INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Introduction to the IHCP

LIBRARY REFERENCE NUMBER: PROMOD00001
PUBLISHED: FEBRUARY 13, 2017
POLICIES AND PROCEDURES AS OF AUGUST 1, 2016
(*Core*MMIS UPDATES AS OF FEBRUARY 13, 2017)
VERSION: 1.1

Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of August 1, 2016 (*Core*MMIS updates as of February 13, 2017) Published: February 13, 2017	Semiannual update: • Replaced Web interChange with Provider Healthcare Portal (Portal) and Automated Voice Response (AVR) with Interactive Voice Response (IVR) • Updated the customer assistance telephone number and added Saturday hours • Added the Portal option for submitting written correspondence • Updated information in the *Self-Referral Services* section • Clarified information in the *Provider Reimbursement Methodologies* section • Added subsections for *Division of Aging*, *Division of Disability and Rehabilitative Services*, and *Division of Mental Health and Addiction* • Updated the *Contractors* section, including changing ADVANTAGE reference to CMCS • Clarified information in the *OptumRx Provider Services* section • Updated the *Hewlett Packard Enterprise Provider Services* section and subsections	FSSA and HPE

Table of Contents

Overview

Indiana's Medicaid program, collectively referred to as the Indiana Health Coverage Programs (IHCP), provides a healthcare safety net for low-income children and adults, including those who are aged, disabled, blind, pregnant, or meet other eligibility requirements. The IHCP receives federal and State funds to operate the program and reimburse providers for reasonable and necessary medical care for eligible members. Each state administers its own Medicaid program within the provisions of federal legislation and broad federal guidelines issued by the Centers for Medicare & Medicaid Services (CMS). The Indiana Family and Social Services Administration (FSSA) administers the IHCP.

Information on IHCP services is available in the *Indiana Code* (IC) and *Indiana Administrative Code* (IAC), which are published online at in.gov. The administrative rules for the IHCP, including but not limited to member eligibility, provider types, and covered services, are published in Titles 405 and 407 of the IAC.

The *IHCP Provider Reference Modules* are the primary reference for billing and policy guidance for providers conducting business with the IHCP. Modules include instructions for submitting IHCP claims and prior authorization (PA) requests, as well as other related topics. All modules can be accessed on the *Provider Reference Materials* page of the IHCP provider website at indianamedicaid.com.

IHCP medical coverage and reimbursement policy is defined in the *Medical Policy Manual*, which is also available at indianamedicaid.com.

Additional resources on the website include:

- *IHCP Banner Pages*
- *IHCP Bulletins*
- News and announcements
- Fee Schedule
- Code tables
- Provider enrollment and profile maintenance packets
- Program descriptions
- Contact information
- Provider education opportunities
- Forms, including prior authorization request forms
- Provider Healthcare Portal (Portal)
- Electronic data interchange (EDI) information, including *IHCP Companion Guides* for *Health Insurance Portability and Accountability Act* (HIPAA) version 5010

Delivery Systems

The following sections describe the delivery systems the IHCP uses for administering Medicaid benefits and healthcare.

For information on specific IHCP programs and associated benefit packages, see the *Member Eligibility and Benefit Coverage* module.

Fee-for-Service

The fee-for-service (FFS) delivery system reimburses providers on a per-service basis. Providers bill the appropriate IHCP claim-processing contractor for services rendered to members under the FFS delivery system – OptumRx for pharmacy services and Hewlett Packard Enterprise for all other services.

Managed Care

The State has mandated a managed care delivery system for members enrolled in the Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise. Under the managed care system, members are enrolled with a managed care entity (MCE), which is responsible for the members' healthcare services. Each MCE maintains its own provider network, provider services unit, and member services unit.

The MCE pays claims, performs PA, and is responsible for subrogation activities. The MCE with which the member is enrolled should be contacted for specific billing, PA, and reimbursement policies and guidelines. Providers can find a member's assigned MCE by checking the member's eligibility in the Portal. For MCE contact information, see the *IHCP Quick Reference Guide*, available at indianamedicaid.com.

All providers wanting to offer services to HIP, Hoosier Care Connect, or Hoosier Healthwise members must first enroll with the IHCP prior to contracting with the MCEs. Providers rendering services to a member enrolled with an MCE must be contracted with the MCE assigned to the member. This provision also includes out-of-state providers. See the *Provider Enrollment* module for details.

Managed Care Service Carve-Outs

The MCE is responsible for the delivery and payment of most care for its members; however, certain services are not paid by the MCE. These services, referred to as *carved-out services*, are billed for reimbursement as FFS claims. See the *Claim Submission and Processing* module and the individual service-specific modules for more information about carved-out services. MCEs must provide care coordination and associated services related to carved-out services, including, but not limited to, transportation.

Self-Referral Services

Most services in managed care require referral from a primary medical provider (PMP). Self-referral services are an exception. The MCE reimburses for the following self-referral services without a PMP referral:

- Chiropractic services
- Podiatry services
- Routine eye care services (except eye care surgical services)
- Diabetes self-management training (DSMT) services rendered by a chiropractor, podiatrist, optometrist, or psychiatrist
- Immunizations

- Family planning services
- Services rendered for the treatment of a true medical emergency
- Urgent care services (for HIP members only)
- Behavioral health services, such as mental health, psychiatric, substance abuse, and chemical dependency services

Members enrolled in managed care may self-refer to any IHCP-enrolled psychiatrist. Members may also self-refer to the following mental health providers *within the MCE's network*:

- Outpatient mental health clinics
- Community mental health centers (CMHCs)
- Psychologists
- Certified psychologists
- Health service providers in psychology (HSPPs)
- Certified social workers
- Certified clinical social workers
- Psychiatric nurses
- Independent practice school psychologists
- Advanced practice nurses, under *IC 25-23-1-1(b)(3)*, credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center
- Persons holding a master's degree in social work, marital and family therapy, or mental health counseling (under the clinic option)

Note:	*PMP referral is not the same as prior authorization. Contact the member's MCE to determine whether the service or procedure requires prior authorization. Self-referral services may be subject to benefit limitations; providers should contact the MCE for additional guidance.*

Provider Reimbursement Methodologies

The FFS claim-pricing process calculates the IHCP-allowed amount for claims based on claim type and defined pricing methodologies for each provider type. These pricing methodologies include the some of the following:

- Cost-based and case mix reimbursement
- Diagnosis-related group (DRG)
- Fee Schedule
- Manually priced
- Medicare and Medicare Replacement Plan, and IHCP crossover coinsurance and deductible
- Outpatient ambulatory surgical center (ASC) flat rate
- Resource-based relative value scale (RBRVS)

Details about these reimbursement methodologies are found in *405 IAC 1-8* through *405 IAC 1-11.5*. For reimbursement information related to specific provider types and services, see the appropriate provider reference module.

The IHCP Fee Schedule, available at indianamedicaid.com, contains a list of IHCP-covered Current Procedural Terminology (CPT®[1]) codes, Healthcare Common Procedure Coding System (HCPCS), and Current Dental Terminology (CDT®[2]) codes and includes indicators specific to each code, such as program coverage, reimbursement, and prior authorization. The Fee Schedule is searchable by keyword or code and can also be downloaded free of charge. The IHCP automatically updates the Fee Schedule each month or on demand.

> *Note:* *Under managed care, the MCEs reimburse in-network providers as stated in their provider contracts. In the absence of another arrangement, MCEs reimburse out-of-network providers according to FFS pricing methodologies. Providers should contact the MCE for managed care program reimbursement rates.*
>
> *For additional information about managed care reimbursement, contact the member's MCE. See the IHCP Quick Reference Guide, available at indianamedicaid.com, for contact information.*

State, Regional, and Contractor Responsibilities

This section outlines the responsibilities of the entities involved in administering the IHCP.

Family and Social Services Administration

The FSSA is the State agency responsible for administration of the IHCP, which requires coordination with a number of entities. This section outlines the primary agencies involved in program administration.

Office of Medicaid Policy and Planning

The FSSA Office of Medicaid Policy and Planning (OMPP) is responsible for the general planning and oversight of the IHCP, including coordination with program partners and contractors. The OMPP oversees the Medicaid State Plan, Medicaid waivers, and federal reporting. In addition, the OMPP establishes IHCP policy and manages IHCP contractor relationships.

Division of Family Resources

The FSSA Division of Family Resources (DFR) is responsible for determining eligibility for IHCP members, enrolling members in the appropriate program, and maintaining the eligibility files for the IHCP member population. A complete directory of local DFR offices is available on the FSSA website at in.gov/fssa.

Division of Aging

The FSSA Division of Aging is responsible for overseeing two 1915(c) home and community-based services (HCBS) waiver programs: the Aged and Disabled (A&D) Waiver and the Traumatic Brain Injury (TBI) Waiver. The Division of Aging is also responsible for administering the Money Follows the Person (MFP) demonstration grant.

Division of Disability and Rehabilitative Services

The FSSA Division of Disability and Rehabilitative Services (DDRS) manages the delivery of services to children and adults with intellectual and developmental disabilities. The DDRS administers two 1915(c) HCBS waiver programs: Family Supports Waiver (FSW) and Community Integration and Habilitation (CIH) Waiver.

Division of Mental Health and Addiction

The FSSA Division of Mental Health and Addiction (DMHA) administers one 1915(c) waiver program, the Psychiatric Residential Treatment Facility (PRTF) Waiver, and three 1915(i) State Plan HCBS programs: Adult Mental Health and Habilitation (AMHH), Behavioral and Primary Healthcare Coordination (BPHC), and Child Mental Health Wraparound (CMHW).

Contractors

The FSSA contracts with a fiscal agent and other entities to perform the day-to-day program functions associated with administration of the IHCP. The current contractors and responsibilities include the following:

- Hewlett Packard Enterprise – Fiscal agent
  - Fee-for-service (FFS) nonpharmacy claim adjudication
  - Member and provider customer service Provider enrollment
  - Provider relations
  - Managed care coordination
  - Third-party liability
  - Provider Healthcare Portal
- OptumRx – Pharmacy benefit manager (PBM), FFS pharmacy benefits
  - Pharmacy claim processing
  - Pharmacy-related prior authorizations
  - Pharmacy-related member and provider services
  - Drug rebate services
  - Pharmacy rate setting
  - Pharmacy-related claim audit functions
- Cooperative Managed Care Services (CMCS) – FFS PA administrator
  - FFS nonpharmacy prior authorizations
- MAXIMUS – Enrollment broker
  - HIP, Hoosier Care Connect, and Hoosier Healthwise member and provider helplines
  - Potential member program education
  - Counseling for health plan selection
  - MCE assignment for members who do not self-select an MCE
- Myers and Stauffer, LC – Rate-setting contractor
  - Nonpharmacy rate setting
  - Long-term care audits

- Anthem, Managed Health Services (MHS), and MDwise – MCEs for the managed care health plans (HIP, Hoosier Care Connect, and Hoosier Healthwise)
  - Utilization management and prior authorization
  - Establishing a provider network
  - Care management
  - Claim processing
  - Member and provider support
  - Community outreach
  - Provider education

Indiana State Department of Health

The Indiana State Department of Health (ISDH) is responsible for certifying the following provider types:

- Long-term care (LTC) facilities
- Intermediate care facilities for individuals with intellectual disability (ICFs/IID)
- Pediatric nursing facilities
- Residential care facilities
- Rehabilitation facilities
- Home health agencies
- Hospitals
- Rural health clinics (RHCs)
- Ambulatory surgical centers (ASCs)
- Laboratories
- Radiology centers (portable x-ray facilities)
- End-stage renal disease (ESRD) clinics
- Hospice facilities
- Outpatient physical therapy and speech language pathology (OPT/SP) facilities
- Comprehensive outpatient rehabilitation facilities (CORF)

Providers may contact the ISDH at the following address or telephone number:

Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

(317) 233-1325

Provider Services

Being responsive to the needs of IHCP providers is a primary emphasis for the IHCP. Entities contracted with the FSSA perform parallel provider services functions for providers in their respective networks.

MCE Provider Services

Each MCE contracted for HIP, Hoosier Care Connect, or Hoosier Healthwise maintains a provider services unit to address the concerns and questions of providers serving members in their health plans. The *IHCP Quick Reference Guide* at indianamedicaid.com includes contact information for these provider services units.

OptumRx Provider Services

OptumRx, the FFS pharmacy benefit manager (PBM), serves as the liaison between pharmacy providers and IHCP members for FFS programs and carved-out services. OptumRx maintains a provider services unit to address the concerns and questions of pharmacy providers rendering services to members in FFS programs, including the resolution of pharmacy-claim-processing issues. The *IHCP Quick Reference Guide* at indianamedicaid.com includes contact information for the OptumRx Clinical and Technical Help Desk where member and provider telephone inquiries should be directed.

Hewlett Packard Enterprise Provider Services

Hewlett Packard Enterprise, the IHCP fiscal agent, serves as the overall liaison between the provider and member communities for the IHCP. Hewlett Packard Enterprise performs provider services to address concerns and questions for providers conducting business with the IHCP, including the resolution of FFS nonpharmacy claim-processing issues. The following Hewlett Packard Enterprise business units perform provider services:

- Provider Enrollment Unit is responsible for provider enrollment, revalidation, and provider profile maintenance activities.
- Customer Assistance Unit is responsible for answering telephone inquiries.
- Written Correspondence Unit responds to inquiries submitted by mail or through the Portal from members and providers and performs administrative reviews as directed by the FSSA.
- Provider Relations Unit functions as the educational arm of the IHCP.

Provider Enrollment

The Provider Enrollment Unit performs the following key functions:

- Assesses provider eligibility through verification of licensure, certification, insurance, and approval documents required for enrollment. Enrollment requirements are based on provider type and specialty, and adhere to guidelines and rules set by federal and State regulations.
- Ensures that no enrolled provider is excluded from participation by the Office of the Inspector General (OIG), the CMS, or other federal or State agencies.
- Processes provider enrollment packets and profile maintenance forms.
- Deactivates enrolled providers that no longer meet State requirements for participation in the IHCP.
- Maintains provider files for all enrolled, denied, and terminated providers.

Enrollment analysts monitor enrollment activities from initial receipt of an enrollment application or provider profile update through final disposition.

IHCP enrollment applications and provider profile updates may be completed online using the Provider Healthcare Portal. Printable enrollment packets and profile maintenance forms are available on the *Become a Provider* page at indianamedicaid.com. For additional information about provider enrollment and profile maintenance, see the *Provider Enrollment* module or call Customer Assistance.

Customer Assistance

As the front line of communications with providers, Customer Assistance representatives quickly detect the impact of program policy and procedural changes through provider inquiries. Customer Assistance can be contacted toll-free at **1-800-457-4584**.

Live assistance is available 8 a.m. to 6 p.m. Eastern Time, Monday through Friday, and 8 a.m. to 1 p.m. Saturday, excluding holidays. Automated provider inquiries are available 24 hours per day through the Interactive Voice Response (IVR) system, which is accessed by selecting Option 2 for *providers*, followed by Option 5 for *all other provider inquiries*.

To assist with timely processing of inquiries, providers should consider the following guidelines when contacting the Customer Assistance Unit:

- Providers should not inquire about the status of a specific claim until at least 30 business days after submission. This length of time is generally considered reasonable to process a claim.
- For general claim status inquiries, providers can check the weekly Remittance Advice (RA) or inquire through the IVR system, Portal, or 276/277 claim status request and response transaction.
- To verify member eligibility, providers can inquire through the IVR system, Portal, or 270/271 health care eligibility benefit inquiry and response transaction.

> *Note:* *The IVR system allows providers to use a touch-tone telephone to access pertinent claim status information. The Portal allows providers to access claim status through the Internet. Both systems provide access 24 hours a day, seven days a week. Instructions for accessing these features are included in the Interactive Voice Response System and Provider Healthcare Portal modules.*
>
> *The 276/277 and 270/271 transactions are standardized, electronic data interchange (EDI) transactions. Data is sent and received in the same format for all providers. Additional information is available in the Electronic Data Interchange module and the IHCP Companion Guides at indianamedicaid.com.*

- When contacting Customer Assistance to request information about a claim, providers should be prepared with the following information:
  - Billing provider's 10-digit National Provider Identifier (NPI) or IHCP Provider ID
  - Full 9-digit ZIP Code (ZIP Code + 4) of the service location address
  - Facility name or practice name
  - Last four digits of the taxpayer identification number (TIN)
  - Member's name
  - Member's date of birth, Claim ID, or dates of service (including specification of the claim type, such as inpatient, outpatient, medical, dental, and so forth)
  - Amount billed
- If a provider speaks to a Customer Assistance representative, the provider should make a note of the date of the telephone call, the name of the representative who handled the call, and the contact tracking number (CTN). This information is helpful when a follow-up inquiry is necessary.

Written Correspondence

The Written Correspondence Unit is another link between the provider community and the IHCP. Providers should contact the Written Correspondence Unit for assistance with researching complex FFS claim denials or when the provider experiences difficulty receiving claim payment. Additionally, providers can contact the Written Correspondence Unit to obtain other information, including member benefit limit information and clarification of the IHCP rules and regulations.

Providers are encouraged to provide comprehensive information in their correspondence, including a clearly stated reason for the inquiry. Providers should also include any of the following items that are applicable:

- Copies of submitted claim forms (or printouts of Portal claims) and any documentation that was attached
- PA numbers or a copy of PA decision forms
- Copies of RA statements

This information provides necessary details and is helpful in formulating an accurate and complete response to the provider. The more information provided about the history of a particular issue, the more easily an analyst can reach the resolution.

Inquiries and supporting documentation can be submitted electronically through the Portal using the Secure Correspondence feature. Each message is assigned a CTN, which can be used to track the status of the correspondence. When the Written Correspondence analyst resolves the inquiry, a notification email is sent to the provider with a link to the page on the Portal where the response can be reviewed. See the *Provider Healthcare Portal* module for details.

Written inquiries can also be submitted by mail using the *Indiana Health Coverage Programs Written Inquiry* form, available on the *Forms* page at indianamedicaid.com. Using the inquiry form ensures that the Written Correspondence analyst has all the information necessary to conduct thorough research. Written inquiries should be sent to the following address:

HPE Provider Written Correspondence
P. O. Box 7263
Indianapolis, IN 46207-7263

Written Correspondence analysts will respond in writing to the provider within 10 business days of receiving the written inquiry. Responses are assigned a CTN that is important for tracking and should be referred to in subsequent correspondence with the IHCP about the issue.

Providers should not use Written Correspondence to check claim status. Claim status can be determined by checking RA statements or inquiring through the Portal, IVR system, or 276/277 claim status request and response transaction.

Providers should not use the Written Correspondence Unit for claim submission, unless specifically directed to do so.

Requests for Paper Remittance Advice

Providers should access the Portal to view or download a Remittance Advice. However, providers can request a paper RA from the Written Correspondence Unit in the following ways:

- Submit the request as a secure correspondence message through the Portal.
- Email the request to inxixwrittencorr@hpe.com.
- Mail the request either on provider letterhead or using the *Indiana Health Coverage Programs Written Inquiry* form, available on the *Forms* page at indianamedicaid.com

Requests for Administrative Review

The Written Correspondence Unit handles provider requests for administrative review of claim adjudication of all FFS nonpharmacy claims. See the *Claim Administrative Review and Appeals* module for more information.

Provider Relations

The Provider Relations Unit includes a team of regional field consultants that can assist providers through on-site visits. Consultants also offer on-site training to encourage the provider community to use the Portal and *Health Insurance Portability and Accountability Act* (HIPAA)-compliant electronic transactions, and to recruit new providers for the IHCP. Specific region assignments and contact information are available on the *Provider Relations Field Consultants* page at indianamedicaid.com or by calling Customer Assistance.

Provider relations field consultants have the following key responsibilities:

- Work directly with the provider community to provide education and ensure program and claim-processing understanding.
- Create a stable, interpersonal relationship with the providers in their assigned geographical territory.
- Work closely with the financial managers, administrators, and business leaders of the provider community to educate about IHCP policies and objectives, assist with resolving provider issues, and conduct training seminars. To ensure a successful training seminar or on-site visit, it is recommended that the following information is provided to assist the field consultant in structuring the meeting or presentation to best meet the needs of the audience:
  - Provider community segment attending the seminar
  - Number of attendees
  - Time and location of the event
  - Issues to be addressed
  - Point of contact, in case additional information is needed prior to the event

The Provider Relations Unit also coordinates the broader provider education component of the IHCP. In conjunction with other program contractors, the unit works to develop and present educational sessions about all aspects of the IHCP. Scheduled workshops are offered each quarter throughout the year, as well as at an annual seminar. Workshops are announced in IHCP provider bulletins and banner pages, provider association newsletters, and on the *Provider Education* page at indianamedicaid.com. Providers may register for workshops using the Workshop Registration link on the *Provider Education* page.

Provider Resources and Contact Information

Table 1 is designed to provide a quick reference for providers with questions about claims or programs, or in need of clarification on a specific topic.

Table 1 – Provider Resources

Provider Resource	How to Access Resource	When to Use Resource
Medical Policy Manual	View or download from the *Provider Reference Materials* page at indianamedicaid.com	Providers can refer to the *Medical Policy Manual* as the primary resource for IHCP coverage and reimbursement policies. Policy updates are announced in IHCP provider bulletins and added to the published manual at regular intervals.
IHCP Provider Reference Modules	View or download from the *Provider Reference Materials* page at indianamedicaid.com	Providers can refer to the *IHCP Provider Reference Modules* as a primary resource for claim submission and processing, prior authorization request procedures, and other related topics. These modules are the first referral source for answers to billing and other procedural questions. Updates to billing guidance and procedures are announced in IHCP banner pages and bulletins and added to the published reference modules at regular intervals.
IHCP website	indianamedicaid.com	Providers can access the website to obtain program information, such as the following: • *IHCP Banner Pages* • *IHCP Bulletins* • News and announcements • *IHCP Provider Reference Modules* • *Medical Policy Manual* • Fee Schedule • Code tables • Provider enrollment and profile maintenance packet • Program descriptions • Contact information • Provider education opportunities • Forms, including prior authorization request forms • Provider Healthcare Portal • EDI information, including *IHCP Companion Guides* for HIPAA version 5010
Customer Assistance	1-800-457-4584 Live assistance available 8 a.m. – 6 p.m. Eastern Time Monday through Friday and 8 a.m. to 1 p.m. Saturday, excluding holidays	Providers can contact the Customer Assistance Unit with telephone inquiries about IHCP claim processing, policy, covered services, provider enrollment, and updates to the provider file.

Provider Resource	How to Access Resource	When to Use Resource
Written Correspondence	HPE Provider Written Correspondence P.O. Box 7263 Indianapolis, IN 46207-7263 Or via secure correspondence on the Provider Healthcare Portal	Providers can contact the Written Correspondence Unit to address specific questions about the IHCP, for research on complex claims, to get claim-specific assistance, to request a paper RA, or to request administrative review of a claim.
Provider Relations	Field consultant assignments and voice mail extensions are available on the *Provider Relations Field Consultants* page at indianamedicaid.com or from Customer Assistance	Providers can contact field consultants for explanations of IHCP policies and objectives, assistance in resolving issues, and setting up training seminars and on-site visits.
IHCP Quick Reference Guide	View or download from indianamedicaid.com	Refer to this guide for telephone numbers, addresses, and online resources for various entities that support the IHCP.

Avenues of Resolution

The following tools are available to assist providers in resolving concerns related to various issues.

Coverage or Policy

For concerns related to IHCP coverage or policy, submit a *Request for Policy Consideration* form by email to Policyconsideration@fssa.in.gov. The form is available on the *Forms* page at indianamedicaid.com.

Reimbursement

To resolve problems or disagreements related to the denial or payment of FFS claims, see the *Claim Administrative Review and Appeals* module.

To resolve problems or disagreements related to managed care claims, see the grievance procedures established by the individual MCE.

Prior Authorization

To resolve problems associated with FFS prior authorizations, see the *Prior Authorization* module.

To resolve problems associated with managed care prior authorization, see the grievance procedures established by the individual MCE.

Provider or Member Fraud

To report Medicaid fraud or abuse, see the *IHCP Quick Reference Guide* at indianamedicaid.com for contact information. More information about provider or member fraud and abuse is available in the *Provider and Member Utilization Review* module.

Division of Family Resources

To resolve member eligibility problems involving caseworkers or supervisors, contact the FSSA call center or the local DFR office. See the directory of local DFR offices on the FSSA website at in.gov/fssa. The telephone number for the FSSA call center is 1-800-403-0864. This number also serves as the fax number for the Document Center. The address for the Document Center is:

FSSA Document Center
P.O. Box 1810
Marion, IN 46952

If a director does not respond to the complaint to the provider's satisfaction, the provider can write a letter providing facts to the DFR deputy director at the following address:

MS03
Deputy Director
Division of Family Resources
Family and Social Services Administration
402 West Washington Street, Room W392
Indianapolis, IN 46204

Providers should specify in the letter their attempts made to resolve the problem.

Civil Rights Requirements

All programs, services, and benefits administered, authorized, and participated in by the FSSA or the ISDH, its subgrantees, contractors, subcontractors, providers, or other participants are operated in accordance with the nondiscriminatory requirements pursuant to *Title VI* of the *Civil Rights Act of 1964*. The FSSA adheres to *Section 504* of the *Rehabilitation Act of 1973*, as amended, the *Age Discrimination Act of 1975*, and, where applicable, the *Omnibus Budget Reconciliation Act* (OBRA) *of 1981*. The following is observed:

> *No person or persons shall on the grounds of race, color, national origin, handicap, age, sex or religion, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program, service or benefit advocated, authorized or provided by this Office.*

According to a 1988 opinion by the Department of Justice, individuals with acquired immunodeficiency syndrome (AIDS) and individuals with asymptomatic human immunodeficiency virus (HIV) infection are protected under *Section 504* of the *Rehabilitation Act of 1973* as "qualified handicapped persons."

If a provider receives a complaint of an alleged violation of the *Civil Rights Act*, the provider must advise the FSSA of the complaint. Within 10 working days from the date the provider receives notification of a civil rights violation complaint, the provider must send a copy of the complaint to the following address:

MS15
Attn: Kelly Flynn
Civil Rights Plan Coordinator
Office of Medicaid Policy and Planning
402 West Washington Street, Room W374
Indianapolis, IN 46204

Each provider must display the *Civil Rights Compliance Policy Statement* (see Figure 1).

Providers must comply with federal law with regard to the *Patient Self-Determination Act* contained in the *OBRA of 1990*. This law requires that providers advise adult patients about the patient's right to determine treatment before they can no longer make healthcare decisions for themselves. The patient can express their choice in an *advance directive*.

Figure 1 – CMS Civil Rights Compliance Policy Statement

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)
CIVIL RIGHTS COMPLIANCE POLICY STATEMENT

The vision of the current Strategic Plan for the Centers for Medicare and Medicaid Services guarantees that all our beneficiaries will have equal access to the best health care. Pivotal to guaranteeing equal access is the integration of compliance with civil rights laws into the fabric of all CMS program operations and activities. I want to emphasize my personal commitment to and responsibility for ensuring compliance with civil rights laws by recipients of CMS funds. These laws include Title VI of the Civil Rights Act, as amended, Section 504 of the Rehabilitation Act, as amended, the Age Discrimination Act of 1975, as amended, the Americans with Disabilities Act of 1990, as amended, and Title IX of the Education Amendments of 1972, as well as other related laws. The responsibility for ensuring compliance with these laws is shared by all CMS operating components. Promoting attention to and CMS program compliance with civil rights laws are among my highest priorities for CMS, its employees, contractors, State agencies, health care providers, and all other partners directly involved in the administration of CMS programs.

CMS, as the agency legislatively charged with administering the Medicare, Medicaid and Children's Health Insurance Programs, is thereby charged with ensuring these programs do not engage in discriminatory actions on the basis of race, color, national origin, age, sex or disability.

With your help, CMS continues to ensure that persons are not excluded from participation in or denied the benefits of its programs because of prohibited discrimination.

To achieve its civil rights goals, CMS will continue to incorporate civil rights concerns into the culture of our agency and its programs, and we ask that all our partners do the same. We will include civil rights concerns in the regular program review and audit activities: collecting data on access to, and the participation of, minority and disabled persons in our programs; furnishing information to recipients and contractors about civil rights compliance reviewing CMS publications, program regulations, directives and instructions to assure support for civil rights, and working closely with the Department of Health and Human Services (DHHS), Office for Civil Rights, to initiate orientation and training programs on civil rights. CMS will also allocate financial resources, to the extent feasible, to ensure equal access, to prevent discrimination, and to assist in the remedy of past acts adversely affecting persons on the basis of race, color, national origin, age, sex or disability.

DHHS will seek voluntary compliance to resolve issues of discrimination whenever it is possible. If necessary, CMS will refer matters to the Office for Civil Rights for appropriate handling. In order to enforce civil rights laws, the Office for Civil Rights may: 1) refer matters for an administrative hearing which could lead to suspending, terminating or refusing to grant or continue Federal financial assistance; or 2) refer the matter to the Department of Justice for legal action.

CMS' mission is to assure health care security for the diverse population that constitutes our nation's Medicare and Medicaid beneficiaries, i.e., our customers. We will enhance our communication with constituents, partners and stakeholders. In so doing, we will seek input from health care providers, states, contractors, the DHHS Office for Civil Rights, professional organizations, community advocates and program beneficiaries. We will continue to vigorously assure that all Medicare and Medicaid beneficiaries have equal access to and receive the best health care possible, regardless of race, color, national origin, age, sex or disability.