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**To:** "ctarver@hcfa.gov"  
**Date:** 11/30/99 6:06pm  
**Subject:** Indiana State Plan Amendment Conf Call 11/30/99

Please find attached the revised pages of Indiana's State Plan Amendment as discussed during this morning's conference call. The changes are highlighted in bold.

Please note that this document does not address the issue of SSNs under CHIP as mentioned in Section 4.3. It is our understanding that someone will be following-up with Cindy Stamper on that issue.

A copy of the most recent Hoosier Healthwise members questionnaire will be sent to you tomorrow via courier.

Please feel free to contact me if you have any questions about this document or require any additional information.

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**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. **A family may change their child's PMP at any time with cause (including auto-assignment), and every six months without cause.**

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. **The 1941 PMPs who are currently enrolled throughout the state include the almost 110 PMPs who have joined the Hoosier Healthwise program between June of 1998 and June of 1999.** 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 II) 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. **Eligibility will begin the first day of the month that the application was received by the enrollment center or the DFC.** 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. **The CHIP program will monitor CHIP enrollment and keep the Governor's Office, the State Budget**

\*

**Agency and the General Assembly apprised. If enrollment were to be restricted due to insufficient resources, children would be enrolled in the program in the order that their application was received. Since children in families with incomes up to 150 percent of federal poverty level (FPL) are enrolled in the Phase I Medicaid expansion, they would not be subject to a waiting list, if such a situation were to arise. As such, children in families with lower incomes would be given special protection and preference.**

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.

**Indiana is using the same application for Medicaid and CHIP. However, while Social Security numbers are required for Medicaid, they are not required for the CHIP program. Thus, CHIP eligibility will not be denied if a Social Security number is not included on the application.**

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.

- 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 4 0 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.

**Targeted low-income children who are American Indians or Alaskan Natives as defined in the Indian Health Care Improvement Act, 25 USC 1603(c), are not subject to any cost-sharing. Indiana will put into place a manual system override procedure to ensure that American Indian and Alaskan Natives do not pay any cost sharing. A local DFC supervisor will delete the system-created eligibility category and manually create the category usually used for children who are eligible for the CHIP Medicaid expansion. In this category, the children will not be subject to any cost-sharing. A permanent solution that does not require this manual intervention and inappropriate category placement will be pursued.**

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.

**Indiana does not have a significant population that speaks any language other than English or Spanish. Issues regarding other languages would be handled locally, should they arise. The Hoosier Healthwise Helpline utilizes the AT&T language line to address any language barriers. Also, the State has contracted with the Wishard Hispanic Health Access Initiative to foster communication between the State and Indiana's Hispanic population, which resides primarily in Indianapolis,**

**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.

<b>9.1 Strategic Objective</b>	<b>9.2 Performance Goal</b>	<b>9.3 Objective Means of Measuring Performance</b>
<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 services.</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-child services.</p>
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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:

Currently, Indiana is using state-designed focus studies to measure the percentage of Hoosier Healthwise enrollees who receive preventive services. These focus studies were designed as measurement tools when HEDIS measures for Medicaid were still in their infancy. Data is obtained through chart and administrative reviews. The stated-designed focus studies address some of the HEDIS measures and provide additional levels of detail. HEDIS measures will be used once the State begins to examine medical records of children who enroll in Hoosier Healthwise in calendar year 1999. This review will begin in year 2000. Since HEDIS measures have evolved in a way that makes them comparable to state-designed studies, the data from the focus studies and the data from the HEDIS measures should be consistent.

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.
- 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.
- 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.

- 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.
- 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, 2002)**

	FFY 1999	FFY 2000	FFY 2001	FFY 2002
<b>BENEFIT COSTS</b>				
Insurance Payments				
Managed Care	63,434,880	79,292,160	99,118,080	117,702,720
Per member per month @ # of eligibles	146.84 per month @ 36,000 (Phase I)	137.66 per month @ 48,000 (36,000 in Phase I and 12,000 beginning January 1,2000)	129.06 per month @ 64,000 (36,000 in Phase I and 28,000 in Phase II)	129.06 per month @ 76,000 (36,000 in Phase I and 40,000 in Phase II)
Fee for Service	0	0	0	0
<b>TOTAL BENEFIT COSTS</b>	63,434,880	79,292,160	99,118,080	117,702,720
(Offsetting beneficiary cost sharing payments)	0	1,188,000	3,696,000	5,280,000
<b>Net Benefit Costs</b>	<b>63,434,880</b>	<b>78,104,160</b>	<b>95,422,080</b>	<b>112,422,720</b>
<b>ADMINISTRATION COSTS</b>				
Personnel	130,000	385,000	400,000	420,000
General Administration	1,658,000	3,615,000	3,625,000	3,806,250
Contractors/ Brokers (enrollment centers)	600,000	1,385,000	1,285,000	1,349,250
Claims Processing	540,000	1,165,000	865,000	908,250
Outreach/ Marketing Costs	0	100,000	100,000	105,000
Other	0	1,146,000	146,000	153,300

TOTAL ADMIN COSTS	2,928,000	7,796,000	6,421,000	6,742,050
10% Admin Cost Ceiling	0	0	0	0
Federal Share (Multiplied by enhanced-FMAP rate)	48,252,450	62,896,097	74,783,373.64	87,502,690.61
State Share	18,110,430	23,004,063	27,059,706.36	31,662,079.39
TOTAL PROGRAM COSTS	66,362,880	85,900,160	101,843,080	119,164,770

Notes:

1. The estimates for beneficiary cost-sharing payments were based on an average of **\$11** per month per beneficiary enrolled in CHIP Phase II. Although the monthly premium amount for one child is either **\$11** or **\$16.50** depending on family income, an average of **\$11** was used to calculate the cost-sharing offset because families with more than one child enrolled will only be required to pay an annual one-third of the cost for a second child and there will be no additional cost for more than two children.
  2. 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.
  3. An enhanced FMAP rate of 73.43 percent was used to calculate the federal match for FFY **2001** and FFY **2002**. This is the preliminary estimate for FFY **2001** provided by HHS.
- It was anticipated that during the first year of CHIP Phase I benefit costs would be higher than in subsequent years as a result of pent-up demand and adverse selection. Therefore, the estimated per member per month benefit costs are higher in FFY **1999** than in subsequent years. Similarly, it is anticipated that benefit costs will be higher during the first year of CHIP Phase II than in subsequent years due to pent-up demand and adverse selection. Thus, benefit costs should decrease during FFY **2001** and FFY **2002** as more healthy children enroll.

***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.

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## IMPORTANT INFORMATION ABOUT HOOSIER HEALTHWISE

### I. The Benefits of Hoosier Healthwise and How your Eligibility will be Determined

There are 4 Benefit Packages as explained below. We will determine your eligibility for the most benefits possible based on your situation and family income. If you are applying for Hoosier Healthwise for your children, we will ask you to agree to pay the premiums and co-payment amounts that are required for Package C. If you do not agree to do this, we will still check eligibility for the premium-free plans.

◆ Package A – Standard Plan

Provides comprehensive health care coverage to eligible adults and children. There are no premiums.

◆ Package B – Pregnancy Coverage

Provides coverage for pre-natal care, treatment of conditions that may complicate the pregnancy, delivery, and 60 days of after-pregnancy care. There are no premiums.

◆ Package C – Children's Health Plan

Provides comprehensive health care coverage for children under age 19. There is a premium based on family income and the number of children covered. If one child is covered, the premium will be at least \$11.00, but not more than \$16.50 per month. If two or more children are covered, the premium will be at least \$16.50 but not more than \$24.75 per month. Premiums can be paid quarterly at a 5% savings or annually at a 10% savings. When children are approved for the Children's Health Plan, we send a notice that tells the amount of the premium. When you receive your first bill, you decide how often you want to pay the premium.

◆ Package E – Emergency Services Only

Provides coverage for treatment of serious medical emergencies. This plan is for certain immigrants, such as those who are in the United States without lawful papers from the Immigration and Naturalization Service.

### II. Your Rights and Responsibilities as a Hoosier Healthwise Applicant and Member

1. Eligibility for benefits is considered without any regard to race, color, creed, sex, age, disability, national origin, or political belief. We ask about your racial-ethnic heritage to comply with the Federal Civil Rights Law, however you are not required to provide this information.
2. Certain information given on your application, such as your income, must be verified. If you cannot get the necessary papers, you will need to sign a release form so that we can get them for you.
3. You must provide accurate information. A person who gives false information or misrepresents the truth is committing a crime and can be prosecuted under federal law or state law, or both. The value of

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benefits received by a person who was not entitled to receive them must be repaid to the Hoosier Healthwise program.

4. Information you give is kept confidential under state and federal law.
5. If you move, please tell us your new address so that important mail about your application and membership will reach you without delay. Also, tell us if you become covered under other health insurance. Your interviewer will tell you more about reporting changes to the information you give on your application.
6. A Social Security Number must be given for each applicant. An applicant who does not have a number must apply for one. Exception: This requirement does not apply to children who qualify for health coverage under Benefit Package C.

The number(s) you provide will be used to check information kept by the Social Security Administration, the Internal Revenue Service, Workforce Development, and other state and federal agencies. This is required by Section 1137 of the Social Security Act. We ask for the Social Security Numbers of family members, however, it is not required that you provide them.

7. We will send you a notice telling you the decision on your application. You may request a fair hearing if you disagree with any decision about your eligibility, or if your application is not processed within 45 days.
8. The immigration status of non-citizens who are applying for health coverage is subject to verification by the Immigration and Naturalization Service (INS). However, the Hoosier Healthwise Program does not report undocumented immigrants to the INS.
9. PLEASE CAREFULLY READ THE FOLLOWING ABOUT ASSIGNMENT OF MEDICAL RIGHTS AND ESTABLISHMENT OF PATERNITY. *Ask your interviewer if you have any questions.*

An important service that is available to members under Package A and B is that you will be able to have paternity established (if applicable) for eligible children at no cost to you. This service is not available for children who are found eligible for Package C. We will ask for information about the non-custodial parent and then forward it to the Child Support Office of your County Prosecutor. They will contact you about the steps that will take place in order to have paternity established. If you believe that cooperating in having paternity established will cause physical or emotional harm to the children, you may ask to be excused from this requirement.

If you receive a medical insurance payment or personal injury settlement, you must repay the Hoosier Healthwise program for any expenses it paid.

***Your children's eligibility for Hoosier Healthwise will not be affected if you do not cooperate in establishing paternity or do not sign the medical assignment on the application.***

10. FOR MEMBERS ENTITLED UNDER PACKAGE C - THE CHILDREN'S HEALTH PLAN, there is cap on the amount of cost-sharing that you will have to pay. This amount is 5% of your annual income before taxes. It is your responsibility to keep track of the amount of premiums and co-payments you pay. If you reach the cap, you will need to contact the Office of Family and Children and provide your receipts so that you will no longer have to make payments.

# HOOSIER HEALTHWISE

## for Children & Pregnant Women

DRAFT

1931

1. Tell us about the members of your family living in your household. Put your name first, and list only children, spouses, and parents. **Place a ✓ in the last column if that person is applying for health coverage.**

Name (First, MI, Last)	Date of Birth	Social Security Number <i>(Required for applicants otherwise optional)</i>	Marital Status	Race	Sex	Relationship to You	Citizen of U.S. Yes / No / ?	✓ if applying
							<i>(Required for applicants otherwise optional)</i>	

*Put names*

Home address	City	State	Zipcode	County	Telephone
Mailing address, if different	City	State	Zipcode	County	Other contact number

Name of expecting mother	Date Pregnancy Began	Due Date	Number of unborn babies

Name of applicant	Blind	Disabled	Name and Address of the doctor

Completed by Enrollment Center:	Date of application:	Center's Code:	Interviewer:
Completed by DFC:	Date received:	Case Number:	

9. Tell us how much work income you and other members of your family make.

Name of person working _____	Start Date: _____
Start Date: _____	Start Date: _____
How often Paid? Weekly Bi/weekly Monthly Twice a Month	How often paid? Weekly Bi/weekly Monthly Twice a month.
Amount of Gross Pay Per Pay Period: _____	_____
Do hours vary? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is person self-employed? Yes No	Is person self-employed? Yes No
Employer name and phone number _____	Employer name and phone number _____

Name of the Person Receiving the Payments	What Type (from above)	How Often are Payments Received	When did Payments Begin	Amount of the Payments

11. Was the household income in the prior 3 months the same as it is now? Yes No If no, please explain:

12. Do you pay for child care?  Yes  No Do you pay for care of an incapacitated adult?  Yes  No

13. Does anyone living in the household pay support payments? Yes No

14. Assignment of rights

I hereby assign to the state of Indiana, my rights to medical support and payments for medical care, which I have on behalf of myself and other persons under this application whose rights I can legally assign.

Signature: \_\_\_\_\_

15. Please read the following statements and initial if you agree, and sign your application below.

\_\_\_\_ I certify under penalty of perjury, that all of the information I have provided is complete and correct to the best of my knowledge and belief and that I have received the notice entitled "Important Information about Hoosier Healthwise" and understand what it states.

\_\_\_\_ If the children applying for health coverage on this application, are found to qualify for Package C - Children's Health Plan, I agree to pay the premiums and co-payments that are required.

Your Signature : \_\_\_\_\_ Date: \_\_\_\_\_

Signature of witness if signed with "X": \_\_\_\_\_

*All Hoosier Healthwise members need to choose a primary care doctor.  
To choose a doctor or to find out more about the doctors in your area, call the  
Hoosier Healthwise Helpline at 1-800-889-9949*

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◆ Package A – Standard Plan

Provides comprehensive health care coverage to eligible adults and children. There **are** no premiums.

◆ Package B – Pregnancy Coverage

Provides coverage for pre-natal care, treatment of conditions that may complicate the pregnancy, delivery, and 60 days of after-pregnancy care. There **are** no premiums.

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1. Eligibility for benefits is considered without **any** regard to race, color, creed, sex, age, disability, national **origin**, or political belief. We ask about your racial-ethnic heritage to comply with the Federal Civil Rights Law, however you are not required to provide this **information**.
2. Certain **information** given on **your** application, such **as your** income, must be verified. If you cannot **get the necessary** papers, you will need to sign a release **form** so that we **can** get **them** for you.
3. **You** must provide accurate information. **A** person who gives false information or misrepresents the **truth** is committing a **crime** and **can** be prosecuted under federal law or state law, or both. The value

APPLICATION FOR HOOSIER HEALTHWISE  
FOR CHILDREN AND PREGNANT WOMEN

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of benefits received by a person who was not entitled to receive them must be repaid to the Hoosier Healthwise program.

4. Information you give is kept confidential under state and federal law.
5. **If** you move, please tell **us** your new address so that important mail about your application **and** membership will reach **you** without delay. Also, tell us if you become covered under other health insurance. **Your** interviewer will tell you more about reporting changes to the information **you** give on your application.
6. A Social Security Number **must be given** for each applicant. Anyone who does not have a number must apply for one. The **number(s)** you provide will be used to check information kept by the Social Security Administration, the Internal Revenue Service, Workforce Development, and other state and federal agencies. This is **required** by Section 1137 of the Social Security Act.
7. We will send you a notice telling you the decision on **your** application. You may request a fair hearing **if** you disagree with any decision about your eligibility, or if your application is not processed **within 45** days.
8. The immigration status of non-citizens is subject to verification by the Immigration and Naturalization Service (**INS**). However, the Hoosier Healthwise Program does not report undocumented immigrants to the **INS**.
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