any industrial development project owned by the authority.
- (7) Require any type of security that the authority considers reasonable and necessary.
- (8) Obtain or aid in obtaining property insurance on all industrial development projects owned or financed, or accept payment if any industrial development project property is damaged or destroyed.
- (9) Enter into any agreement, contract, or other instrument with respect to any insurance, guarantee, letter of credit, or other form of credit enhancement, accepting payment in such manner and form



as provided in the instrument if a developer or user defaults, and assign any such insurance, guarantee, letter of credit, or other form of credit enhancement as security for bonds issued by the authority.

(10) Finance for eligible developers and users in connection with their industrial development projects:

(A) the cost of their industrial development projects; and

(B) in the case of a program funded from the proceeds of taxable bonds, working capital associated with the operation of such industrial development projects;

in amounts determined to be appropriate by the authority.

(11) Issue bonds to fund a program for financing multiple, identified or unidentified industrial development projects if the authority finds that issuance of the bonds will be of benefit to the health, safety, morals, or general welfare of the state and complies with the purposes and provisions of this chapter by promoting a substantial likelihood for:

(A) creating opportunities for gainful employment;

(B) creating business opportunities;

(C) educational enrichment (including cultural, intellectual, scientific, or artistic opportunities);

(D) the abatement, reduction, or prevention of pollution; ~~or~~

(E) the removal or treatment of any substances in materials being processed that would otherwise cause pollution when used; or

(F) **promoting affordable and accessible child care.**

The authority may by resolution approve the proposed taxable bond issue. **The authority may use appropriations to create a debt service reserve fund for the purpose of allowing the authority to issue pooled bonds, either tax exempt or taxable, for the construction or renovation of licensed child care facilities under the authority's industrial development project section.**

(b) As each unidentified industrial development project is identified for possible funding from a program under subsection (a)(11), the requirements of sections 17(a), 17(b), 17(c), and 17(e) of this chapter shall be complied with as a condition precedent to entering into a financing agreement for the funding of the industrial development project.

(c) Bonds issued to fund a program under this section are not in any respect a general obligation of the state, nor are they payable in any manner from revenues raised by taxation.

(d) Any resolution adopted to authorize the issuance of taxable bonds to fund a program under subsection (a)(11) may provide that the bonds are payable solely from:

(1) revenues and receipts derived from the various financing agreements; or

(2) the payments made under any other agreements to secure the obligations of the developers, users, related persons, or the authority.

(e) The obligations described in subsection (d)(2) may be secured under the agreement by the authority under the industrial development project guaranty fund or by the developers, users, or related persons.

SECTION 198. IC 4-4-26-25 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]:

Sec. 25. The lender shall determine the premium charges payable to the reserve fund by the lender and the borrower in connection with a loan filed for enrollment. The premium paid by the borrower may not be less than one and one-half percent (1.5%) or greater than three and one-half percent (3.5%) of the amount of the loan. The premium paid by the lender must be equal to the amount of the premium paid by the borrower. The lender may recover the cost of the lender's premium payment from the borrower in any manner on which the lender and borrower agree. When enrolling a loan, the authority must transfer into the reserve fund from the account premium amounts determined as follows:

(1) If the amount of a loan, plus the amount of loans previously enrolled by the lender, is less than two million dollars (\$2,000,000), the premium amount transferred must be equal to one hundred ~~fifty~~ percent (150%) of the combined premiums paid into the reserve fund by the borrower and the lender for each enrolled loan.

(2) If, before the enrollment of the loan, the amount of loans previously enrolled by the lender is equal to or greater than two million dollars (\$2,000,000), the premium amount transferred must be



equal to the combined premiums paid into the reserve fund by the borrower and the lender for each enrolled loan.

(3) If the aggregate amount of all loans previously enrolled by the lender is less than two million dollars (\$2,000,000), but the enrollment of a loan will cause the aggregate amount of all enrolled loans made by the lender to exceed two million dollars (\$2,000,000), the authority shall transfer into the reserve fund an amount equal to a percentage of the combined premiums paid into the reserve fund by the lender and the borrower. The percentage is determined as follows:

STEP ONE: Multiply by one hundred fifty (150) that part of the loan that when added to the aggregate amount of all loans previously enrolled by the lender totals two million dollars (\$2,000,000).

STEP TWO: Multiply the remaining balance of the loan by one hundred (100).

STEP THREE: Add the STEP ONE product to the STEP TWO product.

STEP FOUR: Divide the STEP THREE sum by the total amount of the loan.

The authority may transfer two (2) times the amount determined under this section to the reserve fund if the borrower is a disadvantaged business enterprise (as defined in IC 5-16-6.5-1). The authority may transfer to the reserve fund three (3) times the amount determined under this section if the borrower is a child care facility. Unless money is paid out of the reserve fund according to the specific terms of this chapter, all money paid into the reserve account by the lender shall remain in that account.

SECTION 199. IC 12-14-28 IS ADDED TO THE INDIANA CODE AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]:

Chapter 28. Temporary Assistance to Needy Families Expenditures

Sec. 1. As used in this chapter, "qualifying family" means a family that meets all the following conditions:

(1) The family consists of:

(A) a pregnant woman;

(B) a child who is less than eighteen (18) years of age; or

(C) a child who is at least eighteen (18) years of age but less than twenty-four (24) years of age who is attending secondary or post secondary school at least half-time.

(2) The child described in subdivision (1)(B) or (1)(C) resides with a custodial parent or other adult caretaker relative, which may include a child that may be temporarily living away from the custodial parent or other adult caretaker relative while attending school.

(3) The gross family income is less than two hundred fifty percent (250%) of the federal poverty level.

Sec. 2. (a) The division shall use the criteria for a qualifying family set forth in section 1 of this chapter to determine and apply all other state or local program expenditures by all state agencies and by political subdivisions that qualify as expenditures toward Indiana's maintenance of effort under the federal Temporary Assistance to Needy Families (TANF) program (45 CFR 260 et seq.).

(b) The division shall determine whether the amount of expenditures that it projects will be reported to the federal government as Indiana's maintenance of effort under the federal Temporary Assistance to Needy Families (TANF) program (45 CFR 265) will be less than necessary to avoid a reduction in the federal TANF distribution to Indiana.

Sec. 3. (a) The division may provide assistance under a plan of temporary assistance to needy families for a qualifying family.

(b) Individuals who may receive assistance for a qualifying family must reside with the qualifying family and include the following individuals:

(1) The custodial parent or other adult caretaker relative.

(2) The spouse of the custodial parent or other adult caretaker relative.

(3) A child who is less than eighteen (18) years of age.

(4) A child who is at least eighteen (18) years of age but less than twenty-four (24) years of age and who is attending secondary or post secondary school at least half-time, even though the child may be temporarily living away from the custodial parent or other adult caretaker



relative while attending school.

(5) A pregnant woman and her spouse if the family's eligibility is based on the pregnancy.

(6) The noncustodial parent of a child described in subdivision (3) or (4) even though the noncustodial parent is not residing with the eligible family.

Sec. 5. The division may establish income eligibility limits that are lower than those specified in section 1 of this chapter for a particular type of benefit or service.

Sec. 6. This chapter shall not be interpreted as an entitlement for an individual or family to assistance under a program established under Indiana's plan of temporary assistance to needy families.

Sec. 7. The division may adopt rules under IC 4-22-2 necessary to implement this chapter.

SECTION 200. IC 20-8.1-9-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 2. The department shall adopt procedures that must be followed by applicants in order for them to qualify for assistance under this chapter. These procedures must include obtaining information needed by the family and social services administration to determine if the recipient is a child who is a member of a qualifying family, as defined in IC 12-14-28-1, including the familial relationship of the child to the head of the household. The financial eligibility standard for an applicant under this chapter must be the same criteria used for determining eligibility for receiving free or reduced price lunches under the national school lunch program.

SECTION 201. IC 20-12-22.1-10.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 10.5. The commission may establish accumulated credit requirements as a condition of eligibility for an award made under this chapter.

SECTION 202. IC 20-12-22.1-14 IS REPEALED [EFFECTIVE JULY 1, 1999].

SECTION 203. IC 20-12-75 IS ADDED TO THE INDIANA CODE AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2000]:

Chapter 75. Community College System

Sec. 1. As used in this chapter, "general education" means education that is:

- (1) not directly related to a student's formal technical, occupational, or professional preparation;
- (2) a part of every student's course of study, regardless of the student's area or emphasis; and
- (3) intended to impart common knowledge, intellectual concepts, and attitudes that every educated person should possess.

Sec. 2. As used in this chapter, "occupational and technical education" means education that is:

- (1) job employment oriented and
- (2) intended to deliver occupational specific skills that are necessary for employment.

Sec. 3. As used in this chapter, "system" refers to a community college system established by this chapter.

Sec. 4. (a) A community college system is established as a coordinated partnership of Vincennes University and Ivy Tech State College that:

- (1) offers a community college curriculum at all major instructional sites of Ivy Tech State College; and
- (2) provides an opportunity for students to earn associate degrees that are accepted by four (4) year colleges and universities.

(b) Notwithstanding any provision of this chapter, no courses may be offered by the community college system established by this section before January 1, 2000.

Sec. 5. Although the community college system is a coordinated partnership of Vincennes University and Ivy Tech State College, under the community college system:

- (1) each institution remains an independent entity; and
- (2) the coordinated system shall not in any way limit the independence of each institution.

Sec. 6. Vincennes University shall offer:

- (1) associate of arts and associate of science degrees, which consist of courses that are in the liberal arts, and which are designed and articulated explicitly to prepare students for



junior-level standing in baccalaureate degree programs at four **(4)** year institutions; and
(2) general education courses, including calculus and 200-level mathematics courses, except those general education courses to be taught by Ivy Tech State College under section 7(2) of this chapter.

Sec. 7. Ivy Tech State College shall offer:

- (1) associate of science and associate of applied science degrees, which are designed to prepare individuals for the job market and which may also transfer, one year technical certificates and short term certificates;
- (2) anatomy and physiology, computer literacy, and 100-level mathematics courses; and
- (3) all remedial education.

Sec. 8. (a) For purposes of this section, "business and industry responsibilities" include the delivery of workforce literacy programs such as programs designed to enhance the language arts, mathematics, and literacy **skills** of workers.

(b) Ivy Tech State College shall have responsibility for providing business and industry training throughout the state, except for the regions surrounding the Vincennes University campuses in Vincennes and Jasper.

(c) Vincennes University shall continue its coordination of business **and** industry training at the level that existed as of January 1, 1999, but shall do **so** in cooperation with Ivy Tech State College.

Sec. 9. **A** framework for implementing sections 6 through 8 of **this** chapter shall be mutually agreed upon by both the Vincennes University board of trustees and Ivy Tech State College state board of trustees and shall be approved by the community college policy committee.

Sec. 10. Establishment of the community college system shall not constrain the ability of:

- (1) Ivy Tech State College to offer the array of degree programs it offered as of January 1, 1999; and
- (2) Vincennes University to offer the array of degree programs it offered as of January 1, 1999, at Vincennes, Jasper, and the aviation technology center in Indianapolis.

Sec. 11. (a) The commission for higher education established by IC 20-12-0.5-2 shall make a community college system report to the budget committee and the legislative council by August **1** of each year. Vincennes University and Ivy Tech State College shall assist the commission for higher education in the preparation of this report.

(b) The report described in subsection (a) must include all of the following information:

- (1) Enrollment at each community college system site.
- (2) Projected enrollments.
- (3) Costs to students.
- (4) Revenues, expenditures, and other financial information.
- (5) Program information.
- (6) Other information pertinent to the educational opportunity offered by the community college system.

Sec. 12. (a) **A** community college policy committee shall be created to:

- (1) oversee the implementation of the community college system, including the selection of the sites at which the community college system will be offered and the timetable for implementing these sites;
- (2) review the broad policies and principles to be used to carry out and guide the implementation; and
- (3) serve as a communication link among the two (2) **boards** of trustees and the commission for higher education with regard to implementing the community college system.

(b) The community college policy committee shall not exercise any powers that have been assigned to the Vincennes University board of trustees, the Ivy Tech State College state board of trustees, or the commission for higher education.

(c) The community college policy committee consists of three (3) members of the Vincennes University board of trustees, three (3) members of the Ivy Tech State College state board of



trustees, and five (5) members appointed by the governor. The president of Vincennes University, the president of Ivy Tech State College, and the commissioner for higher education shall serve as ex officio members of the community college policy committee.

Sec. 13. (a) For purposes of this section, the IUPUI campus of Indiana University is not considered to be a regional campus.

(b) Except as provided by subsection (c), the community college system may not be implemented at any site where an Indiana University or Purdue University regional campus is located until after June 30, 2002.

(c) One **(1)** community college system site may be implemented at a site where a regional campus of Indiana University or Purdue University is located if approved by the governor.

(d) **A** community college site selected by the community college policy committee may not be implemented unless:

(1) the legislative council has recommended the approval of the site to the state budget committee; and

(2) the state budget committee has approved the site.

(e) The community college system may not be implemented at more than ten **(10)** Ivy Tech State College sites before July 1, 2002.

SECTION 204. IC 11-8-1-5.4 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 5.4. "Community corrections program" has the meaning set forth in IC 11-12-1-1.

SECTION 205. IC 11-8-1-5.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 5.5. "Community transition program" means assignment of a person committed to the department to:

(1) a community corrections program; or

(2) in a county or combination of counties that do not have a community corrections program, a program of supervision by the probation department of a court; for a period after a person's community transition program commencement date until the person completes the person's fixed term of imprisonment, less the credit time the person has earned with respect to the term.

SECTION 206. IC 11-8-1-5.6 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 5.6. "Community transition program commencement date" means the following:

(1) Sixty **(60)** days before an offender's expected release date, if the most serious offense for which the person is committed is a Class **D** felony.

(2) Ninety **(90)** days before an offender's expected release date, if the most serious offense for which the person is committed is a Class **C** felony.

(3) One hundred twenty **(120)** days before an offender's expected release date, if the most serious offense for which the person is committed is a Class **A** or Class **B** felony.

SECTION 207. IC 11-8-1-8.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 8.5. "Expected release date" means the most likely date on which a person would be entitled under IC 35-50-6-1(a)(2) or IC 35-50-6-1(a)(3) to release to the committing court for probation or release on parole considering:

(1) the term of the sentence;

(2) the term of any other concurrent or consecutive sentence that the person must serve;

(3) credit time that the person has earned before sentencing;

(4) credit time that the person has earned on and after sentencing; and

(5) the amount of credit time that the person would earn if the person remains in the credit time class in which the person is currently assigned during the person's period of imprisonment.

SECTION 208. IC 11-10-1 1.5 IS ADDED TO THE INDIANA CODE AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]:



Chapter 11.5. Assignment to Community Transition Program

Sec. 1. This chapter applies to a person who is committed to the department under IC 35-50 for one (1) or more felonies other than murder.

Sec. 2. Not earlier than sixty (60) days and not later than forty-five (45) days before an offender's community transition program commencement date, the department shall give the court that sentenced the offender written notice of the offender's eligibility for a community transition program. The notice must include the following information:

- (1) The person's name.
- (2) A description of the offenses for which the person was committed to the department.
- (3) The person's expected release date.
- (4) The person's community transition program commencement date.
- (5) The person's current security and credit time classifications.
- (6) A report summarizing the person's conduct while committed to the department.
- (7) Any other information that the department determines would assist the sentencing court in determining whether to issue an order under IC 35-38-1-24 or IC 35-38-1-25.

Sec. 3. The department shall provide any other information requested by the sentencing court.

Sec. 4. The department shall send a copy of the notice required under section 2 of this chapter to the prosecuting attorney where the person's case originated. The notice under this section need not include the information described in section 2(6) through 2(7) and section 3 of this chapter.

Sec. 5. (a) This section applies to a person if the most serious offense for which the person is committed is a Class C or D felony.

(b) Unless the department has received:

- (1) an order under IC 35-38-1-24; or
- (2) a warrant order of detainer seeking the transfer of the person to a county or another jurisdiction:

the department shall assign a person to a community transition program beginning with the person's community transition program commencement date until the person completes the person's fixed term of imprisonment, less the credit time the person has earned with respect to the term.

Sec. 6. (a) This section applies to a person if the sentencing court orders the department to assign a person to a community transition program under IC 35-38-1-25.

(b) The department shall assign a person to a community transition program beginning with the date specified in the sentencing court's order until the person completes the person's fixed term of imprisonment, less the credit time the person has earned with respect to the term.

Sec. 7. Not later than the first regular business day after a person is assigned to a community transition program under this chapter, the department shall:

- (1) comply with the procedures in IC 11-10-12-1(a)(1) and IC 11-10-12-1(a)(2); and
- (2) transport the person to the sheriff of the county where the person's case originated or to any other person ordered by the sentencing court.

The department may, upon request of the person, issue the work clothing described in IC 11-10-12-1(b).

Sec. 8. The person receiving the offender under section 7 of this chapter shall transfer the offender to the intake person for the community transition program.

Sec. 9. A person assigned to a community transition program shall remain in the assignment until the person completes the person's fixed term of imprisonment, less the credit time the person has earned with respect to the term, unless the sentencing court orders the person returned to the jurisdiction of the department under IC 35-38-1-26. IC 11-10-12-2 does not apply to a person who completes an assignment in a community transition program.

Sec. 10. A person assigned to a community transition program continues to earn credit time during the person's assignment to a community transition program.

Sec. 11. While assigned to a community transition program, a person must comply with:



(1) the rules concerning the conduct of persons in the community transition program, including rules related to payments described in sections 12 and 13 of this chapter, that are adopted by the community corrections advisory board establishing the program or, in counties that are not served by a community corrections program, that are jointly adopted by the courts in the county with felony jurisdiction; and

(2) any conditions established by the sentencing court for the person.

Sec. 12. (a) Any earnings of a person employed while in a community transition program, less payroll deductions required by law and court ordered deductions for satisfaction of a judgment against that person, shall be collected by the Community transition program. Unless otherwise ordered by the sentencing court, the remaining earnings shall be distributed in the following order:

(1) To pay state and federal income taxes and Social Security deductions not otherwise withheld.

(2) To pay the cost of membership in an employee organization.

(3) Not less than twenty-five percent (25%) of the person's gross earnings, if that amount of the gross is available after the above deductions, to be given to that person or retained for the person, with accrued interest, until the person's release or discharge.

(4) To pay for the person's room and board or electronic monitoring provided by the community transition program.

(5) To pay transportation costs to and from work and other work related incidental expenses incurred by the community transition program.

(6) To pay court ordered costs, fines, or restitution.

(b) After the amounts prescribed in subsection (a) are deducted, the remaining amount may be used to:

(1) when directed by the person or ordered by the court, pay for the support of the person's dependents (if the person's dependents are receiving welfare assistance, the appropriate office of family and children or welfare department in another state shall be notified of such disbursements); and

(2) with the consent of the person, pay to the person's victims or others any unpaid obligations of that person.

(c) Any remaining amount shall be given to the person or retained for the person according to subsection (a)(3).

(d) The collection of room and board or electronic monitoring costs under subsection (a)(4) may be waived.

Sec. 13. (a) This section does not apply to a person in a community transition program who:

(1) maintains a policy of insurance from a private company covering:

(A) medical care;

(B) dental care;

(C) eye care; or

(D) any other health care related service; or

(2) is willing to pay for the person's own medical care.

(b) Except as provided in subsection (c), a person in a community transition program may be required to make a copayment in an amount of not more than ten dollars (\$10) for each provision of any of the following services:

(1) Medical care.

(2) Dental care.

(3) Eye care.

(4) Any other health care related service.

(c) A person in a community transition program is not required to make the copayment under subsection (b) if:

(1) the person does not have funds in the person's account or trust account at the time the service is provided;



(2) the person does not have funds in the person's account or trust account within thirty (30) days after the service is provided;

(3) the service is provided in an emergency;

(4) the service is provided as a result of an injury received in the community transition program; or

(5) the service is provided at the request of the community transition program.

(d) Money collected must be deposited into the program's community transition program fund.

(e) Rules for the implementation of this section must be approved by the county legislative bodies of the counties served by the community transition program.

SECTION 209. IC 11-12-10 IS ADDED TO THE INDIANA CODE AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]:

Chapter 10. Community Transition Programs

Sec. 1. A county or a combination of counties shall establish a community transition program as part of its community corrections program. If a county does not participate in a community corrections program, each court with felony jurisdiction in the county shall provide community transition program services through the probation department for the court.

Sec. 2. A community transition program for a county must provide services that improve an offender's chances of making a successful transition from commitment to employment and participation in the community without the commission of further crimes. The program may include any of the services described in IC 11-12-1-2.5.

Sec. 3. There is established a community transition program fund for each community transition program. The fund shall be administered by the community corrections advisory board in each county served by a community corrections program. In a county that is not served by a community corrections program, the courts in the county with felony jurisdiction shall jointly administer the fund. Money in the fund may be used for community corrections programs and, in counties that are not served by a community corrections program, for probation services.

Sec. 4. (a) The department shall reimburse communities on a per diem basis for services provided to persons assigned to a community transition program under IC 11-10-11.5.

(b) The department shall set the per diem rate under this section. In setting the per diem rate for a community, the department may consider the direct costs incurred by the community to provide a community transition program. The per diem may not be less than seven dollars (\$7).

(c) Funding provided under this section is in addition to any other funding received under IC 11-12-2 for community corrections programs or IC 11-13-2 for probation services.

(d) Money received by a community under this section shall be deposited in the community transition program fund for the community.

SECTION 210. IC 35-38-1-24 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 24. (a) This section applies to a person if the most serious offense for which the person is committed is a Class C or Class D felony.

(b) Not later than forty-five (45) days after receiving a notice under IC 11-10-11.5-2, the sentencing court may order the department of correction to retain control over a person until the person completes the person's fixed term of imprisonment, less the credit time the person has earned with respect to the term, if the court makes specific findings that support a determination:

(1) that placement of the person in a community transition program:

(A) places the person in danger of serious bodily injury or death or

(B) represents a substantial threat to the safety of others; or

(2) of other good cause.

If the court issues an order under this section, the department of correction may not assign a person to a community transition program.

(c) The court may make a determination under this section without a hearing.

(d) The court shall make written findings for a determination under this section, whether or not a hearing was held.



(e) Not later than five (5) days after making a determination under this section, the court shall send a copy of the order to the:

- (1) prosecuting attorney where the person's case originated; and
- (2) department of correction.

SECTION 211. IC 35-38-1-25 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 25. (a) This section applies to a person if the most serious offense for which the person is committed is a Class A or Class B felony.

(b) A sentencing court may sentence a person or modify the sentence of a person to assign the person to a community transition program for any period that begins after the person's community transition program commencement date (as defined in IC 11-8-1-5.6) and ends when the person completes the person's fixed term of imprisonment, less the credit time the person has earned with respect to the term, if the court makes specific findings of fact that support a determination that it is in the best interests of justice to make the assignment. The order may include any other condition that the court could impose if the court had placed the person on probation under IC 35-38-2 or in a community corrections program under IC 35-38-2.6.

(c) The court may make a determination under this section without a hearing.

(d) The court shall make written findings for a determination under this section, whether or not a hearing was held.

(e) Not later than five (5) days after making a determination under this section, the court shall send a copy of the order to the:

- (1) prosecuting attorney where the person's case originated; and
- (2) department of correction.

SECTION 212. IC 35-38-1-26 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 26. A sentencing court, after a hearing, may take any of the following actions if a person assigned to a community transition program fails to comply with a rule or condition established under IC 11-10-11.5-11:

- (1) Order the person reassigned to a program or facility administered by the department.
- (2) Reassign the person from one (1) credit time classification to another or deprive the person of any credit time earned while assigned to a community transition program, or both.
- (3) Recommend to the parole board that the person be released on parole under IC 35-50-6-1 after the person completes the person's fixed term of imprisonment, less the credit time that the person has earned with respect to that term.

The sentencing court shall send a copy of any order issued under this section to the department of correction.

SECTION 213. IC 35-41-1-4.4 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 4.4. "Community transition program" has the meaning set forth in IC 11-8-1-5.5.

SECTION 214. IC 35-41-1-15 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 15. "Imprison" means to:

- (1) confine in a penal facility; ~~or to~~
- (2) commit to the department of correction; or
- (3) assign to a community transition program under IC 11-10-11.5.

SECTION 215. IC 35-50-6-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 1. (a) Except as provided in subsection (d), when a person imprisoned for a felony completes his fixed term of imprisonment, less the credit time he has earned with respect to that term, he shall be: ~~released:~~

- (1) discharged, if the person is assigned to a community transition program and the committing court does not recommend to the parole board that the person be released on parole;
- (1) (2) released on parole for a period not exceeding twenty-four (24) months, as determined by the parole board; or



~~(2)~~ (3) released to the committing court if his sentence included a period of probation.

(b) Except **as** provided in subsection (d), a person released on parole remains on parole from the date of his release until his fixed term expires, unless his parole is revoked or he is discharged from that term by the parole board. In any event, if his parole is not revoked, the parole board shall discharge him after the period set under subsection (a) or the expiration of the person's fixed term, whichever is shorter.

(c) A person whose parole is revoked shall be imprisoned for the remainder of his fixed term. However, he shall again be released on parole when he completes that remainder, less the credit time he has earned since the revocation. The parole board may reinstate him on parole at any time after the revocation.

(d) When an offender (as defined in IC 5-2-12-4) completes the offender's fixed term of imprisonment, less credit time earned with respect to that term, the offender shall be placed on parole for not more than ten (10) years.

SECTION 216. [EFFECTIVE JULY 1, 1999] IC 11-10-11.5, **as** added by this act, applies only to persons whose community transition program commencement date (as defined in IC 11-8-1-5.6, as added by this act), occurs after August 31, 1999.

SECTION 217. IC 5-2-10.1-0.3 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 0.3. **As** used in this chapter, "commission" refers to a county school safety commission established under section 10 of this chapter.

SECTION 218. IC 5-2-10.1-1.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 1.5. **As** used in this chapter, "institute" refers to the Indiana criminal justice institute established under IC 5-2-6.

SECTION 219. IC 5-2-10.1-1.7 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 1.7. As used in this chapter, "safety plan" refers to any school safety plan required by the Indiana state board of education.

SECTION 220. IC 5-2-10.1-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 2. (a) The Indiana safe schools fund is established to do the following:

(1) Promote school safety through the:

- (A) purchase of equipment for the detection of firearms and other **deadly** weapons;
- (B) use of dogs trained to detect firearms, drugs, explosives, and illegal substances; and
- (C) purchase of other equipment and materials used to enhance the safety of schools.

(2) Combat truancy.

(3) Provide matching grants to schools for school safe haven programs,

(4) Provide grants for school safety **and** safety plans.

(b) The fund consists of amounts deposited:

(1) under IC 33-19-9-4; and

(2) from any other public or private source.

(c) The institute **shall** determine grant recipients from the fund with a priority on awarding grants in the following order:

(1) A grant for a safety plan.

(2) A safe haven grant requested under section 10 of this chapter.

(3) A safe haven grant requested under section 7 of this chapter.

(d) Upon recommendation of the council, the institute shall establish a method for determining the maximum amount a grant recipient may receive under this section.

SECTION 221. IC 5-2-10.1-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 3. The **Indiana criminal justice** institute established by IC 5-2-6 shall administer the fund. Costs of administering the fund shall be paid from money in the fund.

SECTION 222. IC 5-2-10.1-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 6. (a) A school corporation may receive a grant from the fund for programs, equipment, services, **or** activities included in a **safe schools** safety plan submitted with the application for funds to the **Indiana criminal justice** institute.

(b) A safety plan submitted under this section must include provisions for zero (0) tolerance for



alcohol, tobacco, drugs, and ~~deadly~~ weapons on school property. If the ~~Indiana criminal justice~~ institute approves the safety plan and application, the treasurer of state shall disburse from the fund to the applicant the amount of the grant certified to the treasurer of state by the ~~Indiana criminal justice~~ institute.

SECTION 223. IC 5-2-10.1-7 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 7. (a) ~~As used in this chapter, "criminal justice institute" refers to the Indiana criminal justice institute established under IC 5-2-6.~~

~~(b)~~ **(b)** As used in this section, "program" refers to a school safe haven program.

~~(c)~~ **(b)** A school corporation may apply to the ~~criminal justice~~ institute for a grant for matching funds under this chapter to establish and operate a school safe haven program.

~~(d)~~ **(c)** A program must include at least the following components:

(1) The school must be open to students of the school before and after normal operating hours, preferably from 7 a.m. to 9 p.m., on days determined by the school corporation.

(2) The program must operate according to a plan to do the following in the school:

(A) Reduce alcohol, tobacco, and drug abuse.

(B) Reduce violent behavior.

(C) Promote educational progress.

~~(e)~~ **(d)** The ~~criminal justice~~ institute shall adopt rules to administer the program, including rules concerning evaluations by school corporations on the use and impact of grant money received through the program.

SECTION 224. IC 5-2-10.1-9 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 9. (a) Each school corporation shall designate an individual to serve as the school safety specialist for the school corporation.

(b) The school safety specialist shall be chosen by the superintendent of the school corporation with the approval of the governing body.

(c) The school safety specialist shall perform the following duties:

(1) Serve on the county school safety commission, if a county school safety commission is established under section 10 of this chapter.

(2) Participate each year in a number of days of school safety training that the council determines.

(3) With the assistance of the county school safety commission, if a county school safety commission is established under section 10 of this chapter, develop a safety plan for each school in the school corporation.

(4) Coordinate the safety plans of each school in the school corporation as required under rules adopted by the Indiana state board of education.

(5) Act as a resource for other individuals in the school corporation on issues related to school discipline, safety, and security.

SECTION 225. IC 5-2-10.1-10 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 10. (a) A county may establish a county school safety commission.

(b) The members of the commission are as follows:

(1) The school safety specialist for each school corporation located in whole or in part in the county.

(2) The judge of the court having juvenile jurisdiction in the county or the judge's designee.

(3) The sheriff of the county or the sheriff's designee.

(4) The chief officer of every other law enforcement agency in the county, or the chief officer's designee.

(5) A representative of the juvenile probation system, appointed by the judge described under subdivision (2).

(6) Representatives of community agencies that work with children within the county.

(7) A representative of the Indiana state police district that serves the county.

(8) A representative of the Prosecuting Attorneys Council of Indiana who specializes in the



prosecution of juveniles.

(9) Other appropriate individuals selected by the commission.

(c) If a commission is established, the school safety specialist of the school corporation having the largest ADM (as defined in IC **21-3-1.6-1.1**) in the county shall convene the initial meeting of the commission.

(d) The members shall annually elect a chairperson.

(e) A commission shall perform the following duties:

(1) Perform a cumulative analysis of school safety needs within the county.

(2) Coordinate and make recommendations for the following:

(A) Prevention of juvenile offenses and improving the reporting of juvenile offenses within the schools.

(B) Proposals for identifying and assessing children who are at high **risk** of becoming juvenile offenders.

(C) Methods to meet the educational needs of children who have been detained as juvenile offenders.

(D) Methods to improve communications among agencies that work with children.

(E) Methods to improve security and emergency preparedness.

(F) Additional equipment or personnel that are necessary to carry out safety plans.

(G) Any other topic the commission considers necessary to improve school safety within the school corporations within the commission's jurisdiction.

(3) Provide assistance to the school safety specialists on the commission in developing and requesting grants for safety plans.

(4) Provide assistance to the school safety specialists on the commission and the participating school corporations in developing and requesting grants for school safe haven programs under section **7** of this chapter.

(5) Assist each participating school corporation in carrying out the school corporation's safety plans.

(f) The affirmative votes of a majority of the voting members of the commission are required for the commission to take action on a measure.

SECTION 226. IC 5-2-10.1-11 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE **JULY** 1, 1999]: Sec. **11.** (a) The school safety specialist training and certification program is established.

(b) The school safety specialist training program shall provide:

(1) annual training sessions, which may be conducted through distance learning or at regional centers; and

(2) information concerning best practices and available resources;

for school safety specialists and county school safety commissions.

(c) The department of education shall do the following:

(1) Assemble an advisory group of school safety specialists from around the state to make recommendations concerning the curriculum and standards for school safety specialist training.

(2) Develop an appropriate curriculum and the standards for the school safety specialist training and certification program. The department of education may consult with national school safety experts in developing the curriculum and standards.

(3) Administer the school safety specialist training program and notify the institute of candidates for certification who have successfully completed the training program.

(d) The institute shall do the following:

(1) Establish a school safety specialist certificate.

(2) Review the qualifications of each candidate for certification named by the department of education.

(3) Present a certificate to each school safety specialist that the institute determines to be



eligible for certification.

SECTION 227. IC 6-3.1-21 IS ADDED TO THE INDIANA CODE AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 1999 (RETROACTIVE)]:

Chapter 21. Earned Income Tax Credit

Sec. 1. This chapter creates the Indiana earned income tax credit.

Sec. 2. As used in this chapter, "earned income" means the sum of the:

- (1) wages, salaries, tips, and other employee compensation; and
- (2) net earnings from self-employment (as computed under Section 32(c)(2) of the Internal Revenue Code);

of an individual taxpayer, and the individual's spouse, if the individual files a joint adjusted gross income tax return.

Sec. 3. As used in this chapter, "Indiana total income" means gross income (as defined in Section 61 of the Internal Revenue Code) for an individual, and if the individual files a joint return, the individual's spouse, for a year.

Sec. 4. As used in this chapter, "qualifying child" has the meaning set forth in Section 32(c)(3) of the Internal Revenue Code.

Sec. 5. An individual who, in a year, has:

- (1) at least one (1) qualifying child;
- (2) Indiana total income from all sources of not more than twelve thousand dollars (\$12,000); and
- (3) Indiana total income from earned income that is at least eighty percent (80%) of the individual's Indiana total income;

is entitled to a credit against the taxpayer's adjusted gross income tax liability for the taxable year in the amount determined in section 6 of this chapter.

Sec. 6. The credit authorized under section 5 of this chapter is equal to three and four-tenths percent (3.4%) of:

- (1) twelve thousand dollars (\$12,000); minus
- (2) the amount of the individual's Indiana total income.

If the credit amount exceeds the taxpayer's adjusted gross income tax liability for the taxable year, the excess shall be refunded to the taxpayer.

Sec. 7. (a) If a husband and wife file a joint Indiana income tax return for a year, a joint credit application must be used under this chapter for that year.

(b) If a husband and wife file separate Indiana income tax returns for a year, separate credit applications must be used under this chapter for that year.

Sec. 8. To obtain a credit under this chapter, a taxpayer must claim the credit on the taxpayer's annual state tax return or returns in the manner prescribed by the department of state revenue. The taxpayer shall submit to the department of state revenue all information that the department of state revenue determines is necessary for the calculation of the credit provided by this chapter.

Sec. 9. (a) The division of family and children shall apply the refundable portion of the credits provided under this chapter as expenditures toward Indiana's maintenance of effort under the federal Temporary Assistance to Needy Families (TANF) program (45 CFR 265).

(b) The department of state revenue shall collect and provide the data requested by the division of family and children that is necessary to comply with this section.

Sec. 10. This chapter expires December 31, 2001.

SECTION 228. IC 6-3-2.5 IS REPEALED [EFFECTIVE JANUARY 1, 1999 (RETROACTIVE)].

SECTION 229. [EFFECTIVE JANUARY 1, 1999 (RETROACTIVE)] IC 6-3.1-21, as added by this act, applies to taxable years beginning after December 31, 1998.

SECTION 230. IC 21-6.1-2-9 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 9. (a) The board shall determine the funds undistributed income reserve as of June 30, 1998, and, under the fund's actuarial valuation as of June 30, 1998, shall allocate the reserve effective July 1, 1998. Thereafter, the board shall do the



following:

- (1) First credit interest to the members' annuity savings accounts in the guaranteed fund and actual earnings to the alternative investment programs.
 - (2) After complying with subdivision (1), distribute an amount up to the interest credit rate (but not to exceed any remaining earnings) to the reserve accounts.
 - (3) After complying with subdivisions (1) and (2), distribute any remaining undistributed income reserve as of the end of each fiscal year on a pro rata basis (based on fiscal year beginning balances) to all reserve accounts in the pre-1996 account, including the pension stabilization fund, and in the 1996 account.
- (b) Income may not be distributed under subsection (a)(2) or (a)(3) to the following:
- (1) Members' annuity savings accounts in the guaranteed fund or the alternative investment program.
 - (2) The annuity reserve for benefits-in-force.

SECTION 231. IC 5-10-1.1-1.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE **JULY** 1, 1999]: Sec. 1.5. (a) The state, through the budget agency, may adopt a defined contribution plan, under Section 401(a) of the Internal Revenue Code, for the purpose of matching all or a specified portion of state employees' contributions to the state employees' deferred compensation plan.

(b) The deferred compensation committee shall be the trustee of a plan established under subsection (a) as described in section 4 of this chapter. A plan established under subsection (a) shall be administered by the auditor of state as described in section 5 of this chapter.

(c) The deferred compensation committee may approve funding offerings for a plan established under subsection (a), which may be the same as offerings for the state employees' deferred compensation plan. All funds in each plan shall be separately accounted for but may be commingled for investment purposes.

(d) Contributions to a plan established under subsection (a) are limited to the amount of biennial appropriations made for that purpose.

(e) A plan established under subsection (a) must include appropriate provisions concerning the plan's day to day operation and any other provisions that are appropriate. Notwithstanding IC 22-2-6-2, the plan may also include provisions for the use of automated voice response units and telephonic communications, online activities, and other technology for participant elections, directions, and services if the technology has sufficient capacity to record and store the elections and directions,

(f) The state is obligated at any particular time only for the current market value of the funding previously made to a plan established under subsection (a).

SECTION 232. IC 4-12-1-14.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 14.3 There is hereby created the tobacco settlement fund for the purpose of depositing money received by the state from the master settlement agreement with the United States' tobacco product manufacturers. The fund shall be administered by the budget agency. The treasurer of state shall invest the money in the fund not currently needed to meet the obligations of the fund in the same manner as other public money is invested. Interest that accrues from these investments shall be deposited in the fund. Money in the fund at the end of the state fiscal year does not revert to the state general fund.

SECTION 233. [EFFECTIVE UPON PASSAGE] If any provision of this act or its application to any person or circumstance is held invalid, the invalidity of that provision does not affect other provisions of this act that can be given effect without the invalid provision.

SECTION 234. An emergency is declared for this act.



President of Senate

President Pro Tempore

Speaker of the House of Representatives

Approved: _____

Governor of the State of Indiana

(Attachment C)

CHIP Benefit Package

Service	Indiana Medicaid Benefits	CHIP Benefit Package
Inpatient Hospital Services*	Inpatient and outpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the recipient's condition. Does not include services that are not medically or clinically reasonable or necessary; post-stabilization services that are not prior authorized; experimental services; personal comfort or convenience items; services for remediation or learning disabilities; amphetamines when prescribed for weight control; fallopian tuboplasty for infertility or vasovasostomy; air fluidized suspension type hospital beds; cybex services; autopsy; cryosurgery for chloasma; contrast dye injection	Inpatient and outpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the recipient's condition. Coverage is subject to the same limitations as Medicaid.
Outpatient Hospital Services**	supervision; day care or partial day care or partial hospitalization; pulmonary exercises and rehabilitation programs; cognitive rehabilitation; telephone consultation; nonlegend stop smoking aids; artificial insemination; private duty nursing.	
Rural Health Clinics	Reimbursement available for services provided by a physician, nurse practitioner, or appropriately licensed, certified, or registered therapist employed by the rural health clinic.	Reimbursement available for services provided by a physician, nurse practitioner, or appropriately licensed, certified, or registered therapist employed by the rural health clinic.
Federally Qualified Health Centers (FQHCs)	Reimbursement available for medically necessary services provided by licensed health care practitioners.	Reimbursement available for medically necessary services provided by licensed health care practitioners.
Laboratory and Radiology Services*	Must be ordered by a physician.	Must be ordered by a physician.
Nurse Practitioners	Reimbursement is available for medically necessary services or preventative health care services provided by a licensed, certified nurse practitioner within the scope of the applicable license and certification.	Reimbursement is available for medically necessary services or preventative health care services provided by a licensed, certified nurse practitioner within the scope of the applicable license and certification.
Early Intervention Services*	The Indiana EPSDT program includes initial and periodic screenings, and treatment services in accordance with the Health Watch EPSDT periodicity and screening schedule. Covers comprehensive health and development history, comprehensive physical exam, appropriate immunizations, laboratory tests, health education, vision services, dental services, hearing services, and other necessary health care services.	Covers immunizations, and initial and periodic Screenings according to the Health Watch EPSDT periodicity and Screening schedule. Coverage of treatment services is subject to the CHIP benefit package coverage limitations.
Family planning services and supplies	Provided with limitations.	Provided with limitations.

(Attachment C)

CHIP Benefit Package

Service	Indiana Medicaid Benefits	CHIP Benefit Package
Physicians' surgical and medical services**	Covers reasonable services provided by a M.D. or D.O. for diagnostic, preventive, therapeutic, rehabilitative or palliative services provided within scope of practice. Prior approval required for services not provided directly by M.D. or D.O. Will not reimburse for preparation of reports; missed appointments; writing or telephoning prescriptions to pharmacies; telephone calls to laboratories; after-hours services. PMP office visits limited to a maximum of 30 per year per recipient without prior authorization.	Covers reasonable services provided by M.D. or D.O. for diagnostic, preventive, therapeutic, rehabilitative or palliative services provided within scope of practice. Prior approval required for services not provided directly by a M.D. or D.O.. Will not reimburse for preparation of reports; missed appointments; writing or telephoning prescriptions to pharmacies; telephone calls to laboratories; after-hours services. PMP office visits limited to a maximum of 30 per year per recipient without prior authorization.
Nurse-midwife services	Reimbursement is available for services rendered by a certified nurse-midwife when referred by a PMP. Coverage of certified nurse-midwife services is restricted to services that the nurse-midwife is legally authorized to perform.	Reimbursement is available for services rendered by a certified nurse-midwife when referred by a PMP. Coverage of certified nurse-midwife services is restricted to services that the nurse-midwife is legally authorized to perform.
Podiatrists	No more than 6 routine foot care visits per year are covered.	Surgical procedures involving the foot, laboratory or x-ray services, and hospital stays are covered when medically necessary.
Optometrists*	Reimbursement for the initial vision care examination will be limited to one (1) examination per year for a recipient under nineteen (19) years of age unless more frequent care is medically necessary. Optical supplies covered when prescribed by ophthalmologist or optometrist.	Reimbursement for the initial vision care examination will be limited to one (1) examination per year for a recipient under nineteen (19) years of age unless more frequent care is medically necessary. Optical supplies covered when prescribed by ophthalmologist or optometrist.
Eyeglasses'	Reimbursement for eyeglasses, including frames and lenses, will be limited to a maximum of one (1) pair per year except when a specified minimum prescription change makes additional coverage medically necessary. Repairs or replacements of eyeglasses will be reimbursed only after receiving documentation that the repair or replacement is necessary due to extenuating circumstances beyond the recipient's control, for example, fire, theft, or automobile accident. Reimbursement will be made for frames, including, but not limited to, plastic or metal. The maximum amount reimbursed for frames is twenty dollars (\$20) per pair except when medical necessity requires a more expensive frame. Contact lenses are covered only when medical necessity is documented and are not covered for cosmetic purposes.	Reimbursement for eyeglasses, including frames and lenses, will be limited to a maximum of one (1) pair per year except when a specified minimum prescription change makes additional coverage medically necessary. Repairs or replacements of eyeglasses will be reimbursed only after receiving documentation that the repair or replacement is necessary due to extenuating circumstances beyond the recipient's control, for example, fire, theft, or automobile accident. Reimbursement will be made for frames, including, but not limited to, plastic or metal. The maximum amount reimbursed for frames is twenty dollars (\$20) per pair except when medical necessity requires a more expensive frame. Contact lenses are covered only when medical necessity is documented and are not covered for cosmetic purposes.

**Prior Approval Always Required
*Prior Approval Required Under Certain Circumstances
'Federally Required CHIP Benefits

(Attachment C)

CHIP Benefit Package

Service	Indiana Medicaid Benefits	CHIP Benefit Package
Chiropractors*		
Home Health Services**	Reimbursement is available to home health agencies for skilled nursing services provided by a registered nurse or licensed practical nurse; home health aide services; physical, occupational, and respiratory therapy services; speech pathology services; and renal dialysis. Provided with limitations.	Reimbursement is available to home health agencies for skilled nursing services provided by a registered nurse or licensed practical nurse; home health aide services; physical, occupational, and respiratory therapy services; speech pathology services; and renal dialysis. Provided with limitations.
Medical supplies and equipment (includes prosthetic devices, implants, hearing aids, dentures, etc.)**	Medicaid reimbursement is available for medical supplies, equipment, and appliances suitable for use in the home. Coverage does not include equipment that basically serves comfort or convenience functions; physical fitness equipment; first aid or precautionary type equipment; self-help devices; training equipment; cosmetic equipment; adaptive or special equipment; air fluidized suspension beds; supportive foot devices or orthotics for the foot; motorized vehicles are covered only when the recipient is enrolled in a school, sheltered workshop, or work setting, or if the recipient is left alone for significant periods of time.	Covered when medically necessary. Maximum benefit of \$2,000 per year or \$5,000 per lifetime for durable medical equipment. Equipment may be purchased or leased depending on which is more cost-efficient.
Dental Services	Covers sealants, restorations and pulp caps. Either full mouth series radiographs or panorex is limited to one set per recipient every three years; bitewing, intra-oral, and extra-oral radiographs are limited to one set per recipient every twelve months; one comprehensive or detailed oral evaluation per lifetime; one periodic evaluation every six months; study models are not covered; mouth gum cultures and sensitivity tests are not covered; one topical application of fluoride every six months for patients eighteen months of age or older but younger than nineteen; periodontal root planing and scaling for recipients over three years of age and under twenty-one is limited to four units every two years; infection control not covered; palliative treatment of facial pain is limited to emergency treatment only; payment for office visits is not covered. In accordance with Federal law, all medically necessary dental services are provided for children under age twenty-one even if the service is not otherwise covered under the State Plan.	Covers sealants, restorations and pulp caps. Either full mouth series radiographs or panorex is limited to one set per recipient every three years; bitewing, intra-oral, and extra-oral radiographs are limited to one set per recipient every twelve months; one comprehensive or detailed oral evaluation per lifetime; one periodic evaluation every six months; study models are not covered; mouth gum cultures and sensitivity tests are not covered; one topical application of fluoride every six months for patients eighteen months of age or older but younger than nineteen; periodontal root planing and scaling for recipients over three years of age and under twenty-one is limited to four units every two years; infection control not covered; palliative treatment of facial pain is limited to emergency treatment only; payment for office visits is not covered. Like Medicaid, all medically necessary dental services are provided for CHIP children even if the service is not otherwise covered under CHIP.

**Prior Approval Always Required

*Prior Approval Required Under Certain Circumstances

† Federally Required CHIP Benefits

(Attachment C)

CHIP Benefit Package

Service	Indiana Medicaid Benefits	CHIP Benefit Package
Physical Therapy**	Must be ordered by M.D. or D.O. and provided by qualified therapist or assistant. Covered for no longer than two years. No more than one hour per day per type of therapy. Not to exceed twelve hours per 30 calendar days.	Must be ordered by M.D. or D.O. and provided by qualified therapist or assistant. Maximum of 50 visits per year per type of therapy.
Speech, Hearing and Language Disorders.	Prior authorization not required for initial evaluations. Evaluations and reevaluations limited to three hours of service per evaluation.	
Occupational Therapy**	Must be performed by registered occupational therapist or assistant under direct supervision. Evaluations and reevaluations limited to three hours of service per evaluation. May continue for a period not to exceed twelve hours in thirty calendar days.	
Respiratory therapy'	Prior authorization not required for inpatient or outpatient hospital, emergency, oxygen in nursing facility, thirty days following discharge from hospital when ordered by physician prior to discharge.	
Prescribed (Legend) Drugs'	Agents to promote weight loss, topical monoxidil, fertility enhancement drugs, and drugs for cosmetic purposes not covered.	Agents to promote weight loss, topical monoxidil, fertility enhancement drugs, and drugs for cosmetic purposes not covered. Insulin, a non-legend drug, will also be covered.
Inpatient Rehabilitative Services**	Prior authorization is required. Educational services not covered.	Covered up to 50 days per calendar year. Prior authorization is required. Educational services not covered.'
Outpatient mental health/substance abuse services*	Includes mental health services provided by physicians, psychiatric wings of acute care hospitals, outpatient mental health facilities and psychologists endorsed as Health Services Providers in Psychology. Office visits limited to a maximum of 4 per month or 20 per year per recipient without prior approval.	Covers outpatient mental health/substance abuse services when the services are medically necessary for the diagnosis or treatment of the recipient's condition except when provided in an institution for mental diseases. Office visits limited to a maximum of 30 per year per recipient without prior approval to a maximum of 50 visits per year.
Inpatient mental health/substance abuse services**	Each patient admitted must have an individually developed plan of care developed by the physician and interdisciplinary team. Plan of care must be reviewed and updated every thirty days by the interdisciplinary team. Recertification is required every 60 days.	Inpatient mental health/substance abuse services are covered when the services are medically necessary for the diagnosis or treatment of the recipient's condition except when they are provided in an institution for mental diseases with more than 16 beds.

**Prior Approval Always Required

*Prior Approval Required Under Certain Circumstances

'Federally Required CHIP Benefits

(Attachment C)

CHIP Benefit Package

Service	Indiana Medical Benefits	CHIP Benefit Package
Hospice care ¹	Must be expected to die from illness within six months. Coverage of two consecutive periods of 90 days followed by an unlimited number of periods of 60 days.	Must be expected to die from illness within six months. Coverage of two consecutive periods of 90 days followed by an unlimited number of periods of 60 days.
Emergency Transportation.	No limit or prior approval for emergency ambulance or trips to/from hospital for inpatient admission/discharge.	Covers emergency ambulance transportation using the prudent layperson standard as defined in state insurance law I.C. 27-13-1-11.7. Ambulance services for non-emergencies between medical facilities are covered when requested by a participating physician.
Diabetes Self Management Training Services ²	Limited to 16 units per recipient per year. Additional units may be prior authorized.	Limited to 16 units per recipient per year. Additional units may be prior authorized.
Out-of-state Medical Services ³	Covers acute general hospital care; physician services; dental services; pharmacy services; transportation services; therapy services; podiatry services; chiropractic services; durable medical equipment and supplies.	Covers acute general hospital care; physician services; dental services; pharmacy services; transportation services; therapy services; podiatry services; chiropractic services; durable medical equipment and supplies. Coverage is subject to any limitations included in the CHIP benefit package.
Orthodontics	When medically necessary.	When medically necessary.
Food Supplements, Nutritional Supplements, and Infant Formulas ⁴	Covered only when no other means of nutrition is feasible or reasonable. Not available in cases of routine or ordinary nutritional needs.	Covered only when no other means of nutrition is feasible or reasonable. Not available in cases of routine or ordinary nutritional needs.

¹prior Approval Always Required
²prior Approval Required Under Certain Circumstances
³Federally Required CHIP Benefits